

"Crisis is often when it comes out":

CATS workers' experiences of sexual
assault disclosures in crisis
psychiatric settings.

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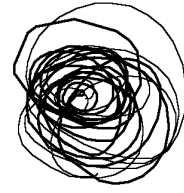
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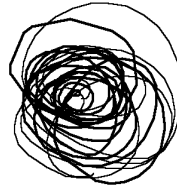


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Abstract



Crisis Assessment and Treatment Service (CATS) workers are often the first point of contact between an individual and the mental health system, thus these mental health professionals are the gatekeepers to further mental health service use and referral to other service sectors. Among the users of mental health services, there is an overrepresentation of women who have been the victim/survivors of sexual assault while research documents that these service users have a predominantly negative experience of disclosing, in other words, talking about sexual assault to mental health workers.

The aim of this study was to explore the research question – *what are the ways in which CATS workers understand their response to victim/survivors who disclose sexual assault in psychiatric crisis service settings?* To achieve this aim, fifteen CATS workers from a Melbourne metropolitan service took part in a small scale, feminist based, exploratory study utilising a qualitative and quantitative survey design.

Key findings of this research were that firstly, a majority of participants do not feel well equipped to respond to disclosures of sexual assault; secondly, workers indicated the need for training in this area; thirdly some participants held misconceptions about sexual assault including the lack of a gendered understanding; fourthly, some workers expressed a problematic understanding of trauma and awareness of how to effectively respond to a disclosure of sexual assault; and, finally, this study found minimal communication between CATS and specialist sexual assault services. The implications of these findings highlight the need for sexual assault training; a review of CATS role in relation to women disclosing sexual assault; and the need for cross-sectoral practice.

INTRODUCTION

Won't somebody please listen to me, believe me and understand me?

Graham (1995, p. 90)

The issue

Sexual assault is a common experience for women in Australia (Chung, O'Leary & Hand 2006, p. 4; Gavey 2005, p. 50-55; Australian Bureau of Statistics [ABS] 1996, 2004; Western Australia Crime Research Centre & Donovan Research 2001), and the impact of the trauma of gendered violence can be experienced in a number of ways (Simon 1999, p. 463, Bullen, Jacobs, Le Pont, Martin & Smith 2004). Women are the primary users of mental health services and many of these women's stories include the experience of some form of sexual assault (Keel 2005; Martin 2003, p. 155; Sheppard 1991, p. 664; Kravetz 1986). It is known that the impact of this trauma will affect how women present to mental health services (Simon 1999, p. 463). Over the past two decades, research has cemented the link between sexual assault and mental health, furthering understandings of the impact of sexual violence (Spataro, Mullen, Burgess, Wells & Moss 2004, p. 416; Fergus & Keel 2005, p. 3).

Sexual assault¹ refers to a continuum of sexual violence that makes a person feel uncomfortable, frightened or threatened and it is gendered violence to which a person does not consent. This may include sexual abuse, intimidation, coercion, intrusion, threat or force, which can occur in childhood through to adulthood (Scott, Walker & Gilmore 1995, p. 4). Previous research has documented the many effects on a woman's mental health arising from the significant trauma of sexual assault (Keel 2005; Victorian Health Promotion Foundation 2004, p.12; Bullen *et al.* 2004; Humphreys & Thiara 2003; Graham 1995).

¹ Sexual violence against women, such as rape and sexual harassment, is the most common form of violence perpetrated against women (Bennett, Manderson & Astbury 2000).

Disclosures of sexual assault refer to any act of talking about it, not just the first time it is discussed, and these are often made in primary health and mental health settings rather than specialist sexual assault services (Radcliffe, Green & McLaren 2003-04, p. 22). Thus, primary health care providers play a critical role in creating an atmosphere that is conducive to discussing gendered violence. The reactions of others to disclosures of sexual assault impact significantly in traumatic effect and the process of healing (Burstow 2003, p.1306; D'Arcy 1999). Research has documented female service users' predominantly negative experience of disclosing sexual assault to mental health workers (Graham 1995, p. 89).

Since the issue of responding to disclosures of sexual assault would appear to be part of the core business of mental health workers, it can be seen as important to ask these workers about their experiences of listening, conceptualising and responding as it is mental health workers' voices that are missing from within this picture. Many specialist sexual assault services (for example, Centre Against Sexual Assault [CASA] House²) operate from a 'Rights Advocacy' Model which recognises that sexual assault is a gendered crime which is both a consequence and reinforcer of the power inequality between women and men (CASA House 2006). Psychiatric services work from within the medical model which many victim/survivors³ who utilise mental health services have found to be pathologising through the medicalisation of their reactions to trauma (Graham 1995, p. 90).

Crisis Assessment and Treatment Services (CATS) are a 24-hour mobile service based in the community to provide urgent psychiatric assessment and short-term intensive treatment for adults between the ages of 18 and 65. CATS workers also staff a psychiatric triage service located in the Emergency Department of hospitals. The role of this service is to assess the most effective and least restrictive service option for service users. CATS workers may come from a variety of professional backgrounds – nursing, social work, medical, occupational therapy and psychology

² CASA House is a feminist service that provides 24 hour crisis care to recent victim/survivors of sexual assault, 24 hour telephone support to victim/survivors and their support network, short-term counselling, support groups and advocacy, as well as community education, advice and consultancy to other professionals (CASA House 2006).

³ The term 'victim/survivor' is commonly used to refer to people who have experienced sexual assault and is employed within this thesis in recognition of the strength and resilience of women and men who have survived sexual assault the perpetrator's abuse of power and responsibility for the crime.

and these workers are very often the first point of contact for an individual with the mental health system; assessing further service use and alternative referral. As the quotation from a CATS worker in the title of this thesis suggests, service users often disclose sexual assault in crisis services. Understanding how the women and men who work on a CATS respond to disclosures can be understood as critical to improving their training and support and, therefore, strengthening their response to service users.

Aim of this study

The aim of this thesis is to explore the research question – *what are the ways in which CATS workers understand their response to victim/survivors who disclose sexual assault in psychiatric crisis service settings?* The goal of this study is to highlight areas where specific sexual assault training is required based on the needs of participants and to posit recommendations for training programs and the ongoing support and supervision of psychiatric crisis workers.

To achieve this aim, the current study surveyed a team of CATS workers about their own experience of responding to disclosures of sexual assault and the origins of those responses. The study sought to understand and document how CATS workers conceptualise the causes, prevalence and impact of sexual assault and how discussions/disclosures are responded to in their work settings. The workers were asked about any professional development or training they had received in the area of sexual assault and its perceived impact, the elements of effective practice with victim/survivors and knowledge about and communication with specialist sexual assault services. The three themes of gender, power and medicalisation are critical to a discussion of sexual assault and mental health service use and these three themes are used to frame the critical review of the literature, interpret the findings and discuss their implications.

The feminist positioning of self as researcher

As the author, I acknowledge a feminist self-identity and consciously use a feminist perspective, recognising gender as a fundamental social division. In taking such an approach, sexual assault is interpreted as a gendered crime, perpetrated by men against women and children and supported by male power and privilege.

My personal experience of undertaking a 70-day Social Work Student field placement at a metropolitan CATS provided the initial impetus for this research project. While undertaking this placement, I observed CATS workers' very different responses to disclosures of sexual assault. While some of these violent experiences were recent, some service users disclosed experiences that had occurred decades earlier. I gained insight into the sometimes enormous difficulties and pain for victim/survivors associated with the impact of the trauma as well as its discussion, including feelings of self-blame or guilt and a fear that the worker's response would be one of disbelief or shock. I acknowledge experiencing personal issues of anger and grief listening to these disclosures. I observed the many quite significant challenges in CATS work, which at times impacted upon a worker's capacity to respond to victim/survivors discussing sexual assault. These challenges will be discussed in more detail in Chapter 1.

Burstow (2003, p. 1301) argues that in order to further radical understandings and directions of trauma work, there must be a fundamental break with psychiatry. In contrast with this theoretical position however, I align myself with the argument of Humphreys and Joseph (2004, p. 565), who, speaking with reference to recognising trauma as a result of gender-based violence, argue that it is critical to continue to engage in awareness raising and lobbying of the psychiatric profession in order to challenge current practice that is oppressive to women, particularly because of the numbers of victim/survivors currently using the mental health system. These issues and ideas, and the discussions and readings that brought them to life, were the basis of this research project.

Overview of this thesis

Chapter 1 critically evaluates the literature about sexual assault and mental health service use, arguing that an effective and enabling response to sexual assault disclosure by CATS workers is possible and important. Chapter 2 approaches the research question and develops a research method for understanding CATS workers' experiences of responding to disclosures using a survey method. The findings from the survey are documented and interpreted within the context of the literature in Chapters 3, 4, and 5. Chapter 6 presents three implications that impact on service users, psychiatric crisis workers and their organisation, and these are drawn from

several key findings. This final chapter also integrates recommendations towards providing a better service response to victim/survivors who disclose sexual assault in psychiatric crisis settings.

CHAPTER ONE: A critical review of the literature

"The mental health system is filled with survivors of prolonged, repeated childhood trauma . . . abuse in childhood appears to be one of the main factors that lead a person to seek psychiatric help as an adult." (Herman 2001, p. 122)

Scope of critical literature review

This chapter initially explores the issue of sexual assault and its impact on women followed by an examination of the relationship between such an experience and subsequent use of mental health services. The role of mental health professionals in listening and responding to service users talking sexual assault is then discussed and communication and collaboration between the service sectors of sexual assault and mental health is examined. To steer this critical review, the three themes of gender, power and medicalisation, which were presented in the Introduction, are developed.

GENDER

Sexual assault

The term *women* will be used throughout this study in reference to victim/survivors; this is not to discredit the painful reality and significant trauma experienced by male victim/survivors, but rather to acknowledge that sexual violence is most often an abuse of power against women perpetrated in the great majority of instances by men (Scott *et al.* 1995, p. 34). Sexual assault is an abuse of power that does not divide along socio-economic, religious, racial or familial lines (Pease 2004-05, p. 35) but is a common experience for many women and myths and misconceptions exist in the general community to explain its cause (Rokvic & Leigh 1999, p. 9). One common myth that will be briefly explored here is the *Family Dysfunction* explanation for sexual assault (Breckenridge & Carmody 1992, p. 98; Radcliffe 2002, p. 59; Scott *et al.* 1995, p. 20). Breckenridge and Carmody (1992, p. 98) argue that this explanation is based on myths such as, "family dysfunction precipitates sexual abuse – it has been allowed (by the mother) to occur, and mothers intuitively know of the child sexual

abuse and it is their duty to protect the child(ren) from the father”. There is little evidence to support this theory of sexual assault or to interpret it as useful, however it is important to be aware of since Taft (2003, p. 16) and Radcliffe *et al.* (2003-04, p. 23) argue that health professionals often share community myths in their understandings of gendered violence which therefore contributes to poorer practice and outcomes for victim/survivors.

Due to feelings of guilt and shame and fears of not being believed, many women do not talk about sexual assault, thus there is much ambiguity surrounding prevalence rates (D’Arcy 1999). The recent Australian 2005 Personal Safety Survey found that during the previous twelve months 1.6 percent of women and 0.6 percent of men experienced an incident of sexual violence (ABS 2005, p.11). It also found that since the age of fifteen, 19 percent of women compared with 5.5 percent of men have experienced sexual violence (ABS 2005, p. 11). In 1994, Fleming (1997) randomly selected and surveyed 710 women in the first national survey of Australian women on the prevalence of childhood sexual assault. This study found that 20 percent of women had experience sexual assault, however only 10 percent of assault experiences were ever reported to the authorities (Fleming 1997). These prevalence findings were comparable to international studies; for instance, in 1977, Russell (1982, 1984 in Gavey 2005, p. 53) interviewed 930 San Franciscan adult women about their experiences of sexual assault and found that 24 percent of the women interviewed had experienced rape and 44 percent of the total sample had experienced either rape or attempted rape at some time in their lives. While the literature about prevalence rates varies widely, it largely reflects a shared awareness that sexual violence is a common experience for many women (Chung, O’Leary & Hand 2006, p. 4; Fergus & Keel 2005, p. 3; Gavey 2005, p. 50-55; ABS 2004, 1996; Western Australia Crime Research Centre & Donovan Research 2001).

Sexual assault and mental health service use

While a history of sexual assault does not necessarily lead women to seek mental health care it is thought that a significant number of women using mental health services are survivors of sexual violence (Keel 2005; Fergus & Keel 2005, p. 3; Morely 2004, p. 5; Spataro *et al.* 2004, p. 416; Martin 2003, p. 155; Taft 2003; Simon 1999, p. 463; SOCA 1998, p. 9; Fergusson, Horwood & Lynskey 1996; Gibbons

1996, p. 1757; Herder & Redner 1991, p. 51). Research has linked this trauma with long-term emotional effects including depression, anxiety, aggression, isolation, poor self-esteem, self harm, relationship, trust and sexual issues and diagnoses of complex trauma, dissociative disorder, depression, anxiety, antisocial behaviour, substance use, maladaptive eating patterns, suicidal behaviour, psychosis and/or personality disorder (Chesler 2005, p. 35; Herman 2001, p. 47; SOCA 1998, p. 9-10; Crowell & Burgess 1996, p. 79-80). Feminist researchers have identified that many coping mechanisms have been wrongly diagnosed in the past as symptoms of mental illness (Morley 2005, p. 5; Burstow 1992). Herman's (1992) book *Trauma and Recovery*, was radical in understanding the experiences of trauma suffered by victim/survivors of gendered violence within a social context, paralleling their trauma to that experienced by soldiers at war. Herman (2001, p. 122) argued that assault in childhood was a core experience in the stories of the majority of women who sought mental health services. Herman's (1992) innovative research provoked a number of ensuing studies which examined the correlation between childhood sexual assault and adverse psychological and social impacts (Fergus & Keel 2005, p. 3; Keel 2005, p. 10). Table 1 summarises five studies from around the world which examine the relationship between sexual assault and mental health service use.

Table 1: Research literature about sexual assault and mental health service use

Author(s)	Date	Country	Findings
Spataro, Mullen, Burgess, Wells & Moss	2004	Australia	This study examined the association between girls and boys who had been the victim of childhood sexual assault and their subsequent treatment for psychiatric disorder(s) in adulthood. Utilising a prospective cohort design, the medical records of 1,612 girls and boys who had their experiences of childhood sexual assault substantiated by the Victorian Institute of Forensic Medicine, were linked with cases registered on the Victorian Psychiatric Case Register, which were then compared with the general population of the same age over a specified time period. This study found, significantly, that close to four times as many of those in the childhood sexual assault group had used the public mental health system. This research strongly documents the association between childhood sexual assault adult psychiatric diagnosis and treatment.
Goodman, Salyers, Muesser, Rosenberg, Swartz, Essock, Osher, Butterfield	2001	United States of America	This study found that 68% of women and 40% of men with severe mental illness had a history of sexual assault. This study also found that women and men with severe mental illness were more likely to have experienced sexual assault in the last twelve months

& Swanson			than people in the general community.
Fergusson, Horwood & Lynskey	1996	New Zealand	This study found that child sexual assault was associated with an increased risk of psychiatric disorder in young adults even when other factors such as childhood development, intelligence, delinquent peers and adolescent life events were taken into account.
Briere & Zaidi	1989	United States of America	This study found that 70% of non-psychotic women seeking emergency support for psychiatric issues, when asked, identified a history of sexual assault in childhood. These women were able to link their experience(s) of sexual assault to signs/symptoms which commonly form the basis for psychiatric diagnoses.
Bryer, Nelson, Miller & Krol	1987	United States of America	This study found that between 59-63% of psychiatric inpatients had a history of sexual assault and such trauma played a role in the development of later psychopathology.

The table above briefly touches on some of the research linking sexual assault and mental health, however, the body of literature is substantial. Despite this, Keel (2005, p. 10) argues that mental health workers and policy makers have, “generally been slow to recognise the extent to which child sexual abuse and abuse in adulthood impacts on mental health, and slow to provide services to victim/survivors of sexual assault suffering from mental ill-health”. While there is much literature looking at the medicalisation and pathologisation of women within mental health services, it would appear that some of those services continue to under appreciate the impact of trauma for service users and/or label their distress without recognising the social context in which distress is experienced, has its origins and/or from which these women seek to recover.

Many theorists in the gendered/domestic/family violence and sexual assault fields argue that it is important to systematically screen for women’s experiences of violence during an initial health setting assessment (Humphreys & Thiara 2003, p. 220; Davidson, King, Garcia & Marchant 2000, p. 2; Warshaw & Alpert 1999, p. 2; Draucker 1992, p. 24; Heins, Gray & Tennent 1990, p. 565). This can act to develop a staff consciousness about the role of violence in emotional distress as well as signal to the service user that these issues are important and the woman is safe to discuss them (Humphreys & Thiara 2003, p. 220; Draucker 1992, p. 24). Davidson *et al.* (2000, p. 2) argues that women expect health care services to understand and act on experiences

of violence and Warshaw and Alpert (1999, p. 2) contend that screening is an intervention in itself because it lets women know that gender-based violence is never acceptable and assistance is available. However, Gibbons (1996, p. 1761) contends that routine screening has rarely been implemented, interpreting this to indicate “resistance to acknowledging the impact of physical and or sexual assault or an inability (in terms of skills or resources) to respond if it does emerge”. While routine inquiry does present challenges such as time, training and resources (Mezey, Bacchus, Bewley & Hawarth 2002 in Humphreys & Thiara 2003, p. 220), with screening would come worker awareness about the impact of violence and may also produce a heightened ability to respond appropriately to disclosures and plan effective intervention.

Disclosures of sexual assault

As the literature linking sexual assault and mental health service use suggests, disclosures of sexual assault are often made in primary health and mental health settings, making them critical for intervention and prevention (Radcliffe *et al.* 2003-04, p. 22; Warshaw & Alpert 1999, p. 1). Burstow (2003, p. 1306) warns that the reactions of others impact significantly upon how trauma is processed, stating that:

Traumatising reactions by others greatly compound trauma and constitute part of the objective basis for the sense of aloneness, the terror, the worthlessness, the despair and the collapse of witnessing.

There exists much evaluated knowledge regarding how professionals can effectively respond to disclosures of sexual assault (for example see Fraser 2004-05, p. 25; Marriot & Hughes 1997; Gibbons 1996, p. 1761; Pahl 1995, p. 144-145; Burke 1992, p. 110). In a comprehensive literature review, Taft (2003, p. 16) summarises several recent reviews and books which outline critical features of a good practice response to women’s disclosure of assault. Characteristics of this type of response include belief and empathy for the women’s reality, understanding and validation that her reactions may be contrary to her preferred way of living, reassurances against blame, and allowing the opportunity to talk and provide resource (Taft 2003, p. 16; Herman 1992, p. 127). Service user research has identified some effective characteristics of a response to the disclosure of sexual assault as including - its location within a socio-

political context whilst ensuring the immediate safety of the woman, the separation of blame and communicating that the service user may be experiencing common effects of trauma (Fraser 2004-05, p. 25; Warshaw 1997; Burke 1992, p. 110). The above named features of an effective and enabling response to the disclosure of sexual assault are not complex; however, for mental health services to respond in this way, a review of current practice and a new model of conceptualising the issues may be required.

MEDICALISATION

Women and madness

Since the 1970s research into gender-based violence, which is predominantly feminist, has proposed several theories concerning the reasons for women's overrepresentation within the mental health system (Chesler 1972; Herman 2001). A vast amount of literature exists about women and madness and, while some of this will be briefly canvassed here, a detailed analysis is beyond the scope of this thesis. Gerrand (1987) summarising Chesler (1972 in Keel 2005, p. 12) writes,

More women than men are users of mental health services because they are more oppressed, hence more distressed and unhappy. They are more likely to seek help for their problems; are exposed to masculinist standards of mental health when they do seek help; and will be perceived as sick whether they display behaviour at odds or in keeping with a stereotypical female role.

Kravetz (1986, p. 110) argues that psychiatry individualises signs of social discontent and intensifies women's powerlessness, thus reinforcing and maintaining the patriarchal social order. Feminist critiques have revealed the denial of women's experiences of violence in psychiatric assessment and women's alienation from contributing to definitions of mental health and illness (Morley 2004-05, p. 6; Rummery 1996, p. 125; Robertson 1990, p. 183; Kravetz 1986, p. 110). Feminists have reframed the mental health system as a social construct, an institution that can medicalise and privatise *normal* expressions of distress at societal conditions, and can support women to accept the societal conditions which produced their distress (Sheppard 1991, p. 681; Robertson 1990, p. 184).

In the last three decades there have been significant challenges to mental health theories that had tended to pathologise women and so understand their mental health as a product of biological, reproductive and hormonal factors (Keel 2005, p. 13). With the critique of psychiatry, the role of social factors in women's mental health such as the impact of gendered sources of stress, for example, economic dependence and the family role, has also been examined (Martin 2003, p. 156). Feminists have normalised the discourse of trauma (Burstow 2003, p. 1295). Keel (2005, p. 13) argues that social factors are now recognised to impact on the higher rates at which women experience mental health problems, as well as the mental health problems that form part of those experiences. However, research literature has argued that these feminist findings have not challenged the mental health system to cease the medicalisation and privatisation arising from gendered violence. This occurs predominantly through the use of medications and hospitalisation; by the referral of women to private psychiatrists (Morley 2004-05, p. 6; Jarvis & McIlwaine 1997, p. 3; Graham 1995, p. 90); and the negative connotations associated with diagnoses such as Personality Disorder (PD) which are overwhelmingly assigned to women who have experienced childhood sexual assault (Herman 2001, p. 123; Ellenson 1986, p. 156).

Trauma

There is a plethora of literature exploring trauma; the usefulness of the diagnostic category of complex trauma in terms of intervention; the appropriateness of a diagnosis of trauma above other diagnoses which are significantly correlated with sexual and physical violence; and the psychiatrisation of the concept of trauma. It is not the aim here to examine all of these arguments but rather, to raise some of the issues and their implications for mental health service users. Reactions to trauma first formed a constellation of symptoms on which a diagnosis of Post-Traumatic Stress Disorder (PTSD) was based in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R APA 1987), following a political campaign by Vietnam Veterans and some psychiatrists (Davis 1999, p. 757). Humphrey and Joseph (2004) express that recognition of trauma within the powerful discourse of the DSM had the effect of legitimating access to health and counselling services, compensation and insurance. Trauma is political because of the social, cultural and political contexts within which trauma is recognised, defined and processed (Davis

1999, p. 760). The trauma framework as it has been used by psychiatry is contentious because of the profession's failure to locate the social context in which trauma occurs or challenge this context through the maintaining of individual, private responses which can have the effect of taking power away from the service user and divert attention from inequality (Davis 1999, p. 763; Burstow 2003, p. 1296; Humphrey & Joseph 2004).

Trauma is recognised by many as a more effective and enabling diagnostic category than PD and during the last two decades there has been agreement within specialist sexual assault research and practice services that trauma is a more appropriate concept to understand and position peoples' experiences than a label of PD (Herman 2001, p. 126). This is due to the overrepresentation of sexual assault experiences that many researchers have documented in the stories of people with the diagnosis of PD (Zanarini, Frankenburg, Reich & Marino 2000; Goldman, D'Angelo & DeMaso 1992, p. 1723; Herman, Perry & van der Kolk 1989; Herman and van der Kolk 1987). For example, the findings of a study about the complex interactions between trauma, PTSD and PDs by Yen, Shea, Battle, Johnson, Zlotnick, Dolan-Sewell, Skodol, Grilo, Gunderson, Sanislow, Zanarini, Bender, Rettew and McGlashan (2002, p. 517) demonstrated a specific association between sexual trauma and PDs and, consistent with other studies, found that participants with a diagnosis of Borderline Personality Disorder (BPD) had experienced particularly high rates of sexual trauma (between 26 and 71 percent). Herman (2001, p. 126) regarded diagnosis of BPD as derogatory and unhelpful in understanding and working with women's signs/symptoms⁴ of complex trauma since such a label implies an indwelling pathological permanence from which somebody is not able to recover. As well, no clear link is made between assault, trauma and a woman's response, nor the ecological context in which she makes sense of the risk to herself which may result in inappropriate treatment (Humphreys & Joseph 2004; Burstow 2003, p. 1296; Taft 2003, p. 13; Gilfus 1999; Lewis 1999; Gibbons 1996, p. 1759; Root 1992). Ellenson (1986, p. 156) argues that PD labels can further stigmatise a victim/survivor who "already feels ashamed, worthless and

⁴ It is acknowledged that within mental health services, behaviours which commonly form the basis for a psychiatric label are referred to as 'symptoms'. It is the belief of this author that the term 'symptoms' can be interpreted as pathologising behaviours which a feminist perspective understands as 'coping mechanisms', thus, the term 'signs/symptoms' is used in this thesis.

crazy”. Even considering this, it would appear that mental health services have yet to embrace the discourse of trauma as a more clinically useful diagnostic category than PDs (Humphreys & Joseph 2004). Davidson and McNamara (1999, p. 101) argue that the mental health system lags behind in its knowledge of and response to the trauma of sexual assault. Psychiatric journals still house many articles pertaining to the correlation between a service users’ diagnosis of BPD and history of childhood abuse without critiquing the validity of the diagnosis⁵ as well as mental health workers’ often negative attitudes to diagnostic labels which are significantly correlated with histories of childhood trauma⁶.

POWER

Mental health service responses

Earlier in this literature review the elements of an effective and enabling response to the disclosure of sexual assault were identified. With reference to the experience of talking about gendered violence, research has thus far focused on victim/survivors’ experiences of mental health service responses or generalist health and welfare workers such as general practitioners (GPs). Graham’s (1995) feminist study was one of the initial explorations and documentations of the impact of mental health practices on women who had experienced sexual assault. While victim/survivors in Graham’s (1995, p. 89) study were clear about what an effective response to the disclosure of sexual assault should encompass, the reality of the response they received was quite different. An experience which united the victim/survivors’ stories was that mental health professionals, in particular psychiatrists, were not interested in exploring or responding to what the women believed had given birth to their distress and treatment was based on medication to relieve signs/symptoms;

⁵ To illustrate, see Wonderlich, Crosby, Mitchell, Thompson, Smyth, Redlin, and Jones-Paxton (2001) whose study was consistent with previous studies in finding that traumatic experiences have pervasive effects on personality functioning, particularly when they occur in childhood.

⁶ For instance, see Leonard, Brann and Tiller (2005) whose recent study examined clinician’s attitudes to dissociative disorders, themselves characterised by a high probability that the service user assigned the label has experienced childhood abuse. This study found that 83% of the 250 clinicians surveyed were sceptical about the validity of dissociative disorder diagnoses, expressing their belief that alternative explanations for the “symptoms” of dissociative disorders included underlying psychoses, organic disorders such as epilepsy, or the effects of drug intoxication, factitious disorders, malingering, iatrogenesis and BPD (Leonard, Brann & Tiller 2005, p. 942).

I have disclosed many times...they put you on medication and it's a vicious cycle. They talk about what happened in the last week but they never talk about the underlying problem that makes you feel unhappy and depressed (Graham 1995, p. 90).

As this and the quotation that began the Introduction imply – women are very often aware of the relationship between their experience of sexual trauma and their emotional distress – psychiatry can take away the voice to name and give meaning to the context of the distress (Graham 1995, p. 90).

Humphreys and Thiara (2003) examined domestic violence survivors' experiences of mental health services and some of those experiences raised concerns about a lack of recognition of trauma, a maintaining of the invisibility of the abuser, victim-blaming and the use of medication (Humphreys & Thiara 2003, p. 216). The Womens Incest Survivors Network (1995 in Gibbons 1996, p. 1759) argue that “many of the coping mechanisms displayed by survivors of child sexual abuse have been wrongly diagnosed in the past as a symptom of mental illness”. Service user literature shows that women's experiences of mental health service responses to discussions of gendered violence are often denied an interpretation of the ecological context of the trauma. Another common theme to this research is that no clear link is made between the trauma and a victim/survivor's response and further isolation, stigmatisation and silence can occur through inappropriate psychiatric diagnosis, treatment and/or referral. A socio-political analysis of gendered violence is characteristic of a feminist informed response to disclosures of sexual assault. This is the type of response which victim/survivors report to be more effective and enabling through lifting the blame, helping women name gendered violence and normalising women's coping responses to the significant trauma of sexual assault (Morley 2004-05, p. 6; Humphreys & Thiara 2003, p. 220; Jarvis & McIlwaine 1997, p. 5; Graham 1995, p. 90).

Even with what is known about the responses that victim/survivors have received within mental health services, Jarvis and McIlwaine (1997, p. 5) contend that the impact of sexual assault can and should be understood within psychiatry, but it is important that service users are not pathologised, and that the story of their experiences is “privileged”. Strategies to improve responses to victim/survivors at the

level of the organisation, that Gibbons (1996, p. 1760) has proposed, include acknowledgement in agency policy and practice of the prevalence and impact of child sexual assault on women and men, the inclusion of routine inquiry into sexual assault in intake procedures, the training, support and supervision of staff, and the identification and management of gender issues in service provision. Disclosures of sexual assault within mental health settings are common, thus listening and responding to these disclosures is a core element of mental health service work, particularly for CATS workers who operate at the intersection between service users and their contact with the mental health system or referral elsewhere. Mental health workers have specific expertise to assist victim/survivors as well as respond effectively to issues such as suicidal and/or dissociative behaviour (Gibbons 1996, p. 1760).

Crisis psychiatric services

CATS Teams were established in Victoria in 1988 to provide crisis intervention and home treatment as an alternative to hospitalisation for the seriously mentally ill following an era of decommissioning large-scale psychiatric institutions (Sawyer 2005, p. 283). As a CATS practitioner for the last ten years, Sawyer (2005, p. 283) has critiqued the focus shift of CATS work from therapeutic consciousness inherent in crisis assessment focused on providing home treatment, to the current centrality of risk consciousness, focused on protocols to evaluate and document a client's 'risk factors'. This creates a paradox – deinstitutionalisation formally marked a shift in the goal of psychiatry from containment to therapy, however, in practice deinstitutionalisation has brought 'new rationales' for containment (Sawyer 2005, p. 293). CATS continue to come under attack from many angles – including distressed family members and the media. CATS workers must negotiate many ongoing stressors such as time constraints, lack of training provision, the challenge of working with people who may be extremely distressed and/or chaotic, the difficulty of negotiating the public mental health system which has primarily become a psychosis based service and is often short of acute inpatient beds (Spataro *et al.* 2004, p. 420) as well as working with other strained professionals and service users' families/support networks who may have varying levels of understanding about the role and capacity of CATS. These services are often the first to respond to women who display common signs/symptoms of trauma such as dissociation, self-harm and suicidal

behaviour and thus effectively responding to disclosures and maintaining a consciousness about trauma are fundamental elements of CATS work.

Mental health service system review recommendations

The policy document *Victoria's Mental Health Service: Tailoring Services to Meet the Needs of Women* (1997) is a Victorian example of an effort to improve service delivery to women using mental health services. This document recognises that “women’s life roles and experiences of mental ill health are different from men” and a “significant” number of women using mental health services will have previously experienced some form of sexual assault (Simon 1999, p. 461). This policy “encourages” mental health staff to respond “appropriately” to disclosures of sexual assault and to provide a safe and non threatening environment for service users. Recommendations for staff are largely premised on increased training and supervision. Many Victorian health service providers operate within a policy framework with a *Gender Sensitivity* policy, which recognises the importance of gender as a fundamental social division and one through which people’s experiences must be understood (see for example St. Vincent’s Mental Health Service [SVMHS] 2002). At a policy level then, it would seem that mental health agencies are prepared to name and address the issue of sexual assault, and support staff to recognise and respond effectively to it, which Gibbons (1996, p. 1760) argues is critical for an effective response to the needs of victim/survivors.

Communication and collaboration between service spheres

Many studies have concluded that a better model of care for mental health service users who have survived sexual assault can only be realised through communication and collaboration with specialist sexual assault services, which research strongly suggests is not currently happening (Keel 2005, p. 15; Humphreys & Joseph 2004; Martin 2003, p. 165; Davidson & McNamara 1999, p. 102; Cohen, De Vos & Newberger 1997, p. 19; Jarvis & McIlwaine 1997, p. 5; Graham 1995, p. 90). It may be safely speculated that both professional groups have much to gain from links with each other that would enhance the quality and outcome of their interaction with service users. Davidson and McNamara (1999, p. 102) argue that the mental health system would be advantaged by being receptive to the specialist knowledge and contribution of specialist agencies. Morley (2004-05, p. 8) argues that competing

discourses between the two service spheres reflect distinct ways of defining and responding to sexual assault and mental illness which has resulted in gaps and fragmentation. With reference to this, Taft (2003, p. 16) has expressed that good collaboration must address the different perspectives between psychiatric and sexual assault sectors. Morley (2004-05), a sexual assault service worker and researcher, authored an Australian investigation into the exchange of ideas between a sexual assault and mental health service through entering a dialogue about sexual assault with both. Following a process of critical reflection in which preconceived ideas were deconstructed, an opportunity for interaction, dialogue and a space for mutual exchange, information and learning could be envisaged which greatly benefited the two services (Morley 2004-05, p. 11). As has continued to be argued throughout this thesis, effective responses to disclosures of sexual assault are not outside the frame of reference of mental health services, which can play a fundamental role in offering meaningful responses, however, they must be in open communication with specialist services for the purposes of information sharing and referral (Taft 2003, p. 16; Jarvis & McIlwaine 1997, p. 3).

Conclusion

Sexual assault is a common experience for many women and both victim/survivors' voices and the research literature support a causal connection between women's experiences of gender-based violence and mental health issues. Crisis psychiatric workers are often the first contact for a victim/survivor with the mental health system, thus they must be confident in effectively responding to disclosures of sexual assault. Victim/survivors have identified core features of an effective response as informed by a feminist analysis, which is in some opposition to the historical ideological perspective of psychiatric services. While the concept of trauma is regarded as a more accurate description of severe emotional distress than the contextless diagnosis of personality disorder, it has been evidenced that this concept is not widely utilised by psychiatry. Mental health and specialist sexual assault services are responding to a group of women with similarly complex needs and yet, the communication and collaboration which is crucial to women receiving a beneficial service is not common practice. It is in this context that the current research sought to understand the experiences of CATS workers in a Melbourne metropolitan based team.

CHAPTER TWO: Approaching the research question

Theoretical underpinnings / Framework for research

This research is a feminist based, small-scale exploratory project which asks – *what are the ways in which CATS workers understand their response to victim/survivors who disclose sexual assault in psychiatric crisis service settings?* A feminist perspective understands social problems as gendered and therefore the approach explores experience as positioned and structured by patriarchy and inequality between women and men (Dominelli 1997, p. 26-47 in D’Cruz & Jones 2004, p. 47). The theoretical framework underlying feminist research is defined by Law (1986 in Kelly 1988, p. 4) as the belief “that women are oppressed and [have] a commitment to end that oppression”. Feminist research is embarked upon by people who hold a feminist self-identity and consciously use a feminist perspective to highlight the worldviews of women and other oppressed groups as fundamentally different to those of people in positions of power (Neumann & Kreuger 2003, p. 90; Grinnell & Unrau 2005, p. 90). It often involves the use of multiple research techniques such as qualitative and quantitative forms of data collection. Reinharz (1992) refers to the obligation of feminist research to contribute to social change through consciousness raising or specific policy recommendations, acknowledging that the personal is political (Reinharz 1992). Darlington and Scott (2002, p. 5) argue that feminist research traditions challenge the boundaries of research methods to address the power imbalances between the researcher and the researched and to allow the voice of the participant to be heard through qualitative research.

A feminist analysis of discourses about and responses to sexual assault

“Second-Wave Feminism” in Australia in the 1970s and 1980s identified power and gender as the core features of sexual violence (Radcliffe 2002, p. 44). A central concern of feminism has been the extent to which the mental health system reinforces and exacerbates women’s powerlessness through medicalisation which encourages

women to accept the societal conditions inherent in the creation of distress (Chesler 2005; Robertson 1990, p. 184). The focus of the current research is listening to CATS workers' experiences of disclosures of gendered violence - these workers come from a medically dominated field where they occupy the powerful position. For these reasons, as well as this authors' own theoretical perspective, this study adopts a feminist analysis that listens for power, medicalisation and gender as core themes in worker discourses.

This study

The study was influenced by Radcliffe's (2002) research which utilised a survey method to explore the attitudes and beliefs of rural health and welfare professionals whose practice experience exposed them to disclosures of sexual assault. The current study also recognised the significance of investigating the mental health service sphere's collaboration and communication with specialist sexual assault services following Morely's (2004-05) critically reflective research. Both the exploration of attitudes about sexual assault of mental health workers, as well as an investigation into the collaboration and communication across service sectors, are steps towards enhancing service provision and thus outcomes for victim/survivors.

Ethical considerations

As this research was conducted under the auspice of The University of Melbourne and a Melbourne metropolitan health service, a two pronged ethics approval process was necessary to meet the research guidelines and standards of both institutions. The project took three months to be approved by the health service Human Research Ethics Committee (HREC). Before the project was approved, this HREC requested reassurance that participant demographic details, primarily gender, not be included in any reports that may be published. The reason stated was protection of participant confidentiality. This request was challenged by myself and the supervisor of the project on the grounds that as a feminist study investigating sexual assault, the sex of the worker was critical demographic information which could not be omitted from any reports that may be published. This challenge was upheld and ethics approval was granted by the health service (see Appendix A), immediately after which time approval was registered with The University of Melbourne HREC

Recruitment and sample

The participants in this research are employed in a CATS located in inner Melbourne, and which provides a specialist mental health service to a population of over 200,000 people. The population in the catchment area is diverse, some localities are characterised by significant socioeconomic disadvantage and high levels of homelessness while others are comparatively affluent. This team was selected purposefully as I had undertaken a student placement with the team for four months in 2005 and believed that would impact positively on CATS management response to the project and enhance worker participation.

Sampling occurred via self-selection following an invitation to participate email (see Appendix B) disseminated to all the workers by a CATS colleague who was nominated in the role of third party recruitment, encouraging peers to participate, complete and submit the survey. Attached to this email was further participant information (the Plain Language Statement - see Appendix C) and the survey itself (see Appendix D). Participants were able to complete the survey using Microsoft Word and consent was implied through completed and returned surveys. Participants had two weeks to complete the survey, and halfway during this period a reminder email was sent, encouraging workers to participate in the research and submit their data. Once they had completed the survey, participants were invited to print and place in an envelope provided and leave in a secure drop-box in the agency.

The pool of potential participants was twenty-nine, (part and full time), comprised of thirteen female and sixteen male workers. The employment demographics of this pool were five allied health workers, four medical workers and twenty psychiatric nursing workers.

Research design

The Critical Social Science theoretical perspective on which feminist research is built contends that all social science must begin with a value or moral point of view (Neumann 1999, p. 71). Qualitative research aims to give privilege to the worldviews of research participants through understanding the subjective meaning, actions and context of participants (Fossey, Harvey, McDermott & Davidson 2002, p. 723). With regards to the current research project, the primarily qualitative approach to research

was selected due to its close relationship with a feminist paradigm and analysis (Campbell & Schram 1995, p. 87). Sampling in qualitative research is undertaken in the pursuit of 'information-richness' and usually focuses in depth on relatively small samples, which are chosen purposefully (Kuzel 1992, p. 33). At the core of this type of research are participants' perspectives, which need to be authentically represented in the research process. Findings are then evaluated in terms of their coherence with the data and the social context in which they are embedded (Fossey *et al.* 2002, p. 723). Campbell and Schram (1995, p. 89) contend that qualitative data is organised and evaluated subjectively in terms of themes, categories and new concepts. Content analysis involves inductive identification of codes from the data and is a very common qualitative methodology (Rice & Ezzy 1999, p. 192). While this research principally employed a qualitative data method, there were quantitative elements through the use of 'yes/no' questions which were always followed by opened ended questions inviting an expanded response. Padgett (1998, p. 126) argues that there are many strengths to engaging in research that comprises both qualitative and quantitative elements.

Survey design

This qualitative project employed a survey design which comprised twenty-eight questions reflected in the five topic areas of *participant demographics; causes, incidence and effects of sexual assault; professional development; responses to disclosure; and knowledge and utilisation of specialist sexual assault services*. It is acknowledged that the survey design may appear inconsistent with feminist research, for which interviews or focus groups are more common methods, however I attempted to adapt my research design in response to the reality of the CATS context I observed during my experience working in that context. Fossey *et al.* (2002, p. 724) discussed the importance of researcher responsiveness to the social context in which research participants are engaged. My experience on a CATS led me to understand that while a worker, and thus potential participant, will often have 'downtime' during the course of a shift, it is extremely difficult to predict this time. Consequently, I anticipated problems with scheduling interviews or focus groups during a participant's work time, and I hypothesised that inviting involvement in the project outside of work time would be a disincentive to participation. Also, as some of the potential participants to this study were known to myself, it was thought that an

anonymous survey would more likely provoke an accurate reflection of the lived experience of CATS workers.

Kuzel (1992, p. 35) argues that it is important to identify somebody in the culture under study who can serve as a “key actor” in the project’s construction. I enlisted a CATS member who had also served as my supervisor while on student placement and who was crucial to the construction of the survey from the perspective of somebody for whom listening to disclosures of sexual assault is part of their professional role. This worker was enlisted as a key stakeholder in the design and conduct of the research in an attempt to reduce the distinction between the ‘researcher’ and those ‘researched’. In the course of constructing one particular section of my survey, I contacted Margaret Radcliffe, whose 2002 Masters study sought to understand the theoretical frameworks adopted by rural health and welfare workers in relation to dominant discourses about sexual assault. This research utilised interviews with participants, and, through correspondence with Margaret Radcliffe, I was assisted in the construction of useful questions regarding the causes, prevalence, incidence, disclosure, and effects of sexual assault. Finally, the survey constructed for the current study was piloted with several people, both mental health and non-mental health workers.

Questions and key themes of the survey

The survey consisted of both closed and open questions. Closed questions were structured to restrict answers to *yes* or *no* responses. The advantage of closed questions was that data could be collected and compared with ease among participants’ responses. The use of open-ended questions predominated throughout this survey and allowed participants to express their responses, to reflect the “richness and complexity of the views held by the respondent” (Denscombe 1998, p. 101). The survey also included a vignette I constructed drawing on elements of stories that I was exposed to during my time on CATS. The vignette was significantly flavoured by recent literature about common trauma responses following sexual assault such as dissociation and perceptual disturbances, nightmares and the re-experience of trauma when a victim/survivor’s child reaches the age she was when assaulted (Bloom 1999, p. 5; Rokvic & Leigh 1999, p. 13; Crowell & Burgess 1996; Herman 1992, p. 33).

This vignette was designed to provide a focus upon which all participants were united in reflection. The survey was divided into five sections, to be explored briefly.

The first section incorporated participant demographic questions - sex, years worked in psychiatric services and occupational background. These particular demographic questions were seen as important to cross-examine and make further sense of the data.

The second section looked at the frequency that CATS workers identify working with victim/survivors and more generally, understandings of the prevalence, cause and impact of sexual assault and reactions to trauma.

The third section sought to document CATS workers' professional development/training in the area of sexual assault and its perceived impact.

The fourth section utilised a vignette (see p. 41) to understand how crisis psychiatric workers respond to disclosures of sexual assault in the settings in which they work.

The fifth section looked at the knowledge and utilisation of specialist sexual assault services as well as opinions of participants regarding specialist sexual assault service views about mental illness.

Data Analysis

In order to establish patterns and connections among emerging concepts in the data, this research utilised a coding system informed by content analysis. An exploratory approach was utilised because of its aims to generate knowledge about a relatively under-researched or newly emerging subject (D'Cruz & Jones 2004, p. 17). With a content type of analysis, themes of important messages inherent in participant response data are looked for. The emerging themes become the categories of the analysis and it is the 'position of the idea in the narrative' that is important (Daly 1997, p. 135 in Rice & Ezzy 1999). As is characteristic of content analysis, in order to make meaning out of the participants' voices, I segmented the text into units of analysis that contained some particular meaning, as opposed to individual words or phrases (Rice & Ezzy 1999). These were then coded, sorted and organised to look for

connections, common themes, themes consistent with the literature and 'emotive' themes. I have attached an example of the process I undertook in Appendix E.

By the conclusion of Chapter 1, I had arrived at the three key feminist themes of power, medicalisation and gender, which I then used as frames through which to understand and interpret the dominant ideas emerging from the data (Moghaddam 2006:4). Consistent with the literature about exploratory, qualitative research, this study was not seeking to generalise its findings, but rather to provide some initial data about a previously underresearched topic area and make initial recommendations. The qualitative approach to this study was appropriate due to the use of narrative responses of participants, which enabled identification of theories and concepts (Robson 1993).

Within the results section the voices of the participants were given preference and direct quotes from participants' responses were used throughout the data reporting. The use of Spell Check in the transcribing of direct quotes was employed where the meaning of a response was clear. Participant responses were divided into themes and only the section of participant responses relating to the issue being discussed was used at one time. The following three findings chapters have been structured to report the main themes that emerged from participants' responses and these were also located within the context of the literature.

CHAPTER THREE: Findings

Causes, prevalence and
impact of sexual assault

This findings chapter begins with a brief examination of the demographic characteristics of those who participated in this project. CATS workers' perceptions of frequency of work with victim/survivors of sexual assault, understandings of individuals most at risk in the community and prevalence, causes and impact of this form of gendered violence then become the focus of this chapter. Participant voices are listened to and understood within the context of the literature. This chapter presents key findings and these are the basis for service user, worker and agency implications that are discussed in Chapter 6.

3.1 PARTICIPANTS

The demographic characteristics of participants in the current study were representative of all the workers employed at the metropolitan CATS Service that this study accessed. As Table 2 shows, fifteen CATS workers took part in this study and participants were reflective of the sex division in the broader team. The majority of participants identified a psychiatric nursing professional background and had worked in psychiatric crisis services for seven or more years.

Table 2: Demographic characteristics of participants

Demographics	Categories	% of Participants
Sex	Female: 7	47% of sample
	Male: 8	53%
Professional Background	Psychiatric nursing: 10	67%
	Medical: 1	7%
	Allied Health: 4	27%
Years in the Field	7+ years: 12	80%
	3-6 years: 1	7%
	Less than 2 years: 2	13%



3.2 CAUSES, PREVALENCE AND IMPACT OF SEXUAL ASSAULT

3.2.1 Working with the issue of sexual assault

All fifteen participants had worked with service users who had experienced sexual assault; which is congruent with the literature regarding the high numbers of women using mental health services for whom this is an element of their story (Simon 1999, p. 463; SOCA 1998, p. 9-10).

Nine respondents, a majority, stated their belief that sexual assault was an issue with which they frequently worked. Three male respondents reported that they infrequently or occasionally worked with service users who had experienced sexual assault. Utilising a feminist framework to interpret this finding, reasons for its emergence may be that signs/symptoms which are characteristic of trauma are not always understood within this context. For example, Keel (2005, p. 10) argues that mental health professionals may not recognise, or may confound, what are normal and common reactions to trauma with the contextless signs/symptoms of other psychiatric diagnoses. Another issue that might have contributed to these three male participants' lack of identification of the high prevalence of victim/survivors within their service is that the gendered nature of sexual violence and the powerlessness of the experience may contribute to women disclosing less to male workers. This issue of a worker's sex is one that is picked up in the following chapter, when it emerges as a challenge in the experience of some male participants. One respondent did not know how often their work brought them into contact with service users who disclosed sexual assault. Two participants did not answer the question and one of these reported confusion with the question regarding whether they were being asked about the frequency of sexual assault or the frequency of how often the participant responded to disclosures of this issue. This question relied on the subjective interpretation of the word *frequent* which may have confused participants and certainly made the interpretation and comparing of responses difficult. With hindsight this question would have been asked differently, for example, *Over a six month period, could you estimate a percentage figure regarding how many of the service users you have worked with have experienced sexual assault?*

3.2.2 Groups of individuals most at risk of sexual assault in the community

Participants were asked to identify the groups of people in the community that they believed were most at risk of sexual assault. From this, five groups emerged as the most commonly identified – these are listed below in order of dominance:

- (Female and male) young people and (female and male) children;
- People who are vulnerable/marginalised;
- People engaged in risk taking behaviours;
- People who are psychiatrically disabled;
- Women.

Male and female children and young people were the most commonly acknowledged group at risk of sexual assault with seven participants identifying this group. To illustrate:

In my experience, children. No particular ethnic, gender, societal factors (R9).

As was discussed in Chapter 1, there is much literature demonstrating the link between women and men who are sexually assaulted in childhood and the adult use of mental health services, with studies by Goodman (2001) in the United States, Fergusson, Horwood and Lynskey (1996) in New Zealand and Taft (2003) in Australia, among others, suggesting a causal link when possible mediating variables have been controlled. Considering this, it may be expected that mental health professionals commonly cite young people and children to be most at risk of sexual assault. However, the gendered nature of sexual assault was not identified within this group which is important because research has reported that girls are sexually assaulted at least three times more often than boys (National Center for Victims of Crime 1997 in Henderson 2000, p. 310).

People who are vulnerable/marginalised were reported by six respondents to be at heightened risk of sexual assault. This category comprised those who are homeless, have low socio-economic status, and people whose access to power is disadvantaged by their ethnicity. For example:

...vulnerable due to homelessness, low SES (socio-economic status), ethnicity, power differentials (R13).

There is a point of contention in the literature regarding differences in the prevalence of sexual assault among social classes and ethnicities. Where studies have found distinctions, the interpretation of this association is fraught with difficulty, in particular, because there is a considerable risk of reporting and ascertainment bias with regards to poverty, for example people from lower socio economic backgrounds are more likely to come into contact with “welfare” professionals and thus sexual assault may be more visible in those families (Sidebotham & Heron 2006). Other studies have not found the prevalence of sexual assault to be related to ethnicity or socio-economic position (National Center for Victims of Crime 1997 in Henderson 2000, p. 311).

Another common theme, reported by six participants, was of women and men who engage in unnamed risk-taking behaviours which then predisposes them to heightened risk of sexual assault. To illustrate:

Individuals in high risk lifestyle, homeless or high level of substance abuse (R5).

This view does not take into account women’s marginalised access to power and could assist in shifting responsibility for sexual assault from the male perpetrator (Scott *et al.* 1995, p. 34).

Another group perceived as being at particular risk of sexual assault was women and men who are psychiatrically disabled. This was expressed by six respondents and considering the focus of CATS work, could be an expected theme. Various diagnostic categories were explicitly stated under the umbrella, ‘women and men who are psychiatrically disabled’, and those were people with BPD, psychosis and hypomania. To demonstrate:

Women (and to a lesser degree men) with ongoing psychotic illness who are vulnerable to others, women with certain personality disorder...(R15).

Davis (1999, p. 759) among many others, states that many people with diagnoses other than that of trauma, may be experiencing post-traumatic reactions. It is important that the role of childhood trauma in the development of 'psychiatric disabilities' informs every aspect of intervention with service users, allowing for the normalisation and validation of victim/survivors' reactions to traumatic experiences while also recognising that these reactions may currently be experienced as maladaptive (Trippany, Helm & Simpson 2006, p. 101; Herman 2001, p. 127).

Only one third of participants explicitly identified 'women' as most at risk of sexual assault. Yet, if a gendered understanding of sexual assault is critical to effective intervention with service users, then its absence may have significant implications. A feminist interpretation of some participants' understandings in relation to the groups most at risk of sexual assault in the community is that they were sometimes characterised by myths or misconceptions about sexual assault.

3.2.3 Occurrence of sexual assault in the community

The majority of participants thought that the occurrence of sexual assault in the general community was either common or very common while only one thought that sexual assault in the community was uncommon. In the Introduction, I discussed the literature that identifies sexual assault as widespread in the community (Gavey 2005, p. 50), thus this male respondent is not only articulating a view which is discordant with that of his colleagues but also with the literature. This participant had worked with CATS for seven or more years and did identify that he 'often' works with service users who have experienced sexual assault, which is congruent with the information available about the proportion of victim/survivors who use mental health services (Simon 1999, p. 463). Therefore, while the participant incorrectly identified sexual assault as uncommon in the community, he did identify prevalence of the issue among the service users with whom he works. The question was framed using the terms 'very common/common/uncommon' because, in reference to the experience of sexual assault, the literature widely utilises the word 'common', as well, I anticipated that it would be extremely difficult to meaningfully compare and contrast responses to an open-ended question regarding how often participants' believed sexual assault to occur in the general community. It is acknowledged, however, that a significant limitation of this question was the subjective nature of the concepts.

3.2.4 Reasons for the occurrence of sexual assault in the community

Interestingly, only one respondent, who was female, explicitly cited power imbalances between males and females as a possible factor in the occurrence of sexual assault in the community:

Entrenched gender inequality... hegemonic male power (R3).

That only one participant stated the role of sex, suggests the lack of a gendered understanding and a marginalised awareness or acknowledgment of the social/political context in which sexual assault occurs within this participant group of psychiatric crisis workers. Fergus and Keel (2005, p. 3) argue that a gendered understanding of sexual assault has not been incorporated into mainstream thinking in the mental health field, which impacts on the delivery of services to victim/survivors because it is critical to focus on the social and political climate in which abuse occurs, and in which victim/survivors are often denied support.

Six respondents cited power and control for the (gender neutral) perpetrator as a factor involved in the occurrence of sexual assault in the community. It is significant that nearly half of the respondents expressed an understanding of the role of power in the occurrence of sexual assault in the community, since the role of power is critical to a non-pathologising and non-blaming response to victim/survivors (Kravetz 1986, p. 114). To illustrate:

Power imbalances between offender and victim (R9).

Seven respondents expressed a belief that people who have been sexually assaulted can go on to sexually assault others, thus perpetuating a cycle of abuse. For example:

...perps previous experiences of being abused... (R8).

The literature does not support this idea, yet it is a pervasive view in society and a misconception that informs nearly half of these participants' understandings about the cause of sexual assault. In the United States, the National Clearinghouse on Child

Abuse and Neglect (1999 in Henderson 2000, p. 823) collected, reviewed and analysed all of the available studies on the cycle of abuse between the years of 1965 and 1996 (twenty-five studies) that provided quantitative information relevant to the question of whether women and men who were sexually assaulted as children were at heightened risk of becoming sexual abusers of children in adulthood. Overall, this research found that, “the retrospective studies, prospective studies and research reviews indicated that the experience of child sexual victimisation is quite likely neither a necessary nor sufficient cause of adult sexual offending” (Henderson 2000, p. 825).

Five respondents identified the impact of substance use/abuse by the perpetrator on the occurrence of sexual assault in the community. To illustrate:

...disinhibition through substances (R4).

To a lesser extent, respondents cited the failure of family as well as the breakdown of the community - four respondents documented community/cultural factors, for example:

Deterioration in societal standards of morality – promotion of sex, violence in the media, and ubiquity of pornographic material. Failure of the education system...to instil fundamental values of respect etc. Diminution of sense of social conscience and responsibility (R7).

Three respondents described the impact of the dysfunctional elements of family as possibly leading to sexual assault. To illustrate:

...familial deficits...increasing destabilisation of family/community structure and integrity (R8).

As referred to in Chapter 1, Breckenridge and Carmody (1992, p. 98) name this as a *Family Dysfunction* explanation for the occurrence of sexual assault. They argue that this is based on mythologies, which serve to blame women and lift the responsibility

from men for the perpetuation of gendered violence (Breckenridge & Carmody 1992, p. 98; Radcliffe 2002, p. 59; Scott *et al.* 1995, p. 20).

Overall, six out of fifteen participants expressed an understanding about the causes of sexual assault based on an analysis of power, however the role of gender was ignored by all but one. Some of the causes of sexual assault that emerged from the responses were based upon myths about sexual assault, which is consistent with the finding of Radcliffe *et al.* (2003-04, p. 28) that attitudes and beliefs of workers can reflect commonly held explanations in the community. This may have considerable implications for mental health service users who have experienced sexual assault.

3.2.5 Impact of sexual assault on victim/survivors

Strong views emerged from participants with reference to the many and varied ways the experience of sexual assault can impact upon victim/survivors. Responses discussed a number of physical, emotional and psychological effects (see Appendix G). To illustrate:

Depends on the severity and nature of the assault (aggravated rape with gross physical damage even death versus for eg fleeting grope), age of the victim at time of the assault and on the resilience and coping resource locus of control of the victim, who the perpetrator was (relation versus stranger) etc. Anything from PTSD and severe psychiatric disturbance and personality disturbance, etc. to very bad memory with negligible sequelae – how long is a piece of string (R7).

The most dominant theme to emerge as an impact of sexual assault was psychiatric signs/symptoms. Eleven out of fifteen participants expressed the impact could result in personality disorders, mood problems, the development of psychosis, and/or an Axis I or II disorder. One participant said:

Traumatic particularly later in life produces personality, mood problems, sometimes psychosis. Some of severest personality disordered clients often have PHx (past history) of sexual abuse (R5).

Of the participants, five expressed PD as a dominant theme in response to the experience of sexual assault. This is an interesting finding because, as discussed in Chapter 1, within specialist sexual assault research and practice services ‘trauma’ is understood to be a more appropriate concept in which to interpret and position experiences than that of PD, which does not provide any clear link between trauma and response nor the social context in which the experience occurs and is given meaning (Burstow 2003, p. 1296; Taft 2003, p. 13; Gilfus 1999; Lewis 1999; Root 1992).

Four participants explicitly stated the potentially catastrophic impact, including the loss of potential life experiences, for example:

It would impact on all areas of their lives, different ways at different times and in intensity (R14).

Six participants ascribed feelings of shame, guilt and self-blame, self-hatred, anger, despair, fear, existential crisis, and lowered self-esteem resulting from sexual assault. which is congruent with the literature (Humphreys & Joseph 2004; Simon 1999, p. 463; SOCA 1998, p. 9-10; Crowell & Burgess 1996, p. 80; Herman 1992, p. 96-114).

Relationship problems were cited by six participants as being another common impact of sexual assault, especially in the longer term. For instance:

Long term relationship issues / sexual issues... (R6).

In summary, this study has documented that all fifteen participants believed that sexual assault has a negative and long-term impact on victim/survivors. These responses reflect an well-informed awareness of the identified consequences of sexual assault on victim/survivors which corresponds with studies by D’Arcy (1999), Frazier (2000), Howgego et al. (2005), Taft et al. (2003) and reported by Bennent et al. (2000), Crowell and Burgess (1996), Draucker (1992), Gavey (2005), Jarvis and McIlwaine (1997), Keel (2005), Matthews (2004, p. 10), SOCA (1998) and VicHealth (2004).

3.2.6 Impact of sexual assault on the community

The main impact of sexual assault on the community described by six participants was the economic effect on services and lack of productivity due to the often devastating effects of violence. This fits with the analysis of Bennett *et al.* (2000) and Campbell (2002) of the cost to the community. To illustrate:

Costs to health care, employers (sick leave) (R15).

It is worth noting that three participants did not respond to the question about effects on the community elicited by sexual assault. One other respondent stated that they were unsure of the effect, but hypothesised emotions such as fear and confusion that the community may experience. Finally, one other expressed confusion regarding the question:

Community not just the affected individuals???(R7).

In moving beyond the micro level of the individual, I wanted to explore the issue of community impact in response to sexual assault because of my belief that an effective short-term response and longer-term preventative strategies must be located at the level of community. Thus, I wondered whether participants thought the problem solely lay with the individuals affected or whether the community was impacted and therefore had a role in response to this issue. I acknowledge that it is difficult to conceptualise the impact of an individual act on the broader community, which may explain why three participants either did not respond to this question or expressed difficulty responding.

3.2.7 Impact of sexual assault on mental health

Participants were asked about the impact of sexual assault on an individual's mental health (see Appendix H). In the table, themes have been listed from most dominant to least dominant, and for themes that were expressed by an equal number of participants their order has been arranged alphabetically. This table reflects the similarity between themes that participants' expressed when asked generally about the impact of sexual assault on an individual and the themes that were voiced when participants' were

asked about the impact of sexual assault specifically in relation to mental health Of the participants, four people believed this question about the effect on mental health was repeating the question about the impact on an individual. To illustrate:

As above (R8).

While this may be anticipated considering the service sector these participants are speaking from within, none of the participants identified a separation between what the feminist literature terms “normal” (or non-psychiatric) reactions to sexual assault such as shock, anger and self-blame and reactions that can contribute significantly to a psychiatric diagnosis such as dissociation, visual and auditory hallucinations and severe self harm. This is an important distinction because it is victim/survivors who are telling us that they feel pathologised and not responded to optimally by psychiatric workers (Graham 1995, p. 90). Jarvis and McIlwaine (1997, p. 4) argue that when reactions to a trauma are conceptualised as ‘psychiatric symptoms’ they are at risk of being interpreted as individual pathology, rather than a victim/survivor’s response to an abusive situation. Victim/survivors’ are telling workers that they want a non-pathologising intervention in which they are encouraged to educate the worker about their reality, being given power over the intervention, however small (Jarvis & McIlwaine 1997, p. 5). This service response incorporates an approach that makes sense of the painful and distressing consequences of sexual assault that a victim/survivor experiences, while at the same time requires that a worker identifies the commonality of the impact of this violence.

3.2.8 Reactions to trauma manifest to reflect psychiatric signs/symptoms

Participants voiced themes congruent with the trauma theory literature about the distinct physical, cognitive, affective, and spiritual responses by individuals and communities to events and situations that are objectively traumatising (Burstow 2003, p. 1305) (see Appendix I). The concept of trauma refers to a constellation of reactions (feminists have reframed these as ‘coping skills’ (Burstow 1992, p. 5) which include reliving the traumatic events through flashbacks or nightmares; avoidance or numbing of responses; and hypervigilance or increased arousal evidenced by irritability, inability to concentrate, and inability to get to sleep or stay asleep (Humphreys & Joseph 2004). The body has an “emotional memory” and trauma is “engraved”

through images, bodily sensations and strong emotions (Bloom 1999, p. 5). One female participant expressed how signs/symptoms of trauma are also signs/symptoms that form the basis of commonly ascribed diagnostic labels:

flashbacks, voices and visions, 'paranoia', mood swings, affective lability/instability, depressive Sx (symptoms) – sadness, feelings of worthlessness and hopelessness, external locus of control, sleep and appetite disturbances, anxiety Sx, anger management problems. compulsive 'self-destructive' behaviours – eg. Binging/purging, self harm etc. suicide/parasuicide attempts, phobic responses, sexual difficulties. These Sx often aggregated to form diagnostic labels such as BPD and other personality disorders, Bipolar Affective Disorder, Schizophrenia, PTSD, Dissociative Identity Disorder, Anxiety Disorders, Depression (R3).

A male participant described in detail a professional experience of meeting a victim/survivor in the Emergency Department:

I recently met women that have thought the devil was inside of her a subsequently she dissociated on the ECC (Emergency Care Centre) trolley and started imitating the sexual abuse that her father did to her, he was the devil inside. The precipitant was of her daughter becoming the age that she was abused. She wanted to kill her children and had been beating them. This precipitant was subconscious. She was then psychotic for some weeks and probably still is. We often get people describing visual hallucinations which are probably flashbacks to sexual abuse. Depression is often the result of the abuse (R11).

Conclusion

This chapter explored participant perceptions of frequency of work with victim/survivors, prevalence of sexual assault, those most at risk, the reasons for assault and its impact on a survivor. There were three significant findings to emerge from this chapter –

- Firstly, while the majority of participants believed that they frequently worked with service users' who had experienced sexual assault, three participants expressed their work with victim/survivors was infrequent or occasional.

- Secondly, participants expressed views that a feminist analysis would identify as reflecting myths and misconceptions about the causes of sexual assault and those groups in the community most at risk. This included the lack of a gendered understanding of sexual assault.
- While all respondents expressed awareness of the significant effects of sexual assault, these were problematically expressed more in terms of PDs than trauma.

CHAPTER FOUR: Findings

Professional
development and
responses to disclosure

This chapter will focus on two issues – findings in relation to participant professional development and CATS worker responses to the disclosure of sexual assault. The key findings from this chapter and their implications will be explored in Chapter 6.

4.1 PROFESSIONAL DEVELOPMENT

This section explores participant professional training history and experience with reference to sexual assault and important influences behind participant beliefs/attitudes.

4.1.2 Important influences on beliefs/attitudes about sexual assault

In being asked about the most important influences on beliefs/attitudes in relation to sexual assault, participants were prescribed three options – *professional training*, *professional experience*, and *personal experience* - and the opportunity to name their own critical influence – *other*; there was also the option of commenting further. The most dominant influence on the formation of beliefs/attitudes about sexual assault was professional experience, with twelve participants citing this; nine regarded personal experience as important; while five stated that professional training had been an especially important factor in their current thinking. Only one participant identified ‘other’:

University, the media (ie movie such as “the accused”) (R10).

Five participants commented further and their remarks included influential factors such as student placement at a specialist sexual assault service, attitudes evolving over time, the experience of being a parent and professional experience in the drug and

alcohol service sector. One male participant with a psychiatric nursing background stated:

My main understanding comes from personal experience, which I am not going to discuss, and that includes social network experience. I am unaware of studies that correlate mental illness with abuse, I am poorly read, but often feel that the link is much more prevalent than documented or tracked (R11).

It is striking that this participant is unaware of any research that links trauma with mental illness, yet has worked in the mental health field for seven or more years. From his comment, it is unclear whether he refers to the relationship between abuse and mental illness that is not fully realised in the research fields and/or his workplace. This was a remark made optionally and not in direct response to a particular question and expresses a problematic awareness of trauma that may have important implications not just for service users but also for this worker.

4.1.3 Professional training about sexual assault

Participants were asked to tick *yes* or *no* in response to a question about whether they had ever received professional training about sexual assault. Eight participants identified that they had received sexual assault training, six, that they had never received training and one declined to answer. When the concept of professional training was further explored, five out of the eight who indicated they had received professional training characterised this training as brief and having occurred ten or more years ago, for example:

2 day course held by CASA almost 10 years ago (R2).

Thus, eleven out of fifteen of the participants have either never received professional training about sexual assault, or it was brief and undertaken a decade or longer ago. This is far from optimal since research literature argues that community attitudes about sexual assault are largely based upon myths and misunderstandings about the facts of gendered violence such as prevalence rates, gender and power issues and the impact on victim/survivors (Radcliffe 2002, p. 3; Breckenridge 1999; Rokvic & Leigh 1999, p. 9). There have also been radical changes in trauma understandings over the

last ten years. This lack of CATS worker training can be presumed to have important implications for service users.



4.2 RESPONSES TO DISCLOSURE

This section focuses on participants' responses to disclosures of sexual assault, including work environment challenges, perceptions of ability to respond, and opinion on the issue of mandatory inquiry into sexual assault. In order to assist CATS workers to identify and reflect upon how they might respond to victim/survivors, a vignette was presented and its rationale can be found in *Questions and Key themes*, Chapter 2. Participants were asked to reflect on how typical the vignette was to their clinical experience, utilising a response set: *typical*, *quite typical* and *not typical at all*. Eight participants believed the case vignette was either 'typical' or 'quite typical' of their experience, five stated that the case vignette was 'not typical at all', one voiced that the vignette resonated between 'quite typical' and 'not typical at all'; and a final participant declined to answer.

Table 3: Vignette from the survey

A 33-year-old woman presents at the emergency department of the hospital. She appears tense and agitated as she informs you that she has a 9-year-old daughter who she is supposed to pick up from school shortly. The woman describes increasing difficulty sleeping due to severe nightmares over the past three weeks. The woman cannot express the content of the nightmares, however she awakes sweating, shaking and overcome with fear. The woman also identifies that irregularly throughout her adult years she has experienced occasional derogatory voices which, when heard provoke intense feeling of fear, as well as transient periods of disassociation. You ask the woman about the family in which she is a parent, and from there, ask about her family of origin. The woman is crying and shaking while she quietly elicits that her uncle sexually assaulted her 20+ years ago. She does not look at you as she says this and upon disclosing the assault the woman suddenly appears closed off, repeating that she must leave to pick her daughter up from school.

4.2.1 Information gained from vignette to inform assessment and treatment

Fourteen participants answered a question in response to the vignette inviting their identification of important elements for hypothetical intervention. They identified a broad range of issues totalling thirty distinct themes (see Appendix J). Responses were detailed, reflecting a comprehensive information gathering process with eight

respondents recognising five or more issues (see Table 4). In their response, they incorporated the elements of the vignette; the way further information could be extracted, and a theoretical intervention. To illustrate:

Usual psychosocial / mental state / risk assessment. – I would not ask specific questions re alleged abuse as I do not feel I have the adequate skills to assist someone in this situation (R12).

Table 4: Number of themes identified by participants (n=14)

Number of themes identified	Number of respondents	Respondent %
1	1	7%
2	2	14%
3	1	7%
4	2	14%
5	4	29%
6	2	14%
7	2	14%
8	0	-
9	1	7%

The following response was selected as an example of the detail into which respondent's delved:

- 1) *Is this the first time she has disclosed the assault?*
- 2) *What is her attitude towards the assault? Does she blame the offender or herself? Has she taken legal recourse? If not does she want to?*
- 3) *Does she still have contact with the offender? Is she concerned for her daughter's welfare?*
- 4) *Are the dissociations and hallucinations present currently? Any command hallucinatory material?*
- 5) *Any self harm issues, Hx (history) of self harming behaviour, current ideation/intent to self harm?*
- 6) *Any significant occurrence 3/52 (three weeks) ago prior to commencement of symptoms?*
- 7) *Are the nightmares of the assault, are the voices any she recognises?(R10).*

The most dominant theme, expressed by eight participants, was that a Mental State Examination (MSE) and Risk Assessment would be conducted. This was not an anticipated response considering participants were not asked to comment on their thoughts about intervention, but rather about the information they assessed as important to inform intervention. However, this is probably not a surprising finding, since MSEs are a core tool in CATS work and their findings are incorporated into every clinical case note written. It is important to note that only six respondents explicitly listed the woman's disclosure of sexual assault as relevant information in their hypothetical formation of an assessment and hypothesis about treatment for this woman. One respondent questioned the woman's "*mental state (as) psychotic/depressed (R6)*", suggesting a lack of understanding about the impact of trauma, two common signs of which are feeling extremely down, dissociation and perceptual disturbances reflecting an "engraving of trauma" (Bloom 1999, p. 5-6).

4.2.2 Intervention

Based on the vignette, participants were asked to hypothesise about an intervention with the limited information they had about the woman. Fourteen participants responded to this question, with two distinct issues arising from their responses - the *role* in terms of the capacity and constraints of CATS in relation to this woman; and *how* workers would respond. Pertaining to the first issue; four participants wrote explicitly about the importance of engaging the woman in order to build rapport with her so that she continue to engage with the service in a therapeutic, symptom management and referral capacity. To illustrate:

Initially the symptoms of nightmares, poor sleep would need to be addressed. Reassurance and a further time to review would be made this would also provide an opportunity to develop some rapport to then address the underlying issue of sexual assault and to help her understand her symptoms in this context. It may be appropriate to refer to a specialist sexual assault service (R1).

The remaining ten participants were very clear that their professional response was referral and/or risk assessment and/or short-term symptom management. The dominant referral was to a specialist assault service such as CASA. To illustrate:

Refer to CASA / specialist counselling (R12).

The implications of this difference in understandings of CATS role in relation to this woman may present challenges between colleagues as well as varying responses to service users.

With respect to the second issue of how participants would respond to the woman at the immediate time of her sexual assault disclosure, only three expressed the importance of the woman receiving an immediately affirming response. These three joined one other in linking the woman's signs/symptoms of distress with her experience of trauma. For example:

Validation, reassurance, support. Normalise her symptoms and experiences as typical sequelae to childhood trauma/boundary violations (ie. reassure her she isn't MAD)
(R3).

That only three respondents explicitly named the critical elements of an effective service provider response is significant. Two of these participants identified having received professional training about sexual assault while the other completed a student placement with CASA Gatehouse Centre many years ago, which suggests the positive impact of specialist training. As discussed in Chapter 1, the research literature argues that the response a victim/survivor receives following their disclosure of sexual assault is critical to the processing of trauma towards recovery (Davidson *et al.* 2000, p. 3; Marriott & Hughes 1997, p. 13; Pahl 1995, p. 144; Draucker 1992, p. 29).

4.2.3 Mandatory sexual assault inquiry in initial psychiatric assessment

Participants were asked to respond *yes* or *no* (and then comment further) regarding whether they thought inquiry into sexual assault should be a mandatory question in initial psychiatric assessment. Interestingly, all but one expressed that they did not think inquiry into sexual assault should be a routine element of assessment. This is at odds with a wealth of literature which argues that direct questioning about women's experiences of violence is critical to the adoption of a worker consciousness about the role of violence in emotional distress and the reflection to service users that these issues are important and safe to discuss (Humphreys & Thiara 2003, p. 220;

Davidson, King, Garcia & Marchant 2000, p. 2; Warshaw & Alpert 1999, p. 2; Draucker 1992, p. 24; Heins, Gray & Tennent 1990, p. 565). Only one participant believed that inquiry into sexual assault should be mandatory. This female commented that:

It is often there but asked in an indirect manner (R10).

An interpretation of what this participant was expressing is that sexual assault is “often” an issue for the service user and workers usually uncover this by asking “indirectly”. While participants were largely in agreement that a direct question regarding sexual assault should not be asked in an assessment, different explanations surfaced (see Appendix K). A theme that emerged as the most dominant, with eight workers in agreement, was that questioning into sexual assault should not occur in crisis settings because rapport between worker and victim/survivor has not been established. For instance:

Need to have rapport/therapeutic r/ship in place to facilitate this, unless pt (patient) volunteers info (R13).

Six participants identified that asking about sexual assault can be confronting, distressing and sometimes dangerous for the victim/survivor, acknowledging the painful reality of individuals for whom this is part of their story. Four expressed that there were other ways of uncovering this information, namely through the use of broad open-ended questions into childhood. While they were not advocating a mandatory assessment question, these participants expressed the importance of being aware of the possibility of distressing signs/symptoms linked to earlier experiences of trauma.

Three particularly interesting issues emerged from this data. The first issue was expressed by three participants who identified a perspective that is congruent with Draucker (1992, p. 29), that disclosure, if not handled skilfully by a clinician, can have deleterious effects on the victim/survivor. For instance, here is the voice of the CATS worker whose words are in the title of this thesis:

Often clients can allude to it but it is not something that needs to be divulged in crisis and often when it is divulged by inexperienced psychologists or counsellors that the client often ends up in crisis...crisis is often when it comes out but it is better to be dealt with when the mind is calm (R11).

Secondly, three participants expressed that the issue of sexual assault does not need to be divulged in crisis, and mandatory questions can emphasise things that are not of immediate concern. Thirdly, another worker stated:

...no clear reason for what we would do with the information if we found out (R12).

These final two comments do not recognise that if workers have an understanding that the service user whom they are assessing has experienced a significant trauma, the signs/symptoms being experienced may be placed within in a context that could assist in the construction of a more appropriate and enabling treatment plan. This demonstrates a lack of awareness about trauma, common signs of which often form the basis of other psychiatric diagnoses, such as BPD and psychosis (Davis 1999, p. 759). Participants have indicated the many complexities embedded in direct questioning about sexual assault, yet the majority of participants are in opposition to the gender-based violence research literature that argues the importance of directly and routinely asking about women's experiences of violence.

4.2.4 Work environment challenges

Participants were asked about whether they experience any challenges within their employment environment to working with the issues arising from sexual assault. The concerns of *time constraints, containment of distress, exhaustion of issue, uncomfortable subject matter, lack of experience/training* and *other* were prescribed options and participants were invited to comment further. These were all challenges I identified during my experience on and observation of the CATS environment. Participants also identified with these challenges, with thirteen reporting time constraints as an obstacle to working with the issue of sexual assault; this emerged as the most dominant challenge. To illustrate:

Disclosure requires time, containment and experience, something not often available to CATS (R4).

Twelve participants stated that the need for containment of distress was a challenge; eight named their lack of experience and/or training; four expressed a belief that if they perceived the issue had been exhausted in previous mental health care episodes they should not explore further and two identified that the issue of sexual assault was uncomfortable subject matter. For two male workers their gender was a barrier, with one saying:

Better to be done with female if female is divulging. I am comfortable with people divulging but often put a lid on it until the person is in therapy but also feel that the client would often be more comfortable with the same sex (R11).

Of the identified challenges to working with the issue of sexual assault, lack of experience/training and uncomfortable subject matter can and should be overcome through sexual assault training. One male and one female worker further articulated their concern about the attitudes of some of their colleagues in relation to women and sexual assault, the impact this has on female service users and the challenge this presents within the workplace. The implications of this are critical and will be picked up in Chapter 5.

4.2.5 Participant perceptions of ability to respond to disclosures of sexual assault

Participants were asked to respond *yes* or *no* to a question pertaining to whether they believed they were “well equipped to respond to a disclosure of sexual assault”. Seven replied that they believed they were well equipped, seven stated that they did not think they were well equipped to respond and one chose not to position himself in either category, commenting:

Will not answer yes or no as my feeling is I am not sure have had no formal training in this field and have to rely on past job experience (R5).

This male psychiatric nurse had been working in psychiatric crisis services for seven or more years and would appear to be expressing an inability to answer because he

has not received adequate training in at least that time and thus has to “rely” on previous job experience. He and the seven participants who stated that they did not believe they were well equipped to respond to a disclosure represent just over half of all participants. This is a key finding and strongly suggests that these workers need further training in effective and enabling ways of responding to disclosures. One participant in this group stated:

Could do with more guidance about eliciting sensitive material from patients, “clues” to sexual assault, strategies to contain distress, short term and long-term interventions of likely benefit (R9).

An analysis of gender elicits an interesting finding when applied to participant perceptions of ability to respond to disclosures of sexual assault. The majority of participants who **believed** that were well equipped to respond were male, and the majority of participants who **did not** believe they were well equipped to respond were female (see Table 5).

Table 5: Ability to respond to disclosures analysed by sex

	Female participants	Male participants
Well-equipped	2	5
Not well-equipped	5	2

This finding is interesting because the issue that all are being asked to respond to is such a gendered one. Why would female participants feel less well equipped in responding to disclosures of sexual assault than their male colleagues, when one of those male colleagues regarded his gender as a barrier? Perhaps this is because female participants have a heightened awareness of the significant impact sexual assault can have on an individual, thus they recognise the implications of their response; so they may be more critical of themselves as workers responding to these disclosures. With hindsight I would have asked workers about what they thought would achieve a better service response, for example, *What would need to be different for you to be able to more effectively respond to sexual assault?*

Conclusion

Five significant findings emerged in this chapter and their implications are explored in Chapter 6:

- The critical lack of professional sexual assault training in the last ten years.
- The belief of over half of the participants' that they are not well equipped to respond to discourses of sexual assault.
- The general expression of a lack of awareness about the elements of an effective response to sexual assault disclosures.
- Participants' divergent interpretations of their role in working with victim/survivors experiencing psychiatric crisis linked to trauma.
- The belief of the majority of workers that inquiry into gender-based violence should not be routine in psychiatric assessment.

CHAPTER FIVE: Findings

Knowledge and
utilisation of specialist
sexual assault services

This chapter explores participant patterns of referral for service users who have disclosed sexual assault in crisis psychiatric services, as well as worker knowledge of and communication with specialist sexual assault services. The barriers to the relationship between the two ideologically distinct service spheres of sexual assault and psychiatry are identified by CATS workers. The implications of the key findings to emerge will be discussed in Chapter 6.

CROSS-SECTORAL PRACTICE

5.1 Participant knowledge and utilisation of community support services

Respondents to this survey expressed knowledge of a broad range of support services that are available in the community for victim/survivors of sexual assault (see Appendix L). All fifteen CATS workers identified CASA as a significant support service, with generic ‘counsellors’ emerging as the next most dominant theme acknowledged by six participants, while two explicitly referred to ‘trauma counsellors’. Support services from the medical sector such as GPs, and psychiatrists were identified by three participants.

While all participants identified CASAs along with other appropriate specialist sexual assault services in the community, when asked how often they refer to these services, eleven participants indicated that they rarely, if ever, refer to them. Two did not specify how often they refer to these services, instead replying “when required” and “when clinically indicated”, while two others indicated they frequently refer to these services:

1/ month (R4)

Once twice a month (R5).

It is noteworthy that only two of the respondents reported frequent communication through referral with specialist sexual assault services. This is interesting in the context of sexual assault being identified by the majority of participants in Chapter 3 as an issue in the stories of service users, while in Chapter 4, more than half of respondents recognised a core role as referral in relation to women disclosing a history of sexual assault. If a significant service response of CATS is appropriate referral and yet workers are not referring to sexual assault services, then to whom are these women referred? This question and the identified lack of communication through referral by these participants with specialist services raises implications for both workers and victim/survivors.

5.2 Participant referral to specialist sexual assault services

Participants were asked about reasons for referral or lack of referral to specialist services. Understanding the reasons that contribute to referral patterns would seem critical to enhancing communication between the two service spheres, which Morley (2004-05, p. 11); Martin (2003, p. 165); Taft (2003, p. 16); Davidson and McNamara (1999, p. 102) and Warshaw (1997, p. 26) among others, argue, is extremely necessary for effective response to victim/survivors. Overall, there was minimal agreement about the reasons for referral to specialist sexual assault services (see Appendix M). The most dominant reason, expressed by five participants, was that they would refer a service user to a specialist service if that person “wanted referral” and four stated that they would refer to a sexual assault service if sexual assault was the primary reason for presentation. These are two interesting findings since in Chapter 3 and 4 some participants’ understandings of trauma were argued to be incongruent with research findings about trauma, and in Chapter 4, participants were strongly in agreement that inquiry about sexual assault should not be mandatory in initial psychiatric assessment. Thus, it is imaginable that if a woman does not make a connection between her distress and her experience of sexual assault, while at the same time, her signs/symptoms are also not understood by a worker to be related to

trauma, she may not receive the most appropriate referral. Below is a quote illustrating the two themes discussed above:

If there has been a disclosure and in consult with the client it is agreed he/she may benefit from further counselling (R8).

Participants were in greater agreement about why they **do not** refer to specialist sexual assault services (see Appendix N); eight said that they do not refer if referral is not wanted, and two workers premised the need for management of the service user's psychiatric signs/symptoms as contributing to lack of referral. For instance:

Would delay referral if they were presently psychotic or unable to cognitively address the assault (R10).

An additional reason that two participants indicated would stop their referral to specialist services was the length of waiting lists as well as the time-limited characteristic of some specialist services:

Their resources are so limited that they can usually only offer very very time limited counselling and they sometimes have prohibitively long waiting lists (R3).

Further, one participant replied:

...perceive some services to focus excessively on feminist ideology and perusal of offender by legal means (R9).

This male voice has important implications for one of the issues that this study has been grappling with - the usefulness of a feminist framework/understanding/perspective for this mental health service. It highlights a potential lack of awareness about the role of specialist services, in which a feminist perspective places control and power with a victim/survivor who is given information and advocacy in relation to different choices, one of which is the choice of police involvement and possible legal proceedings (McCarthy 1990, p. 1).

It is interesting that the most dominant theme in relation to why participants do and do not refer to specialist services was service user choice. This would suggest that the reason that there is not more communication between this mental health and specialist sexual assault service is because service users refuse referral. An interesting question that would have been asked in hindsight is how often a discussion about specialist sexual assault services is entered into with service users and/or whether workers ever utilise specialist services for the purposes of information seeking.

5.3 Services for longer-term therapeutic intervention relating to sexual assault

These primary service providers were asked to nominate other services to which they refer for longer-term therapeutic intervention relating to sexual assault; the survey suggested several services and there was an invitation to nominate others. Table 6 reports the frequency of responses.

Table 6: Referral to longer-term therapeutic services

Service	Number of participants	% of participants
Private psychiatrists	13	87%
Psychologists	13	87%
Psychotherapists	11	73%
Other counsellors	10	67%
General practitioners	7	47%
Self help groups	6	40%
Family therapists	5	33%
Social workers	1	7%

Respondents identified their referral to professionals such as psychotherapists, psychologists and other counsellors who may practice with a social understanding of health; however, private psychiatrists emerged as one group of professionals to whom CATS workers most commonly refer victim/survivors of sexual assault and GPs were nominated by nearly half of the group. While this finding might reflect the availability of rebates, it is interesting in light of the research literature which argues that it is critical that victim/survivors do not engage with a service that medicalises or privatises their distress or takes their power away (Breckenridge 1999, p. 27). For example, Burstow (2003, p. 1300) argues that psychiatric professionals have the power to ‘diagnose’, ‘treat’, ‘medicate’ and/or ‘hospitalise’ which places them at risk of taking away the service user’s power to name their experiences. Davis (1999, p.

766) argues that power relations in trauma interventions are critical because at the core of traumatic experiences is disempowerment and disconnection from others; and Herman (1992, p. 133) contends that recovery must be founded on the empowerment of the service user and the beginning of new relationships.

5.4 Mental health and sexual assault workers' responses to sexual assault

In being asked to comment *yes* or *no* regarding their opinion of whether mental health workers respond differently to disclosures of sexual assault compared to the way sexual assault workers respond to these same disclosures, thirteen participants said *yes*, and two did not respond. The most dominant theme to emerge, expressed by five participants, was that mental health workers would be perceived to focus on psychiatric signs/symptoms and risk issues. To illustrate:

Mental health workers are concerned about the psychosis and depression and are attempting to settle the mind and divulging sexual abuse only distresses the mind in the short term (R11).

What is missing from the comment above is recognition that the 'psychosis' and 'depression' that this respondent identifies may be significantly linked to trauma and worker awareness of this is critical to the construction of an effective intervention plan. There was no agreement about *how* sexual assault workers may respond differently to workers from the mental health field, which is not surprising given that the majority earlier expressed their lack of communication with specialist sexual assault workers. However, one comment was:

Sexual assault workers might be more likely to (?erroneously) attribute all of the person's problems to the assault/abuse (R3).

5.5 Sexual assault service views about mental illness

Earlier in this chapter, the possible impact of the identified lack of referral to sexual assault services by CATS workers was briefly discussed in terms of service users and workers. Morely's (2005) research documented the challenges involved with developing collaborative links between a mental health and sexual assault service, finding that workers from both fields carried understandings about the other's

approach to practice that were fuelled by misconceptions which thus severely hindered collaboration and communication. If this lack of referral is to be challenged, it can be seen as important to understand some of the misconceptions that operate as barriers. With this in mind, participants were invited to respond *yes* or *no* to the question of whether sexual assault services held particular views about mental illness, followed by a discussion of the issue. Four participants responded in the positive, three answered in the negative and eight expressed that they were unsure. The most dominant theme to emerge from the data was the belief that sexual assault services have a lack of knowledge about mental illness, which was stated by three respondents. To demonstrate:

Lack of knowledge, misunderstanding of symptoms eg. dissociation can be mistaken for hallucinations (R6).

Interestingly, each of the three workers who believed that sexual assault workers have a lack of understanding about mental illness also reported that they rarely refer to these same workers. This belief may have arisen as a result of not having contact with these services or it may be a reason for the lack of referral. Morely (2005, p. 12) discusses the beneficial impact of mutual training between the two service spheres in raising consciousness about sexual assault within mental health systems to increase the responsiveness of this system, as well as giving sexual assault workers an insight into the workings of the mental health system and assisting their potential for advocating from within. The current findings support the need for mutual training and information sharing between service spheres.

5.6 Participant comment about their colleagues

This section is the result of attending to three participants' critical reflections within the survey regarding their colleagues' understandings of trauma, sexism, male insensitivity to abuse and the belief that assault is not a significant issue. These comments were made in different sections of the survey without direct reference to a question. These workers' voices sound a concern, perhaps suggesting the desire for change in worker response to the disclosures of sexual assault in crisis psychiatric service settings:

I think generally sexual assault is underrated in terms of its impact on a person's life. Sexism particularly toward women is often an issue which constrains the way in which professionals approach victims of past sexual assault (R1, female).

I find that some professionals have an extreme lack of understanding of trauma especially when exhibited in a personality disordered female...

I also feel there are varied views within the workplace and there are some males that are totally insensitive to abuse and wouldn't know if they were perpetuating it (R11, male).

Mental health workers not trained sufficiently in the field, some don't believe it to be a significant issue (R15, female).

5.7 Additional comments

An unsolicited comment emerged at the end of one male participants' survey (see Appendix O); sceptical of the possibility for the current study being able to collect "any meaningful data". This worker expressed the belief that "professionals have far too much knowledge and experience to respond in a meaningful way to these questions in writing". The voice seemed to assume a position of authority by generalising a subjective viewpoint to that of other workers, yet if his words are juxtaposed with those of his colleagues, it suggests that his is a minority view, since in Chapter 4 it was reported that seven participants were very clear that presently they do not feel well-equipped to respond to disclosures of sexual assault. This chapter reported the comments of three participants critical of some of their colleagues' views about sexual assault and understandings of trauma; and, like service users, they expressed a request for some change in the response of mental health workers to disclosures of sexual assault.

Conclusion

Two key findings surfaced from for this third and final findings chapter:

- The issue of CATS worker's lack of communication through referral and/or information sharing with specialist sexual assault services, and

- The concern of three participants with reference to the attitudes and awareness of some colleagues in relation to women and sexual assault.

The implications of these two key findings will be explored in Chapter 6.

CHAPTER SIX: Implications

This chapter focuses initially on personal reflections; and then explores three implications for CATS workers and their organisation which are drawn from several key findings and discussed under three headings - *the need for sexual assault training; the need for review of CATS role in relation to women disclosing sexual assault; and the need for cross-sectoral practice*. Finally, certain recommendations are presented that emerged from the thesis. While this study has highlighted the strengths of these CATS workers, it also deals with certain issues that require further work. In discussing these implications for change, this chapter focuses on those areas that necessitate a review of some current practices.

Throughout this thesis I have grappled with the issue of how to position myself within the text, because in expressing a feminist perspective I am at risk of dislocating myself from the workers whose voices must be listened to so that they can be the change that is needed within mental health services. I have tried to maintain a reflective stance towards possibilities for feminist informed practice in a psychiatric field dominated by medical discourse. I believe this to be critical at a time when much literature has documented the high number of women using mental health services who have survived gendered violence and many of these women have bravely spoken about their experience of these services. Through the research these women have identified that mental health systems can inappropriately approach victims/survivors' needs and experiences, while feminist informed practice more usefully meets those same needs and experiences (Graham 1995, p. 90; Morley 2005, p. 6).

It is important to acknowledge once again that CATS work is extremely challenging with many ongoing stressors. The fifteen CATS workers who voluntarily took part in this study showed a considerable willingness to engage with issues and critically

reflect upon their own practice. Service users have been saying that change needs to occur within mental health services in response to sexual assault and though small scale, this study has heard the voices of a number of CATS workers expressing that they also want some change in their capacity to respond to women disclosing sexual assault. For change to occur, listening must be engaged with by both workers and the organisation.

Reflection on the project

The voices in this thesis are not comprehensive of all the voices and views of this metropolitan CATS and may not even be completely representative. The participants in this study only comprised half of the workers on the team and may reflect people more likely to engage in a process of thinking about sexual assault and critically reflecting on their own conceptualisation of and practice in response to the issue. Of five allied health workers, four joined in this study, however only half of the workers with a psychiatric nursing background participated and just a quarter of the workers with a medical background took part⁷. A limitation of this study was the utilisation of a survey through which to listen to participant voices as opposed to the richness of qualitative interviews and/or focus groups. Another was that certain survey questions relied heavily on subjective interpretation of words or phrases such as *common/not common at all*. With the value of hindsight I would have asked some different questions (for example see p. 48) and some questions differently (for example see p. 27).

While the reasons that lead me to utilise a survey design were explored in Chapter 2 (p. 22), as having arisen from my student experience of the service, it is important to acknowledge issues with the data analysis that are problematic. An example of this was that while I attempted to see CATS workers practice experience within their own terms and suggest gaps in the practice experiences reported upon if the literature is consulted, at times respondent data seemed to be positioned in *comparison to* current literature. Also, there was perhaps not enough credence given to the distinction between analysing ‘text’, not ‘voice’, and the potential impact of this on the findings.

⁷ It is important to note that there are no fulltime CATS workers with a medical professional background on this metropolitan team, thus one reason for this professional groups’ lack of participation in this study may be because they have less time allocated to a purely CATS role.

This thesis also left unattended the considerable methodological problem of ascertaining whether what people tell us they do in fact what they *do* do, which poses further issues for interpreting and analysing data.

The findings on which this study rests are based on a small sample due to the qualitative nature of the project and the limited scope of an Honours thesis. They suggest however, that further research would be helpful to comprehensively understand the experiences of mental health workers in responding to victim/survivors of sexual assault as well as the need to explore the organisational context in which CATS workers work, and the extent to which their actions are shaped by organisational elements and pressures.

Reflection on self learnings

I was struck by the diverse and distinct voices within this CATS team as well as the willingness of some workers to engage with difficult issues and critically reflect upon their own practice. This has taught me that while it is impossible to go in into a project as a blank slate, your thoughts of what will emerge can be wrong and so it is important to critically reflect upon the preconceived ideas, those that are newly formed, the gap between the two and their impact on the project in the middle. I have felt the awkwardness of one who is trying to maintain a feminist voice and position while not distancing myself from mental health workers who may not share that same ideological position or of dislocating myself from feminist service workers who may not believe that there is a role for psychiatry in the response to victim/survivors of sexual assault. The frankness and depth of the CATS members' responses have led me to be hopeful that, despite the divergent ideological underpinnings of these two service sectors, there can be some development and growth in communication and a genuine move towards collaboration.

Implication 1: The need for sexual assault training

One the major implications of this study is the need for sexual assault training and this is drawn from these key findings.

Key finding 1: *Perception of ability to respond to disclosures of sexual assault*

It is significant that slightly over half of the participants expressed their belief that they were not well equipped to respond to disclosures of sexual assault, an issue which is the core business of mental health services. Three participants explicitly called for sexual assault training to improve their ability to respond, with one of those participants suggesting training on an annual basis.

Key finding 2: *Lack of sexual assault training*

Health and mental health professionals may be the first and only professionals to see a gendered violence victim/survivor, which makes these systems crucial points for early intervention and prevention for women (Matthews 2004, p. 365). It is critical that eleven of fifteen participants in this study reported they had not received sexual assault training in at least the last ten years, while eight participants identified their lack of training as a challenge in their capacity as CATS workers to respond to issues arising from sexual assault. Ten years ago Mamman (1995, p. 102) was arguing that there was an urgent need for knowledge in the public psychiatric sector to meet the needs of victim/survivors of sexual assault who were using mental health services, stating that many health and welfare professionals were insufficiently trained in clinical management of adults disclosing childhood sexual assault. This is still a significant issue and this lack of training has occurred in a health service which, at a policy level at least, acknowledges that many female service users will have had past experiences of sexual assault and these experiences may affect relations to and experience of, psychiatric treatment (Simon 1999, p. 463). It seems this has not been translated into better support through training for workers at the frontline of responding to women. Mental health workers' lack of sexual assault training has important implications for service users who are telling us that mental health services often inappropriately address their needs and experiences (Morley 2005, p. 6; Humphrey & Thiara 2003, p. 216; Jarvis & McIlwaine 1997, p. 4; Gibbons 1996, p. 1755; Graham 1995, p. 90).

Key finding 3: *Identification of victim/survivors as frequent CATS service users*

It was found that while a majority of respondents believed that they frequently worked with service users who had experienced sexual assault, which is congruent with the literature (Keel 2005; Spataro et al. 2004; Martin 2003; Astbury 2001; Simon 1999; Jarvis & McIlwaine 1997; Graham 1995); three male workers stated that they

work with victim/survivors either infrequently or occasionally. The current research is arguing that these workers must be working alongside women for whom this is an element in their story, however a small number of workers are not identifying this. Knowledge of sexual assault history is crucial to a woman receiving an appropriate and enabling service (Humphreys & Thiara 2003, p. 220; Heise, Ellsberg & Gottemoeller 1999, p. 1). Taft (2003, p. 15), summarising key research findings in relation to domestic violence and mental health argues that, “workers who do not understand the links between abuse and mental illness may focus on the intrapsychic symptoms and misrepresent these as chronic psychopathology”. Mental health providers may not recognise the implications of a misdiagnosis for women who are experiencing signs/symptoms of mental health issues associated with gendered violence (Taft 2003, p. 13). However, there are individual and structural implications - the individual, private detriment of the woman and the structural impact of increased costs to the mental health system caused by the revolving door as women seek help which is not effectively provided (Campbell 2002).

Key finding 4: Myths and misconceptions about the cause of sexual assault and the lack of a gendered understanding

Many participants reflected attitudes that a feminist analysis understands to be informed by myths or misconceptions about sexual assault. Myths about the groups of individuals most at risk of sexual assault included a lack of gender recognition, a perception that sexual assault occurs to ‘others’ (for example, people of another ethnicity), and a belief that people engaged in “risk taking” behaviours are most at risk. Misconceptions about the causes of sexual assault included the lack of a gendered understanding, the perception that perpetrators of sexual abuse have been sexually assaulted themselves, and the belief that family deficit causes sexual assault. It is noteworthy that attitudes about sexual assault and understandings of trauma was a cause of concern for three of the participants who explicitly identified their apprehension about the theoretical perspectives and practice of their colleagues. This has implications for service users who come into contact with a worker whose beliefs may be informed by myths or misconceptions, for example - a belief that sexual assault occurs as a result of people putting themselves at risk can, quite unconsciously, blame the victim/survivor. This may then result in that woman

internalising a belief that subjugates her experiences and minimises the consequences of violence.

The lack of a gendered understanding of violence, a crime against women perpetrated by men, has critical implications for victim/survivors (Scott *et al.* 1995, p. 34). Above all it denies the political and social context in which sexual assault occurs, hence reinforcing that context and preventing the possibility of non-sexist practice with women (Robertson 1990, p. 183; Kravetz 1986, p. 114). McLellan (1995, p. 81) argues that, “to diagnose a woman’s personal conflicts as wholly individual and personal when in fact they are systemically socially produced is to encourage her to blame herself for the situation she finds herself in”. A gendered understanding of sexual assault is the beginning of providing an intervention which is informed by a feminist analysis, and which is the sort of intervention that service users voice will more effectively address their needs and experiences (Morley 2005, p. 6; Jarvis & McIlwaine 1997, p. 5; Graham 1995, p. 91).

Key finding 5: *Problematic understanding of trauma*

This study found that all fifteen participants demonstrated a comprehensive understanding of the significant emotional, psychological and physical effects of sexual assault; however, this impact was predominantly addressed in terms of PDs and not trauma. One participant identified that he did not have any substantiated knowledge of the relationship between sexual assault and mental illness nor a good understanding about trauma; another questioned the usefulness of knowing about a service user’s history of sexual assault. In response to the vignette describing a woman’s complex trauma reactions to childhood abuse, only six identified the woman’s disclosure of abuse as relevant information in the construction of a diagnosis and intervention plan. Given the research regarding sexual trauma, the issues above reveal a problematic awareness of trauma, which, for service users, may result in misdiagnosis and increased removal of power through disenfranchising a woman from her experience.

Trauma reactions can be wrongfully interpreted as constituting signs/symptoms of mental illness including anxiety, depression and PDs (Morley 2005, p. 6). Current research recognises that signs/symptoms which commonly form the basis for a PD

diagnosis are more effectively understood as signs/symptoms of complex trauma reactions (Trippany *et al.* 2006; p. 105; Humphreys & Joseph 2004; Herman 2001, p. 126; Yen *et al.* 2002, p. 516). Humphreys and Joseph (2004) argue that the implications of adult trauma continue to occupy a marginalised position in mental health work although this group of service users are over represented within the mental health system. Recent research has argued that if a woman has experienced sexual assault, characteristics that often lead to a diagnosis of BPD are more helpfully understood and treated as trauma coping mechanisms rather than personality deficits (Trippany *et al.* 2006, p. 101). If the normal patterns of a traumatic response are medicalised, and women are labelled in a void outside the context of trauma, workers can be engaging in a form of victim-blaming as well as reinforcing the patriarchal social system which gives rise to sexual assault (Morley 2005, p. 6). If workers have not received training about sexual assault in the last ten years, then the most recent research which understands signs/symptoms of PDs as complex trauma is not able to filter down to service users.

Key finding 6: Lack of awareness of the elements of an effective response to the disclosure of sexual assault

Only three workers of the fifteen recognised that a disclosure of sexual assault should be met with an immediately validating response. Two of these participants identified having received sexual assault training and the remaining participant had completed a student placement with CASA Gatehouse Centre many years ago. This emphasises the benefit of sexual assault training for workers whose job brings them into frequent contact with victim/survivors of sexual assault. It is significant that twelve participants did not identify the characteristics of an effective and enabling response. The initial response of workers to a disclosure of sexual assault is critically important and if it is not managed skilfully, can have a negative impact on victim/survivors (Stenius & Veysey 2005, p. 1155; Burstow 2003, p. 1306; Draucker 1992, p. 29). The literature names some of the elements of a good practice response as belief and empathy, reassurance against blame, validation of perceptions and feelings expressed, allowance for the opportunity to talk and resource provision (Fraser 2004-05, p. 25; Marriot & Hughes 1997; Pahl 1995, p. 144-145; Burke 1992, p. 110). Clearly an effective response to the disclosure of sexual assault is very important for service

users and it is achievable for these CATS workers who already carry extensive practical knowledge.

Implication 2: Need for review of CATS role in relation to women disclosing sexual assault

The second implication to arise from this study is the need for a review of CATS role in relation to women disclosing sexual assault. This point has emerged from these key findings.

Key finding 1: *Difference in participants' understanding of their role in relation to the woman in the vignette*

The enormous pain that may be involved in talking about sexual assault was acknowledged by participants, especially in the context of a crisis service; however, two different interpretations of the CATS role in this context emerged. Four participants thought their role in relation to the woman was engagement, therapeutic counselling, symptom management and referral, while the other ten spoke of referral and/or short-term support and/or risk management. This distinction is important since for women in mental health crisis, CATS is their predominant service option. While workers were in agreement that a core CATS job is referral, these same workers identified that they rarely refer to specialist services, utilising private psychiatrists most commonly. A feminist analysis would argue that these workers are actively engaging in the medicalisation and privatisation of distress which alienates a victim/survivor from her experiences by reinforcing that she is the cause of her problems (Breckenridge 1999, p. 27).

Key finding 2: *Mandatory inquiry about sexual assault in CATS assessment*

Fourteen of the fifteen participants expressed the belief that inquiry into sexual assault should not be mandatory, principally because it would be distressing and potentially harmful for service users to discuss sexual assault in the often time-poor crisis services. Three believed that sexual assault does not need to be divulged in crisis because it may bring to light something which is not the immediate concern, while a fourth was not sure what could be done with knowledge of sexual assault history if it was disclosed. To provide an effective response to service users, workers must have at least a consciousness about sexual assault. Rather than requiring specific questions

about sexual assault, the issue of routine inquiry is more about consciousness-raising because, if gendered violence is not in the discourse, than it cannot be on the agenda. It is critical that women receive a service which is a vehicle of change for how they are feeling not just through appropriate referral but also through the messages about their distress that workers who are in a position of power can send to victim/survivors.

Implication 3: Need for cross-sectoral practice

One the major implications from this study is the need for communication and collaborative practice between CATS and specialist sexual assault services and this is based on the key finding below.

Key finding 1: *Lack of communication between CATS and specialist sexual assault services*

Every participant identified knowledge that CASAs were the specialist sexual assault service, yet thirteen of the fifteen acknowledged that they rarely referred to these services. Three participants reported a belief that sexual assault services have a lack of awareness about mental illness. Here are two service sectors working with a significant overlap of service users but seemingly utilising different conceptualisations of the issues and consequently there appears to be minimal, if any, communication between them. This lack of dialogue between the two service spheres may result in limited information-sharing and consciousness-raising about issues which are core business for both sectors. Morley's (2004-05, p. 12) positive experience of 'mutual information exchange' sessions between sexual assault and community mental health staff was powerful because of the benefit to collaborative service provision, clarification of referral information and development of networks. Mental health services cannot respond alone to what we know are women's multiple needs and experiences - there must be effective communication and collaboration with sexual assault services. This has implications in better service provision for service users as well as heightened support for workers responding to these issues.

Recommendations to emerge from this project

There are two core recommendations to emerge from an analysis of these workers' voices in this thesis. The *first* pertains to CATS workers receiving comprehensive sexual assault training which addresses key areas such as:

- The prevalence of sexual assault in the community and the distinct ways sexual trauma can impact on an individual. Presentation of key research findings that the majority of women who use mental health services have experienced sexual assault;
- Exploration and deconstruction of common myths and misconceptions about sexual assault, including the integration of a socio-political analysis of the role of gender in sexual assault;
- Trauma training which encompasses recent research about trauma, ways to identify the common signs of trauma, the frequent manifestation of signs/symptoms of trauma as signs/symptoms which commonly form the basis of other diagnostic labels such as BPD or psychosis;
- Elements of an effective and enabling response to the disclosure of sexual assault in a crisis psychiatric service setting;
- An analysis of the issues pertaining to CATS workers maintaining a consciousness about sexual assault through the asking of routine questions during an initial crisis psychiatric assessment.

The *second* recommendation is aimed at increasing the communication between the mental health and sexual assault spheres. This may be achieved through mutual training between the service spheres, the core elements of which could incorporate:

- Information about the function and capacity of each service and common service user needs;
- Clarification about the referral process of each service;
- The space to ask questions and begin relationships.

Conclusion

This thesis has explored CATS workers' experiences of listening to disclosures of sexual assault in crisis psychiatric services because, as the participant whose words began this thesis stated, *crisis is often when it comes out*. From the voices of CATS workers, implications for both service users and workers have emerged. These implications are relevant to sexual assault training for CATS workers, a review of CATS role in relation to victim/survivors of sexual assault and communication and collaboration across service sectors. The experience of sexual assault has not been

understood within this thesis as the sole contributor of a woman's distress/signs/symptoms; it has, however, been interpreted as a significant event which can have wide ranging consequences for women and is a common element in many mental health service users' stories. For this reason it is critical that CATS workers maintain a consciousness about the impact of gendered violence and trauma so that their interventions and referrals with women are appropriate and enabling. This requires not only a worker response but also a response that is located at the level of the organisation.

References



American Psychiatric Association (1987) *Diagnostic and statistical manual of mental disorders: DSM-III-R*. Washington, DC: American Psychiatric Association.

Astbury, J. (2001) 'Parallel session on moving sexual violence research forward. Mental health effects of SVAW: outcomes and research questions', *Forum 5*, Geneva. [Online], [Accessed 6th September 2006]. Available from World Wide Web: <www.globalforumhealth.org/non_compliant_pages/forum5/sessionsheet/108.html>

Australian Bureau of Statistics (ABS) (1996) *Women's Safety Australia*. Canberra: Australian Bureau of Statistics.

Australian Bureau of Statistics (ABS) (2004) *Sexual assault in Australia: A statistical overview*. Canberra: Australian Bureau of Statistics.

Australian Bureau of Statistics (ABS) (2005) *Personal Safety Survey Australia*. Canberra: Australian Bureau of Statistics.

Bennett, L., Manderson, L. and Astbury, J. (2000) *Eliminating Sexual Violence Against Women: Towards a Global Initiative*. Melbourne: Key Centre for Women's Health in Society, The University of Melbourne.

Bloom, S. (1999) *Trauma Theory Abbreviated. The Final Action Plan: A coordinated community-based response to family violence*. Attorney General of Pennsylvania's Family Violence Task Force. October, 1999.

Breckenridge, J. (1999) 'Subjugation and silences: the role of professional in silencing victims of sexual and domestic violence'. Chapter 1 in J. Breckenridge and Laing, L. *Challenging Silence: Innovative responses to sexual and domestic violence*. St. Leonards: Allen & Unwin.

Breckenridge, J. and Carmody, M. (1992) *Crimes of Violence: Australian Responses to Rape and Child Sexual Assault*. North Sydney: Allen & Unwin.

Briere, J. and Zaidi, L. (1989) 'Sexual abuse histories and sequelae in female psychiatric emergency room patients', *American Journal of Psychiatry*, 146 (12), 1602-1606.

Bryer, J., Nelson, B., Miller, J. and Krol, P. (1987) 'Childhood sexual and physical abuse as a factor in adult psychiatric illness', *American Journal of Psychiatry*, 144 (11), 1426-1430.

Bullen, J., Jacobs, J., Le Pont, L., Martin, M. and Smith, C. (2004) 'A collaborative approach to working with women who have experienced sexual violence as children – Stepping Out Housing Program', *NSW NGO Conference 2004 – NGOs Mental Health and Community: Turning the Tide*, March 2004. Sydney, NSW: Mental Health Coordinating Council 2004.

Burke, C. (1992) 'Expert on her own story. Working with women's experience of incest', Chapter 9 in J. Breckenridge and M. Carmody (Eds) *Crimes of Violence: Australian responses to rape and child sexual assault*. Sydney: Allen & Unwin. Pp. 109-120.

Burstow, B. (1992) *Radical Feminist Therapy: Working in the Context of Violence*. Newbury Park, CA: Sage.

Burstow, B. (2003) 'Toward a Radical Understanding of Trauma and Trauma Work', *Violence Against Women*, 9 (11), 1293-1317

Busfield, J. (1989) 'Sexism and Psychiatry'. *Sociology*, 23, 3.

Campbell, J. (2002) 'Health consequences of intimate partner violence', *The Lancet*, 359, 331-36.

Campbell, R. and Schram, P. (1995) 'Feminist Research Methods', *Psychology of Women Quarterly*, 19, 85-106.

Centre Against Sexual Assault House (2006) *Breaking the Silence Information Package*. Melbourne: CASA House.

Chesler, P. (1972) *Women and Madness*. New York: Doubleday and Company.

Chesler, P. (2005) *Women and Madness*. Revised and Updated. New York: Palgrave Macmillan.

Chung, D., O'Leary, P. and Hand, T. (2006) 'Sexual violence offenders: Prevention and intervention approaches', *ACSSA Issues*, 5 (June), 1-54.

Cohen, D., De Vos, E. and Newberger, E. (1997) 'Barriers to physician identification and treatment of family violence: lessons from five communities', *Academic Medicine*, 72 (1), S19-25.

Crowell, N. and Burgess, A. (Eds) (1996) *Understanding Violence Against Women*. Washington: National Academy Press.

D'Arcy, M. (1999) *Speaking the Unspeakable*. Victoria: Arena.

Darlington, Y. and Scott, D. (2002) *Qualitative Research in Practice. Stories from the Field*. NSW: Allen & Unwin.

Davidson, J. and McNamara, L. (1999) 'Systems that silence: lifting the lid on psychiatric institutional sexual abuse'. Chapter 6 in J. Breckenridge and L. Laing (1999) *Challenging Silence: Innovative responses to sexual and domestic violence*. St. Leonards: Allen & Unwin. Pp. 86-102.

Davidson, L., King, V., Garcia, J. and Marchant, S. (2000) "Reducing Domestic Violence...What Works? Health Services", *Policing and Reducing Crime Unit*. London: Home Office Research, Development and Statistics Directorate.

Davis, H. (1999) 'The Psychiatrization of Post-Traumatic Distress: Issues for Social Workers', *British Journal of Social Work*, 29, 754-777.

D'Cruz, H. and Jones, M. (2004) *Social Work Research. Ethical and Political Contexts*. London: SAGE Publications.

Den Herder, D. and Redner, L. (1991) 'The Treatment of Childhood Sexual Trauma in Chronically Mentally Ill Adults', *Health and Social Work*, 16 (1), 50-57.

Denscombe, M. (1998) *The Good Research Guide*. Buckingham: Open University Press.

Draucker, C. (1992) *Counselling Survivors of Childhood Sexual Abuse*. London: SAGE Publications.

Ellenson, G. (1986) 'Disturbance of perception in adult female incest survivors', *Social Casework: The Journal of Contemporary Social Work*, 67, 149-159.

Fergus, L. and Keel, M. (2005) 'Adult victim/survivors of childhood sexual assault', ACSSA (Australian Centre for the Study of Sexual Assault) *Wrap 1*, November, 1-6.

Fergusson, D., Horwood, L. and Lynskey, M. (1996) 'Psychiatric outcomes of childhood sexual abuse', *Journal of the American Academy of Child and Adolescent Psychiatry*, 35 (10), 1365-1375.

Fleming, J. (1997) 'Prevalence of childhood sexual abuse in a community sample of Australian women', *The Medical Journal of Australia (eMJA)*, 166: 65-68 [Online], [Accessed 24th July 2006]. Available from World Wide Web: <<http://www.mja.com.au/>>

Fossey, E., Harvey, C., McDermott, F. and Davidson, L. (2002) 'Understanding and evaluating qualitative research', *Australian and New Zealand Journal of Psychiatry*, 36, 717-732.

Fraser, M. (2004-05) 'Working with women who have experienced child sexual assault. Unsettling orthodoxies', *Women Against Violence*, 17, 25-32.

Frazier, P. (2000) 'The role of attributions and perceived control in recovery from rape', *Journal of Personal and Interpersonal Loss*, 5 (2/3), 203.

Gavey, N. (2005) *Just Sex? The Cultural Scaffolding of Rape*. East Sussex: Routledge.

Gibbons, J. (1996) 'Services for Adults who have Experienced Sexual Assault: Improving Agency Response', *Social Science Medicine*, 43 (12), 1755-1763.

Gilfus, M. (1999) 'The price of the ticket', *Women Against Violence*, 5, 1238-1257.

Goldman, S., D'Angelo, E., DeMaso, D. and Mezzacappa, E. (1992) 'Physical and sexual abuse histories among children with borderline personality disorder', *American Journal of Psychiatry*, 149 (12), 1723-1727.

Goodman, L., Salyers, M., Muesser, K., Rosenberg, S., Swartz, M., Essock, S., Osher, F., Butterfield, M. and Swanson, J. (2001) 'Recent victimisation in women and men with severe mental illness: Prevalence and correlates', *Journal of Traumatic Stress*, 14 (4), 615-631.

Graham, C. (1995) 'Won't somebody please listen to me, believe me and understand me? Women who have been sexually assaulted - their experiences of psychiatric services', In Australian Women's Health Network *Changing Society for Women's Health*. Proceedings from the Third National Women's Health Conference 1995. Canberra: Australian National University. Pp. 88-91.

Grigg, M., Herrman, H. and Harvey, C. (2002) 'What is duty/triage? Understanding the role of duty/triage in an area mental health service', *Australian and New Zealand Journal of Psychiatry*, 36 (6), 787

Grinnell, R. and Unrau, Y. (2005) *Social Work Research and Evaluation. Quantitative and Qualitative Approaches* (7th Ed). New York: Oxford University Press.

Heise, L., Ellsberg, M. and Gottemoeller, M. (1999) 'Ending Violence Against Women', *Population Reports*, Series L, No. 11. Baltimore: John Hopkins University School of Public Health, Population Information Program, December.

Henderson, H. (Ed.) (2000) *Domestic Violence and Child Abuse Sourcebook*. United States of America: Omnigraphics, Inc.

Herman, J. (2001) *Trauma and Recovery*. USA: Pandora.

Herman, J. (1992) *Trauma and Recovery*. New York: Basic Books.

Herman, J., Perry, C. and van der Kolk, B. (1989) 'Childhood trauma in borderline personality disorder', *American Journal of Psychiatry*, 146, 490-495.

Herman, J. and van der Kolk, B. (1987) 'Traumatic antecedents of BPD', in B. van der Kolk (Ed.) *Psychological Trauma*. Washington: American Psychiatric Press, Inc. Pp. 111-126.

Howgego, I., Owen, C., Meldrum, L., Yellowlees, P., Dark, F. and Parslow, R. (2005) 'Posttraumatic stress disorder: An exploratory study examining rates of trauma and PTSD and its effect on client outcomes in community mental health', *BMC Psychiatry*, 5:21. [Online], [Accessed 3rd July 2006]. Available from World Wide Web: <<http://www.biomedcentral.com/1471-244x/5/21>>

Humphreys, C. and Joseph, S. (2004) 'Domestic violence and the politics of trauma', *Women's studies international forum*, 27 (5-6), 559-570. [Online], [Accessed 19 April 2006]. Available from World Wide Web: <http://www.sciencedirect.com.ezproxy.lib.unimelb.edu.au/science?_ob=PublicationURL&_cdi=5924&_pubType=J&_auth=y&_acct=C000028178&_version=1&_urlVe

rsion=0&_userid=559483&md5=9506a1358dfecb7e7fe51759d28d0104&jchunk=27#
27>

Humphreys, C. and Thiara, R. (2003) 'Mental Health and Domestic Violence: "I call it symptoms of abuse"', *British Journal of Social Work*, 33 (2), 209-226

Jarvis, S. and McIlwaine, F. (1997) 'A Crisis of Witnessing: Sexually assaulted women in the psychiatric and legal systems', *Domestic Violence and Incest Resource Centre Newsletter*, 3, 3-8.

Keel, M. (2005) 'Sexual Assault and Mental Health in Australia', *ACSSA Newsletter*, 6, 10-22.

Kelly, L. (1988) *Surviving Sexual Violence*. Minneapolis: University of Minnesota Press.

Kravetz, D. (1986) 'Women and Mental Health' in N. Van Den Bergh and L. Cooper *Feminist Visions of Social Work*. USA: National Association of Social Workers.

Kuzel, A. (1992). "Sampling in Qualitative Inquiry". Chapter 2 in B. F. Crabtree and W. L. Miller (eds), *Doing Qualitative Research*. California: Sage. Pp. 31-44.

Leonard, D., Brann, S. and Tiller, J. (2005) 'Dissociative disorders: pathways to diagnosis, clinician attitudes and their impact', *Australian and New Zealand Journal of Psychiatry*, 39, 940-946.

Lewis, T. (1999) *Living Beside*. Canada: McGilligan Books.

McCarthy, T. (1990). "From Margin to Mainstream: Pioneering a Feminist Model of Management in a Traditional Hospital/Medical Organization", *NCASA Conference*, July 1990, Denver, Colorado.

McLennan, W. (1998) *Mental Health and Wellbeing: Profile of Adults, Australia 1997*. Canberra: Australian Bureau of Statistics.

- Matthews, D. (2004) *Domestic Violence Sourcebook* (2nd Ed). USA: Omnigraphics.
- Martin, J. (2003) 'Mental Health: Rethinking Practices with Women' Chapter 10 in J. Allan, B. Pease and L. Briskman (eds) *Critical Social Work – An Introduction to Theories and Practices*. NSW: Allen & Unwin.pp. 155-169.
- Marriot, L. and Hughes, B. WestCASA (1997) *Beyond Sexual Abuse. Enhancing G.P.s Responses*. Victoria: WestCASA.
- Moghaddam, A. (2006) 'Coding issues in grounded theory', *Issues in Educational Research*, 16, [Online], [Accessed 9th June 2006]. Available from World Wide Web: <<http://www.iire.org.au/iier16/moghaddam.html>>
- Morley, C. (2004-05) 'Collaborative social work practice in opposing paradigms: Issues to emerge from a sexual assault and mental health project', *Women Against Violence*, 16, 4-14.
- Neumann, W. (1999) 'The Meanings of Methodology' in W. Neumann *Social Research Methods: Qualitative and quantitative approaches*. Needham Heights: Pearson Education Co.
- Neumann, W. and Kreuger, L. (2003) *Social Work Research Methods. Qualitative and Quantitative Applications*. U.S.A.: Pearson Education.
- Padgett, D. (1998) 'Multimethod research: The synergy of combining qualitative and quantitative methods'. In D. Padgett *Qualitative Methods in Social Work Research*. Thousand Oaks: Sage. Pp. 126-140.
- Pahl, J. (1995) 'Health Professionals and Violence Against Women', Chapter 5 in P. Kingston and B. Penhale (Eds.) *Family Violence and the Caring Professionals*. London: MacMillian Press. Pp. 127-148.
- Pease, B. (2004-05) 'Rethinking profeminist men's behaviour change programs', *Women Against Violence*, 16, 32-40.

Radcliffe, M. (2002) *Attitudes and Beliefs of Rural Health and Welfare Professionals about Sexual Assault*. Master of Arts Thesis. Ballarat: The University of Ballarat.

Radcliffe, M., Green, R. and McLaren, S. (2003-2004) 'Working with survivors of sexual assault', *Women Against Violence*, 15, 22-29.

Reinharz, S. (1992) *Feminist Methods in Social Research*. Oxford University Press: New York.

Rice, P. and Ezzy, D. (1999) *Qualitative Research Methods. A Health Focus*. Victoria: Oxford University Press.

Robertson, M. (1990) in J. Petruchenia and R. Thorpe, *Social Change and Social Welfare Practice*. Sydney : Hale & Iremonger.

Robson, C. (1993) *Real World Researchers: A Resource for Social Scientists and Practitioners-Researchers*. Oxford: Blackwell Publishers.

Rokvic, D. and Leigh, S. (1999) 'Reinventing Old Myths – How the community perpetuates lies about sexual assault', *HealthSharing Women Newsletter of Women's Health Victoria*, 10 (2), 9-13.

Root, M. (1992) 'Restructuring the impact of trauma on personality', in L. Brown, and M. Ballour (Eds.) *Personality and Psychopathology*. New York: Gilford, 108-118.

Sawyer, A-M. (2005) 'From therapy to administration: deinstitutionalisation and the ascendancy of psychiatric 'risk thinking'', *Health Sociology Review*, 14 (3), 283-296.

Scott, D., Walker, L. and Gilmore, K. (1995) *Breaking the Silence. A Guide to Supporting Adult Victim/Survivors of Sexual Assault*. (2nd ed). Melbourne: CASA House.

Sheppard, M. (1991) 'General Practice, Social Work, and Mental Health Sections: The Social Control of Women', *British Journal of Social Work*, 21, 663-683.

Sidebotham, P. and Heron, J. (2006) 'Child maltreatment in the "children of the nineties": A cohort study of risk factors', *Child Abuse & Neglect*, 30 (5), 497-522. [Online], [Accessed 9th September 2006]. Available from World Wide Web: <www.sciencedirect.com.ezproxy.lib.unimelb.edu.au>

Simon, K. (1999) 'Policy Implementation and Women's Issues', *Making History: Shaping the Future – Proceedings of 8th Annual TheMHS Conference 1998*. Hobart, Tasmania: SVHMHU (St. Vincent's Health Mental Health Unit).

SOCA Regional Health Care Project (1998) *Weaving the Parachute. Developing a network of agencies who work with adult survivors of childhood sexual abuser with mental health needs*. Victoria: Department of Human Services.

Spataro, J., Mullen, P., Burgess, P., Wells, D. and Moss, S. (2004) 'Impact of child sexual abuse on mental health. Prospective study in males and females', *British Journal of Psychiatry*, 184, 416-421.

St. Vincent's Mental Health Service (SVMHS) (2002). *Gender Sensitivity*. Policy Document. Melbourne: SVMHS

Stenius, V. and Veysey, B. (2005) "It's the little things": women, trauma and strategies for healing', *Journal of Interpersonal Violence*, 20 (10), 1155-1174

Taft, A. (2003) 'Promoting Women's Mental Health: The Challenges of Intimate/Domestic Violence Against Women', *Australian Domestic & Family Violence Clearinghouse*, 8, 1-24.

Taft, A., Watson, L. and Lee, C. (2003) *The Australian Longitudinal Study on Women's Health. Health and Experiences of Violence among Young Australian Women*. Office of the Status of Women. [Online], [Accessed 2nd February 2006]. Available from World Wide Web: <www.newcastle.edu.au/centre/wha/>

Trippany, R., Helm, H. and Simpson, L. (2006) 'Trauma reenactment: rethinking borderline personality disorder when diagnosing sexual abuse survivors', *Journal of Mental Health Counseling*, 28 (2), 95-111.

Van Den Bosch, L., Verheul, R., Langeland, W., Van Den Brink, W. (2003) 'Trauma, dissociation, and posttraumatic stress disorder in female borderline patients with and without substance abuse problems', *Australian and New Zealand Journal of Psychiatry*, 37, 549-555.

Victorian Health Promotion Foundation (VicHealth) (2004) *The health costs of violence: Measuring the burden of disease caused by intimate partner violence*. Carlton, Victoria: Victorian Health Promotion Foundation.

Warshaw, C. and Alpert, E. (1999) 'Integrating Routine Inquiry about Domestic Violence into Daily Practice', *Annals of Internal Medicine*, 131 (8), 619-620.

Western Australia Crime Research Centre and Donovan Research. (2001) *Young people's and domestic violence: National research on young people's attitudes and experiences of domestic violence*. Canberra: Western Australia Crime Research Centre and Donovan Research.

Wonderlich, S., Crosby, R., Mitchell, J., Thompson, K., Smyth, J., Redlin, J. and Jones-Paxton, M. (2001) 'Sexual Trauma and Personality: Developmental Vulnerability and Additive Effects', *Journal of Personality Disorders*, 15 (6), 496-504.

Zanarini, M., Frankenburg, F., Reich, D. and Marino, M. (2000) 'Biparental failure in the childhood experience of borderline patients', *Journal of Personality Disorders*, 14 (3), 264-275.

Appendix A

St. Vincent's Health HREC approval letter

Appendix B

Hello CATT workers,

You are invited to participate in a study examining sexual assault and its disclosure in the settings in which you work.

If you choose to participate, you will be asked to complete a confidential 20-30 minute survey on your computer at some stage over the next two weeks.

This study is being conducted as part of Liz McLindon's Honours thesis at the University of Melbourne. The project's origins lie in the experiences Liz McLindon had with clients and workers while on student placement with the CAT team last year.

Attached to this email is the Survey and Information Statement which explains the project further.

If you do choose to participate, please complete the survey sometime over the next two weeks, and once completed, please print it, place it in one of the envelopes provided and put it in the locked drop-box in the office behind the clinic reception. Please note that you are free to withdraw from the study at any time.

If you have any further questions about this study, please contact Sara Cantwell at _____ Clinic, Liz McLindon or Dr Louise Harms (University Supervisor) whose details can be found at the end of the Information Statement.

A copy of the main project findings and any recommendations that arise from the research will be sent to you as soon as they are available. Your participation is greatly appreciated.

Cheers,

Liz McLindon, Sara Cantwell and Louise Harms.

Appendix C

Working with Survivors Disclosures of Sexual Assault in Psychiatric Crisis Service Settings



PLAIN LANGUAGE STATEMENT

Introduction

As a psychiatric crisis worker, experienced in listening and responding to many and varied client stories, you are invited to participate in a study examining sexual assault and its disclosure in the settings in which you work. Research has established a strong link between sexual assault and the use of mental health services. The aim of this qualitative study is to gain a heightened understanding of the attitudes and beliefs about sexual assault held by psychiatric crisis, assessment and treatment service (CATS) workers as well as worker responses to disclosures of sexual assault. This study is being conducted as part of Ms Elizabeth McLindon's Honours thesis in the Social Work Honours program at the University of Melbourne.

For the purposes of this study, the term **sexual assault** refers to a continuum of sexual violence that makes a person feel uncomfortable, frightened or threatened. It is sexual activity in which a person does not consent. This may include sexual abuse, intimidation, coercion, intrusion, threat or force, which can occur in childhood and adulthood.

The term **disclosure** is used to describe **any** incident of talking about sexual assault, not specifically the first time it is discussed.

The term **victim/survivor** is used to refer to women and men who have experienced sexual violence.

What will I be asked to do?

Should you agree to participate you will be asked to complete a confidential survey at a time convenient to you within a two-week time frame between _____ to _____. Everybody who currently works in the psychiatric crisis team, including individuals who work in a part-time/causal capacity, will receive this survey via email. If you choose to participate in the study, you can complete the survey using your word processor and, once printed, leave it in a secure drop-box in your workplace. At the beginning of the survey there are questions relating to participant demographics (sex, years in the field, occupational background). Your response to these questions is optional and if you do choose to answer them your demographic data will be grouped with that of other participants, thus de-identifying you in the process. This study will ask you questions regarding your ideas about the causes, prevalence, incidence and effects/impact of sexual assault. You will be asked about any specific sexual assault training you may have had, or not had, and your judgement about its impact. You will be asked to respond to a case study example of a client in a psychiatric triage setting, including your assessment of this client's story and how you may take action. This study will also ask you about specialist sexual assault services and their utilisation as well as other services you may refer to for longer-term therapeutic intervention associated with sexual assault. The researchers will send a reminder email inviting your participation in the study one week after the research commences.

How long will the survey take?

It is difficult to estimate exactly how long it will take people to complete this survey, as it may differ between participants depending on their responses to the questions. However, it is expected that the time commitment requested of you will not exceed 30 minutes.

How will my confidentiality be protected?

We intend to protect your anonymity and the confidentiality of your responses to the fullest possible extent, within the limits of the law. You do not have to attach your name to the survey, and it will be your choice to include any other demographic data. You will be invited to complete the survey on the computer and once printed out and enveloped, drop it in a locked box for the researchers that will be collected after two weeks of initial survey administration. Participant responses will be presented as aggregate (grouped) data within the scope of a small sample. We will remove any references to personal information that might allow someone to identify you as a participant; however you should note that as the number of people we seek to survey is small, it is possible that someone may still be able to identify you from your responses. The service in which you work will not be directly identified. It will be described within the research as a Metropolitan CAT service. The data will be kept securely in the School of Social Work for five years from the date of publication, after which it will be destroyed.

How will I receive feedback?

Once the thesis arising from this research has been completed, a succinct summary of findings will be made available to all study participants. Also, a complete copy of the thesis will be provided to the service in which you work. It is also possible that the results will be presented at academic conferences and/or published journals.

Will participation prejudice me in any way?

Your participation in this study is completely voluntary. Should you wish to withdraw at any stage, or to withdraw any unprocessed data you have supplied, you are free to do so without prejudice. Your decision to participate or not, or to withdraw, will be completely independent of any connection you may have to the researchers.

Where can I get further information?

Should you require any further information, or have any concerns, please do not hesitate to contact either of the researchers via the contact details given below. Should you have any concerns about the conduct of the project, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on ph: 8344 2073, or fax: 9347 6739. Also, if your participation in the study causes you to experience distress, you can contact Dr Louise Harms for de-briefing/support.


How do I agree to participate?

If you would like to participate, please complete the attached survey. Through taking the time to complete this survey, your consent will be implied.

Dr Louise Harms (Supervisor)
School of Social Work
Ph: 83449413
email: louisekh@unimelb.edu.au

Ms Elizabeth McLindon
Honours Student
email:e.mclindon@ugrad.unimelb.edu.au

Appendix D

<p>Working with Survivors Disclosures of Sexual Assault in Psychiatric Crisis Service Settings</p>	 <p>THE UNIVERSITY OF MELBOURNE</p>
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Please complete as many of the questions throughout the survey as you can. Please note that the data will only be presented as **group data** and all your information will be de-identified.

Part One: Demographics

This section is optional.

Please tick the relevant boxes

1.a. Are you: Female? Male?

1.b. For how many years have you worked in psychiatric crisis services?

Less than 2 years

3-6 years

7+ years

1.c. What is your occupational background?

Nursing

Medical

Allied Health

Part Two: Causes, incidence and effects of sexual assault

2.a. In your role have you worked with clients who have experienced sexual assault?

Yes No

2.b. If yes, how frequent is this occurrence?

2.c. What group(s) of individuals do you think are most at risk of sexual assault in the community?

2.d. How common do you think the occurrence of sexual assault is in the general community?

Very common

Common

Uncommon

2.e. Why do you think sexual assault occurs in the community?

2.f. What do you think may be the impact of sexual assault on victim/survivors?

2.g. What do you think is the impact of sexual assault on the community?

2.h. In what ways do you think sexual assault might impact on an adult's mental health?

2.i. How might reactions to trauma manifest themselves to reflect psychiatric symptoms?

Section Three: Professional development

3.a. What do you think have been the most important influences on how you have formed your beliefs/attitudes about sexual assault? You may mark more than one box.

Professional training

Professional experience(s)

Personal experience(s)

Other: _____

Please comment:

3.b. Have you ever received any professional training about sexual assault?

Yes No

3.c. If yes, please describe the training (how long ago was it provided, who was it provided by etc)

Part Four: Responses to disclosure

This section is asking you about a case vignette and your reactions to it.

A 33-year-old woman presents at the emergency department of the hospital. She appears tense and agitated as she informs you that she has a 9-year-old daughter who she is supposed to pick up from school shortly. The woman describes increasing difficulty sleeping due to severe nightmares over the past three weeks. The woman cannot express the content of the nightmares, however she awakes sweating, shaking and overcome with fear. The woman also identifies that irregularly throughout her adult years she has experienced occasional derogatory voices which, when heard provoke intense feeling of fear, as well as transient periods of disassociation. You ask the woman about the family in which she is a parent, and from there, ask about her family of origin. The woman is crying and shaking while she quietly elicits that her uncle sexually assaulted her 20+ years ago. She does not look at you as she says this and upon disclosing the assault the woman suddenly appears closed off, repeating that she must leave to pick her daughter up from school.

4.a. What do you see as the relevant information needed to construct an assessment and hypothesis about treatment for this woman? Please rate/discuss in order of importance.

4.b. While you only have limited information about this woman, what do you think would be your intervention?

4.c. Reflecting on the above vignette, how typical is this case study to your experience?

Typical

Quite typical

Not typical at all

4.d. Do you think inquiry about sexual assault should be a mandatory question in an initial psychiatric assessment?

Yes No

Please comment:

4.e. Do you experience any challenges within your work environment to working with issues arising from sexual assault? Below are some hypotheses. You may mark as many boxes as you wish.

Time constraints

Containment of distress

Exhaustion of issue

Uncomfortable subject matter

Lack of experience/training

Other:

Please comment:

4.f. At present, as a psychiatric crisis worker, do you believe you are well equipped to respond to a disclosure of sexual assault?

Yes No

Please comment:

Part Five: Knowledge and utilisation of specialist sexual assault services

5.a. What are the support services available to victim/survivors of sexual assault in the community?

5.b. How often do you refer to sexual assault services?

5.c. Why would you refer to sexual assault services?

5.d. Why would you *not* refer to sexual assault services?

5.e. What other services have you utilised for clients requiring longer-term therapeutic intervention relating to sexual assault? You may mark more than one box.

None

Psychotherapists

Family therapists

Social workers

Other counsellors

General practitioners

Self help groups

Private psychiatrists

Psychologists

Other:

- 5.f. In your experience, do you imagine mental health workers respond differently to disclosures of sexual assault in comparison the way sexual assault workers respond to these same disclosures?

Yes No

Please comment:

- 5.g. From what you know about sexual assault services, do you think they have particular views about mental illness?

Yes No

Please discuss:

Thank you very much for taking the time to complete the survey.

Please print the completed survey, place it in an envelope provided (located in the paper tray next to the drop-box) & post it in the locked drop-box.

Appendix E



CODING INFORMED BY CONTENT ANALYSIS

2.e. Why do you think sexual assault occurs in the community?

Transcript of all responses to Question 2.e.

R1: No response

R2: Lack of community acknowledgement, inappropriate and draconian judicial system

R3: Entrenched gender inequality, commodification of sex, hegemonic male power

R4: Power relations, entitlement, disinhibition through substances

R5: Variety of reasons poor impulse control dissocial personality traits. Drug alcohol. Poor environment role models. Past sexual assault.

R6: Money, stress, vulnerability, drugs and alcohol

R7: Too broad a question!! Multifactorial and too complex to discuss here – including for eg perpetrators childhood experience – abused themselves, developmental factors. Meaning of power and sense of control for the perpetrator. Deterioration in societal standards of morality – promotion of sex, violence in the media, and ubiquity of pornographic material. Failure of the education system and parents to instil fundamental values if respect etc. Diminution of sense of social conscience and responsibility.

R8: Complex, many things to take into account, perps previous experiences of being abused, socialisation/parenting deficits, familial deficits, socio-economic influences, increasing destabilisation of family/community structure and integrity, increasing populations and social/spiritual neglect

R9: Power imbalances b/w offender and victim. The abused can become the abuser

R10: Cycle of abuse. Abuse of power/authority

R11: What a hard question. Substance abuse (ie. alcoholic parents). Because of power politics (ie. cultural or a family culture). Because it is handed on (ie some paedophiles passing to new victims). Because of objectification of females (ie. media and pornography). Because of antisocials having no conscience. Because of hardwiring that the abused become hardwired to get excited by similar experiences (probably similar to the handing on of paedophilia). How many more reasons ? many im sure but no reason is good enough ie abuse in the media sells, abuse in politics is common, abuse in some countries is accepted (ie genital mutilation)

R12: Not sure, but seems to occur in most societies

R13: No response

R14: very broad question, multitude of possible answers and they are all individual, PHx of same, substance abuse, power dominance, control, relationship issues

R15: For many reasons and in all cultures, across all socio-economic groups. Teenage girls innate desire to be loved by boys (the boys would say it was consent!), power & feelings of entitlement held by perpetrators, unequal power balance perceived in communities such as work places, students-teachers, homes, where women are not heard or able to overt “no), where people live closely together eg. Prisons, religious/cult group situations

Open coding 200606 – All possible themes

- A). No response: R1, R13
- B). Unsure: R12
- C). Complex/Variety of reasons: R5, R7, R8, R11, R14
- D). Draconian judicial system: R2
- E). Gender inequality: R3
- F). Commodification of sex: R3
- G). Hegemonic male power: R3
- H). Power and control (of perpetrator over victim) (gender neutral): R4, R7, R9, R10, R11, R15
- I). Substance use/abuse (drug, alcohol): R4, R5, R6, R11, R14
- J). Entitlement: R4
- K). Poor impulse control: R5
- L). Personality problems of perpetrator (dissocial, antisocial): R5, R11
- M). Poor environment role models: R5
- N). Px sexual assault (cycle of abuse): R5, R7, R8, R9, R10, R11, R14
- O). Socio-economic factors (?lack of money): R6, R8
- P). Stress: R6
- Q). Vulnerability: R6
- R). Developmental factors: R7
- S). Declining societal standards of morality, violence in media, objectification of females, porn: R7, R11
- T). Failure of educational system and parents to instil values: R7
- U). Destabilisation of the family, deficits in socialisation by parents: R5, R7, R8
- V). Community/cultural: R8, R11
- W). Social/spiritual neglect: R8
- X). SA occurs in all cultures: R12, R15
- Y). SA occurs in all socio-eco groups: R15
- Z). Innate desire of teen girls to be loved by boys: R15

Possible groupings of open codes

E and G = Power imbalances between males and females

H and J = Power and control

Q and O = Socio-economic factors

M and S and T and V and W = Community/cultural (poor environment role models, Declining societal standards of morality, violence in media, objectification of females, porn, failure of educational system to instil values, social/spiritual neglect)

X and Y = SA occurs in all cultures and socio-economic groups

Second coding attempt incorporating above groups

- A). No response: R1, R13
- B). Unsure: R12
- C). Complex/Variety of reasons: R5, R7, R8, R11, R14
- D). Draconian judicial system: R2
- E). Power imbalances between males and females: R3
- F). Commodification of sex: R3
- G). Power and control (of perpetrator over victim) (gender neutral): R4, R7, R9, R10, R11, R15
- H). Substance use/abuse (drug, alcohol): R4, R5, R6, R11, R14

- I). Personality problems of perpetrator (dissocial, antisocial): R5, R11
- J). Px sexual assault (cycle of abuse): R5, R7, R8, R9, R10, R11, R14
- K). Socio-economic factors (?lack of money): R6, R8
- L). Stress: R6
- M). Developmental factors: R7
- N). Destabilisation of the family, deficits in socialisation by parents: R5, R7, R8
- O). Community/cultural (poor environment role models, Declining societal standards of morality, violence in media, objectification of females, porn, failure of educational system to instil values, social/spiritual neglect) R5, R7, R8, R11
- P). SA occurs in all cultures: R12, R15
- Q). SA occurs in all socio-eco groups: R15
- R). Innate desire of teen girls to be loved by boys: R15

Prose

Only one respondent (who was female) cited power imbalances between males and females as a possible factor in the occurrence of sexual assault in the community;

Entrenched gender inequality... hegemonic male power (R3).

6 respondents cited power and control for the (gender neutral) perpetrator as a factor involved in the occurrence of sexual assault in the community;

Power imbalances between offender and victim (R9)

7 respondents expressed that people who have been sexually assaulted can go on to sexually assault others, thus perpetuating a cycle of abuse;

perps previous experiences of being abused (R8).

5 respondents documented identified the impact of substance use/abuse on the occurrence of sexual assault in the community;

disinhibition through substances (R4).

To a lesser extent, respondents cited the failure of family as well as the breakdown of the community as issues that can highlight in the act of sexual assault.

4 respondents documented community/cultural factors such as poor environmental/societal role models, declining societal standards of morality, violence in media, objectification of females through pornographic material, failure of educational system to instil values and social/spiritual neglect as reasons for the existence of sexual assault in the community;

Deterioration in societal standards of morality – promotion of sex, violence in the media, and ubiquity of pornographic material. Failure of the education system... to instil fundamental values if respect etc. Diminution of sense of social conscience and responsibility (R7).

3 respondents described the impact of the dysfunctional elements of family as possibly leading to sexual assault;

...familial deficits...increasing destabilisation of family/community structure and integrity (R8).

Appendix F

Definition of terms

Terms utilised in Appendices' tables

Ax: Assessment

CASA: Centre Against Sexual Assault

D/o: Disorder

Dx: Diagnosis

Hx: History

MH: Mental health

MSE: Mental State Examination

PD: Personality Disorder

PHx: past history

Pt: Patient

SA: Sexual assault

S/T: Short term

L/T: Long term

R/s: Relationship

Sx: Symptoms

Tx: Treatment

Appendix G

Table A: Identified effects of sexual assault on victim/survivors

Themes	Numbers	%	Participants
Relationship difficulties	6	40%	R1, R6, R10, R12, R13, R15
Personality disorder	5	33%	R5, R6, R7, R11, R13
Potentially catastrophic / Impact on all areas of life	4	27%	R4, R11, R14, R15
Anger	3	20%	R1, R9, R10
Impact dependent on assault	3	20%	R2, R3, R7
Guilt and self blame	3	20%	R1, R9, R10
Mental health problems/ Axis I or II diagnosis	3	20%	R11, R8, R12
Nightmares	2	13%	R9, R15
Potential to lead to psychosis	2	13%	R2, R11
Shame	2	13%	R1, R9
Trauma	2	13%	R5, R12
Despair	1	7%	R9
Dietary complications	1	7%	R15
Existential crisis	1	7%	R9
Fear	1	7%	R11
Impacted by the meaning attributed by others	1	7%	R3
Mood problems	1	7%	R5
Physical injury	1	7%	R9
Psychosocial development	1	7%	R8
Self hatred	1	7%	R1
Stress reaction	1	7%	R9
Substance abuse	1	7%	R9

(Chapter 3, section 3.2.5)

Appendix H

Table B: Impact of sexual assault on mental health

Themes	Number	%	Participants
As above	4	27%	R5, R7, R8, R13
Decreased self esteem / blurry or degraded sense of self	4	27%	R2, R3, R10, R15
Depression	4	27%	R1, R11, R14, R15
Anxiety	3	20%	R1, R2, R14
Contaminated interpersonal boundaries / relationship difficulties	2	13%	R3, R9
Depends on the assault	2	13%	R4, R12
Guilt	2	13%	R9, R10
Intrusive memories / re-experience phenomena	2	13%	R9, R15
Mood problems	2	13%	R3, R15
Psychosis	2	13%	R1, R11
Obsessive-Compulsive Disorder (OCD)	2	13%	R1, R14
Self harm	2	13%	R1, R14
Shame	2	13%	R9, R10
Increased substance use/abuse	2	13%	R3, R15
Abused can become the abuser	1	7%	R9
Anger	1	7%	R9
Despair	1	7%	R9
Difficulty child bearing	1	7%	R9
Difficulty with affective regulation	1	7%	R3
<i>Dissociative disorder</i>	1	7%	R1
Maladaptive behaviour patterns	1	7%	R6
<i>Paranoia</i>			
Personality disorder	1	7%	R14
disorder	1	7%	R14
Poor coping skills			

Psychological impact	1	7%	R6
Self blame	1	7%	R10
Suicide	1	7%	R10
Withdrawal from community	1	7%	R1
	1	7%	R2

(Chapter 3, section 3.2.7)

Appendix I

Table C: Identified trauma responses manifest to reflect psychiatric symptoms

Themes	Numbers	%	Participants
Anxiety Sx	7	47%	R2, R3, R6, R7, R9, R10, R12
Depression Sx	6	40%	R2, R3, R8, R11, R15
Psychotic Sx	5	33%	R5, R7, R8, R11, R15
Dissociation Sx	4	27%	R6, R8, R10, R13
Flashbacks	4	27%	R3, R7, R11, R12
Personality changes	4	27%	R5, R7, R10, R13
Paranoia/mistrust	3	20%	R2, R3, R12
Substance use	3	20%	R5, R7, R9
Voices and visions	3	20%	R3, R8, R11
As above	2	13%	R1, R14
(Lots of manifestations (and they) have been well documented	2	13%	R4, R7
Mood swings	2	13%	R3, R9
PTSD	2	13%	R7, R15
Relationship difficulties	2	13%	R9, R13
‘Self destructive’ behaviours eg. Binging/purging, self harm etc. suicide/parasuicide attempts	2	13%	R3, R5
Sx of trauma often aggregated to form basis of Dx labels such as BPD and other personality disorders, Bipolar Affective Disorder, Schizophrenia, PTSD, Dissociative Identity Disorder, Anxiety Disorders, Depression	2	13%	(R2, R3)
Affective lability/instability	1	7%	R3
Anger management	1	7%	R3

Body image disturbance	1	7%	R9
(Impact of assault) depends on where, what, how	1	7%	R4
Fearfulness	1	7%	R1
Not quite sure	1	7%	R8
Self loathing	1	7%	R10
Sexual difficulties	1	7%	R3
Sleep disturbances (incl. nightmares)	1	7%	R9

(Chapter 3, section 3.2.8)

Appendix J

Table D: Information (from vignette) to inform assessment and treatment

Themes	Number	%	Participants
MSE & Risk assessment	8	57%	R3, R4, R5, R6, R9, R10, R12, R14
Sexual assault	6	43%	R1, R2, R8, R9, R10, R15
Family/personal Hx	5	36%	R3, R5, R6, R8, R14
Voices	5	36%	R2, R10, R11, R13, R15
Nightmares	4	29%	R2, R10, R13, R15
Why is the wo. presenting now?	4	29%	R3, R9, R10, R13
Age of daughter	3	21%	R1, R11, R13
Dissociation	3	21%	R11, R13, R15
Anxiety	2	14%	R11, R13
Current social supports	2	14%	R5, R14
Difficulty sleeping	2	14%	R2, R13
Experience of having disclosed assault	2	14%	R8, R13
Hx of Sx incl. triggers	2	14%	R3, R8
Hx of Tx	2	14%	R5, R14
Level of distress/disability	2	14%	R3, R10
Mood	2	14%	R2, R13
Willingness to engage w/ services	2	14%	R5, R6
Depression	1	7%	R11
Drug and alcohol issues	1	7%	R5
Establish if this is the first time she has disclosed abuse?	1	7%	R10
Establish if there is still contact w/ offender, ?concerns for daughter's safety	1	7%	R10
Fear	1	7%	R8
Forensic issues	1	7%	R5
Gentle counselling	1	7%	R11
Own attitude to abuse	1	7%	R10
PTSD flashbacks	1	7%	R11

Resources for appropriate engagement	1	7%	R4
Suicidal thoughts	1	7%	R11
Sx management	1	7%	R11
Willingness to engage in Tx	1	7%	R4

(Chapter 4, section 4.2.1)

Appendix K

Table E: Mandatory sexual assault inquiry in initial psychiatric assessment

Issues	Number	%	Participants
Should not occur in crisis, rapport has not been established	8	53%	R1, R3, R5, R9, R11, R13, R14, R15
Confronting, distressing & sometimes dangerous issue to probe	6	40%	R1, R3, R4, R5, R8, R15
There are other ways of asking (ie. open-ended questions)	4	27%	R3, R5, R8, R15
Up to the client to raise issue	4	27%	R5, R6, R11, R15
When disclosed to inexperienced psychiatric professionals, client often ends up in crisis	3	20%	R11, R13, R15
Mandatory questions emphasise things that are not the immediate concern	2	13%	R2, R15
Usually becomes apparent during Ax process	2	13%	R14, R15
Issue does not need to be divulged in crisis	1	7%	R11
No clear reason for what we (workers) do with the information if we find it	1	7%	R12
Should be no mandatory questions, depends on clinician's knowledge & experience	1	7%	R7

(Chapter 4, section 4.2.3)

Appendix L

Table F: Identified community support services for victim/survivors

Support services	Number	%	Participants
CASA	15	100%	R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15
Counsellors (private)	6	40%	R1, R4, R5, R6, R7, R13
Psychologists (private)	4	27%	R1, R4, R7, R10
Crisis lines	3	20%	R4, R6, R13
G.P.s	3	20%	R7, R10, R13
Police / legal bodies	3	20%	R9, R10, R13
Psychiatrists (private)	3	20%	R1, R4, R13
Royal Women's Hospital	2	13%	R10, R15
Trauma workers (counsellors / psychologists / psychiatrists)	2	13%	R14, R15
Victims of Crime organisations	2	13%	R3, R12
Bouverie	1	7%	R8
Child Protection Services (mandatory reporting)	1	7%	R11
DVIRC	1	7%	R3
Family/friends	1	7%	R13
Generic Mental Health Service	1	7%	R9
Public health (general & psych)	1	7%	R13
Refuges	1	7%	R13
Relationships Australia	1	7%	R8
Self	1	7%	R13
SOCA	1	7%	R8
Social workers	1	7%	R7
Women's support groups	1	7%	R7

(Chapter 5, section 5.1)

Appendix M

Table G: Reasons for referral to sexual assault services

Themes	Number	%	Participants
If client wanted referral	5	33%	R7, R8, R10, R14, R15
If sexual assault is the primary reason for presentation	4	27%	R1, R7, R10, R15
Specialist service expertise	2	13%	R9, R12
Recent sexual assault	2	13%	R2, R3
If client is not already receiving counselling	1	7%	R14
If person has good pre-morbid functioning	1	7%	R3
If police involved or legal proceedings pending	1	7%	R3
Longer-term engagement and follow-up	1	7%	R4
To benefit individual	1	7%	R13
When person has never had therapeutic input in the past	1	7%	R3
Where Sx do not require Tx first and specialist referral second	1	7%	R15

(Chapter 5, section 5.2)

Appendix N

Table H: Reasons for non-referral to sexual assault services

Themes	Number	%	Participants
If client did not want the referral	8	53%	R1, R7, R8, R9, R10, R11, R13, R15
If manifest Sx need to be treated	2	13%	R1, R10
Long waiting lists	2	13%	R3, R9
No response	2	13%	R4, R14
Client does not identify sexual assault as a current issue	1	7%	R7
Depends on the immediacy of the situation	1	7%	R6
If client already has a counsellor who can put in the time	1	7%	R11
If the allegations of sexual assault appeared to be delusional / driven by psychotic processes	1	7%	R12
If there has not been a clear disclosure	1	7%	R8
Long term sexual assault (then referral to a counsellor)	1	7%	R2
Often do not refer directly but encourage clients to do so	1	7%	R5
Perceive some services to focus excessively on feminist ideology and perusal of offender by legal means	1	7%	R9
Sometimes the person is not ready to be counselled and it is better to	1	7%	R11

put a lid on it and get on with life			
Specialist services can only offer very time limited counselling (due to lack of resources)	1	7%	R3

(Chapter 5, section 5.2)

Appendix O

COMMENT: Far to broad a questionnaire to extract any meaningful data – there is a thesis in every question – at honours level you need to narrow the research question down significantly!! (even in exploratory research!) If not for the impassioned pleading by a valued and respected friend and colleague to participate then I suspect no one would bother with a survey like this (certainly not me)! For lay people it may be ok but professionals have far too much knowledge and experience to respond in a meaningful way to these questions in writing – perhaps an audio taped interview might be better way! Do some reading about survey design (R7).

(Chapter 5, section 5.7)



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