

Issues paper 10

Advocacy and Support and Therapeutic Treatment Services.

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CONSULTATION QUESTIONS

Defining support services

Many victims and survivors of child sexual abuse seek support outside the informal support of family and friends.

Advocacy and support and therapeutic treatment encompass a range of services victims and survivors need to address the impact of child sexual abuse and trauma as well as assist them to heal and lead a fulfilling and meaningful life. **Advocacy and support** is acting alongside, or on behalf of, victims and survivors of child sexual abuse to support their rights and interests while providing tangible and practical support. This can include helping to navigate and receive support from a range of service systems, such as housing, health and Centrelink systems. Importantly, advocacy and support also often has an element of emotional support to help reduce isolation and build connections and trusted relationships to help with healing and recovery.

Advocacy is often provided for individuals. We also include systemic advocacy, advocating for changes to the systems designed to prevent and respond to child sexual abuse, including advocating for changes to services so victims' and survivors' needs are met.

Therapeutic treatment includes a range of evidence-informed therapies, programs and interventions for individuals or groups that are provided by trained practitioners, such as psychologists, counsellors, psychiatrists, social workers and other health and mental health practitioners. These services are often provided as part of the health system or funded by government and delivered by the non-government sector (such as is the case with specialist sexual assault services in some jurisdictions) but may also be provided by the private sector.

Therapeutic treatment aims to reduce symptoms of ill-health and bring about measurable change in outcomes that improve wellbeing and quality of life. Who are victims and survivors? We consider it critical to understand the needs of both children who experience contemporary abuse and older victims and survivors who suffered child sexual abuse in the past but are still experiencing impacts today that require support services.

In addition, we must consider the **needs of secondary victims**, who include others who have been negatively affected by the abuse such as the victim's partner, their family members (which includes parents and children – including children born from abuse – and extended family), friends or community as well as children and others in the institution where the abuse occurred.

We also recognise **some victim and survivor population groups face additional challenges and barriers** to receiving appropriate services or require more tailored or specific approaches. For example, we have heard cultural and healing practices are particularly important for Aboriginal and

Torres Strait Islander people. Consequently, we want to better understand the barriers to services and possible solutions for diverse groups such as; Aboriginal and Torres Strait Islander people; those from culturally and linguistically diverse backgrounds; people with a disability; men; care leavers; lesbian, gay, bisexual, transgender, intersex people; and, victims and survivors who spent time in correctional facilities.

While it is plain there is a need for more and longer-term support for victims and survivors, it is not yet clear how best to strengthen services. We wish to better understand the issues and options for improvement. Below is a series of questions we are particularly interested in. We have framed each question to cover both advocacy and support as well as therapeutic treatment services. However, we recognise responses may vary for each type of service and you may wish address your response to either advocacy and support or therapeutic treatment services. We welcome submissions on any issues related to advocacy and support and /or therapeutic treatment services. In particular, we would like to hear your suggestions to improve advocacy and support and/or therapeutic treatment services.

Topic A: Victim and survivor needs and unmet needs

1. What advocacy and support and/or therapeutic treatment services work for victims and survivors?

Victims and Survivors of sexual assault trauma have their lives impacted in a wide variety of realms. The proposed DESNOS diagnosis has split the effects into the categories of:

- I. Alteration in Regulation of Affect and Impulses
- II. Alterations in Attention of Consciousness
- III. Alterations in Self-Perception
- IV. Alterations in Relations with Others
- V. Somatization
- VI. Alterations in Systems of Meaning

Effective treatment needs to keep all of these impacts in focus even though the particular modality may be working predominantly in only one area.

Therapy is an art not a science. The therapist is informed by science and theory of practice but at the client-therapist interface it becomes an art of providing what the client needs at that particular point of time in a form that is beneficial to the client. There is a generally accepted principle that the client will move through the following three stages during therapy:

- Safety and Stabilization
- Memory re-processing and Integration
- Consolidation and Maintenance

This is not a linear process. Diagrammatically it can best be conceived as a descending spiral, slowly peeling back layers until the most deeply affected issues are addressed. Despite all the horrendous abuse a client may have suffered, the most intractable issue is often the perceived betrayal by the primary caregiver. Memory processing also follows a stage-based process. Usually the first stage is an ability to narrate the historical facts of the event, followed by a linking of the affect and somatic

effects of the trauma. This then becomes a personalised story of “this happened to me” and in the final stage there is a “zooming out” to see how these events fit into the autobiographical story of my life and an understanding of the context of how the events came to pass.

There are over two hundred models of counselling (commonly referred to as “talk therapy”) and all have merit if appropriately applied. Our service was founded on feminist principles and applied through Narrative Therapy. It is a model that honours all of the client’s life and how they have survived thus far. It also recognises that we exist in a relational environment and that that environment will shape our stories, experience and expectations. Two of the others that are particularly suitable for this client group are Dialectical Behaviour Therapy (Marsha Linehan) and Acceptance and Commitment Therapy (Russ Harris)

We need to heed the findings of Duncan, Miller and Hubble (1999) that when it comes to effective therapy, it is what models have in common rather than what makes them different from each other that makes them effective. Duncan Miller & Hubble also found that the client’s active involvement in their therapy is the best indicator of a successful outcome. They went on to produce, norm and validate simple assessment tools; one to measure client change between sessions and another to measure client satisfaction of the session itself. When used in conjunction with the client, this becomes another avenue to engage the client in their own healing journey.

In counselling we work with a concept of “window of tolerance” or “window of opportunity”. This term refers to a level of arousal under which a person is able to function well and able to focus on the task at hand. If the arousal level is too low then the person is too sleepy, distracted or dissociated. If the level is too high then the person is too agitated, anxious or hyper-vigilant. This is not a linear model, rather a circular one where, once the arousal level gets too extreme, it will flip into extreme hypo-arousal.

In non-traumatised people the window of tolerance is quite large. For trauma survivors this window can become extremely narrow, which means that they are easily tripped into hyper- or hypo-arousal. This affects every area of their day to day functioning. Effective “talk therapy” can only occur within the window of tolerance so treatment needs to include strategies to remain in, or come back to, this optimal arousal level. Medication can be very useful to achieve this but there are also non-pharmacological methods. Breathing techniques, external focus techniques, dual awareness, EMDR, hypnosis, mindfulness and EFT tapping are just a few of the short term strategies. Yoga, Tai Chi, martial arts, meditation, and neuro-feedback therapy are some of the longer term strategies.

Other facilitators to effective client therapy and support include a welcome therapeutic environment and giving power back to the client by allowing them to make their own choices. Having the client’s choices respected even when the therapist would not recommend that choice. An advocate can help disempowered clients navigate the complex world of available services and provide a voice for them when they are too afraid to speak up. A support person can ease the difficulty of attending to forensic medical examinations, dealing with police and later the legal system. A professional support person is not only able to assist the client but also prepare them for what is ahead by giving the survivor the correct information at the appropriate time.

A professional’s attitude to the survivor is very important. Workers need to be genuine and authentic. Survivors tend to have a heightened sense of whether someone presents as being

genuine. It is far better too, for a counsellor/support worker to be honest and say for example, that they do not know the answer, or that they do not understand, and offer to work with the survivor on finding a solution.

This has the benefit of minimalizing the power indifference between worker and client, and can strengthen the relationship. The client sees the worker as being real i.e. human, they are also perceived to be honest: there is no undercurrent of secrecy or the worker attempting to save face for their own benefit. The lack of secrecy is particularly relevant to survivors of childhood sexual assault because it addresses factors inherent in their childhood sexual assault – power imbalance in the relationship and overt or covert secrecy.

Survivors often come to treatment with little understanding that all the different things that are troubling them are in fact a normal response to trauma that has become “stuck” in flight/flight/freeze process that is still playing out way beyond the time that is beneficial for their body. Bio-psycho-social education, in language that the survivor can understand, can educate the survivor about how the brain and body responds to trauma. Suddenly their symptoms make sense! It is not uncommon at the end of such a explanation for the client to say “So you mean I am normal?”

Chronic stress fosters disease by activating the hypothalamic-pituitary-adrenocortical (HPA) axis. Adult survivors of childhood sexual abuse can be stuck in the fight/flight/freeze process for decades, swamping the body with epinephrine, norepinephrine and cortisol. Long term exposure to these hormones is toxic to the human body so survivors are faced with chronic health issues like high blood pressure, cardio-vascular disease, suppressed immune system, autoimmune disorders, skin problems, chronic pain, diabetes and infertility. These physical issues need to be assessed and addressed as part of the survivor’s recovery program. The Stamford Chronic Condition Self-Management Program is an example of a useful tool for this purpose.

It is not uncommon for survivors to work with several professionals in different modalities concurrently. This arrangement works best if the professionals work collaboratively with some effective means of communication between them.

Survivors often feel very isolated and alone. Support groups run by survivors (and others affected) for survivors (and others affected) can be an extremely powerful tool to break the sense of isolation.

Residential therapeutic groups address both therapy and breaking the survivor’s isolation. Australia’s only dedicated Dissociative Disorders Unit is located at the Belmont Private Hospital in Brisbane under the auspices of Professor Warwick Middleton. There are also a small number of privately run Therapeutic Retreats e.g. Byron Clinic Retreats in Byron Bay, Queensland and The Healing Foundation in Quorrobolong, NSW.

Towards the end of the client’s healing journey, becoming involved in advocacy, activism or helping others can not only help further recovery but it may also give the survivor a sense that what they survived was not in vain.

Advocacy needs to be meeting survivor’s desired goals, not goals perceived by the counsellor/support worker, for example, *I am encouraging this person to go forward to the Royal commission because I believe it will assist with their healing.*

It is empowering for the survivor to draw on their strengths and establish what has already been tried to meet their goals because it highlights capabilities they may have overlooked, or never considered. It also highlights the capacity for a desire and hope that things will get better.

Advocacy appears most effective when a survivor is involved as much as possible in the process: this can include letter writing, phone calls, and attending appointments. The presence of an advocate alone can be a respectful way to demonstrate they have faith in the survivor, they are not alone - there is also an ally.

2. What does not work or can make things worse or be harmful for victims and survivors? What do victims and survivors need but not receive?

Over the years, feedback from clients has some common themes when it comes to making things worse, harmful or leading to unmet needs. These include:

- Not being believed
- Children being put back into a dangerous environment or being forced to endure ongoing contact with the perpetrator
- Being told things like “Just get over it”, “It was a long time ago, why are you still on about it?”
- Having what happened to you being minimised
- Being blamed for what happened
- Not being given the opportunity to make your own choices
- A lack of recognition of the grooming process and its power as well as how that then facilitates the later sexual assaults
- Professionals who don’t understand that your behaviour is your best attempt to self-regulate.
- Services that focus on “What is wrong with you?” rather than “What has happened to you and how is that still affecting your life now?”
- Services that only cater to one diagnosis or dysfunction and shy away when co-morbidity is discovered (as is inevitably the case as a result of extreme or multiple traumatic experiences).
- Having time-limited services. It takes time and perseverance to process complex trauma. Once “Pandora’s Box” is opened it is not possible to just shut it at the end of the designated amount of allowable sessions nor reasonable to expect the client to continue to manage to function as they did before therapy commenced.
- Being given a diagnosis that then makes other professionals reluctant to work with the survivor e.g. Borderline Personality Disorder, Opposition Defiance Disorder
- Having mental health professionals who do not believe that extreme dissociative disorders are real e.g. psychogenic seizures, DDNOS and DID
- Being re-abused by professionals you approached for assistance
- Having to endure a legal process that protects the rights of the alleged perpetrator but does not afford the same protection to the victim/witness. Having everything you have ever done in your life regarded as “fair game”, to be paraded in the court process in an attempt to

discredit you as a witness whilst any mention of the perpetrator's past misdemeanours and/or convictions are considered prejudicial.

- The leniency of sentencing, particularly in Tasmania. The client often has a life sentence but the perpetrator, even if found guilty, walks away with a suspended sentence, months or just a small number of years actually in jail and the knowing that the perpetrator is then free to re-offend.
- The use of the word "relationship" in the naming of the crime of ongoing sexual abuse of a minor in the Tasmanian Criminal Code Act Chapter XIV – "125A Maintaining sexual relationship with young person".
- An under-resourced Child Protection system that is unable to provide case management for all children identified as "at risk".
- A culture within the Family Court system (including Independent Child Lawyers) that believes that it is commonplace for mothers to coach their children to report abuse as a way of retaliating against their former spouse and represent their clients or make their orders accordingly.

A case example shows some of the barriers that can face a client. A survivor shared with one of our counsellors that she had been dealing with a legal firm over the phone and by mail. Once she advised the solicitor that she would need her counsellor/support worker to step in to assist due to difficulties with literacy, the solicitor had "changed her approach".

The survivor shared it was not what the solicitor said, it was the change in the solicitor's voice and attitude: "She seemed fed up with me after that. She'd put me in a category. You're one of those types, you know, a bit dopey". The survivor said she had encountered this attitude before many other times during her life, and that is how she recognised what was happening.

The survivor shared she felt inferior, and further victimised. She said she wanted to retract from her involvement with the solicitor, because "I can't even get my words out, I get really nervous."

All professionals working with survivors need to be aware of their own biases, judgements and how their use of language may be conveyed to others. This also includes checking in with how information is being received and interpreted.

3. What helps or facilitates access so victims and survivors receive what they need?

Practical considerations can help/facilitate access:

The organisation may for example:

- a) Offer assistance with public transport costs
- b) Provide a safe, secure space for survivors
- c) Outreach service to those living outside the vicinity of the organisation
- d) Disability accessible building

An organisation's philosophy that is client-centred and transparent with their client base means there is less likelihood of confusion about what can be done in terms of support and interventions.

Survivors can be encouraged to bring a support person of their choice to their therapy sessions for as long as they feel more comfortable that way.

It can be useful to let survivors know that therapy does not necessarily mean re-telling the painful story of what happened to them. It will focus on what the impact of their trauma has been and how that is affecting their life today.

When advocacy is required, a warm-handover and/or offering to go with the client is desirable (where possible).

What are the barriers to receiving advocacy and support and/or therapeutic treatment and how might those barriers be addressed?

The impact of childhood sexual abuse affects the brain's development. The fear circuitry is privileged while other areas such as the hippocampus (memory processing), Broca's area (speech), and the prefrontal cortex (executive functions such as learning, planning and emotional regulation) are neglected and fail to thrive. It is hardly surprising that survivors may experience learning difficulties and concentration problems. This in turn leads to lack of skills and qualifications which in turn leads to a life in the lower socioeconomic strata. Many survivors eke out a life on a disability pension. This puts them at a severe financial disadvantage when it comes to access to suitable services. Free services such as the Sexual Assault Support Services around the country play a vital role in ensuring the disadvantaged can access therapy for the lengthy period that may be required.

Community attitudes can also be very influential. Capital city populations tend to be more advanced in terms of attitude change. In the regional and remote areas change in attitude comes more slowly. In addition communities are small so there is less scope for a survivor to escape their influence. There are still prevailing attitudes that "we don't talk about that kind of stuff", "don't air your dirty linen in public", "talking about it will bring shame on the family", "not being able to manage is a sign of weakness", "good people don't do that", "it only happens to those kind of people", "if it happened, you must have done something to encourage that" and that any flow-on consequences are your fault for disclosing rather than the perpetrator's responsibility when he/she chose to do that behaviour. In this environment it can be very difficult for survivors to access any service linked to sexual abuse survivors.

These barriers can be avoided in part by offering service in a generic medical service setting such as a Community Health Centre.

Another antidote is extensive community education. The constant stream of news items coming out of the Royal Commission's Public Hearings is greatly assisting in breaking down some of these stereotypes, attitudes and misconceptions.

4. How well do advocacy and support and/or therapeutic treatment services currently respond to the needs of secondary victims and survivors? How could these services be shaped so they better respond to secondary victims?

It is difficult to know how well services are currently responding to secondary victims and survivors.

There could be a possibility that some secondary victims/survivors may not be aware that they are eligible to access such a service to begin with, because of their 'secondary status', even though they may be affected.

Advertising more broadly and specifically to include secondary victims/survivors could be useful.

Topic B: Diverse victims and survivors

1. What existing advocacy and support and/or therapeutic treatment services are available that cater to the specific needs of diverse victim and survivor groups?

What types of models and approaches are used to address the particular needs of these populations?

2. How could the needs of victims and survivors from diverse backgrounds be better met? What should be in place to ensure they receive the advocacy and support and/or therapeutic treatment they require?

Refugee arrived women face additional barriers – language, rape being used as an instrument of war and the gender values and customs of their culture. They must obey their husbands, they fear authority figures and fear losing their visas. They can also face exclusion from their culture for speaking out.

Cultural factors for all diverse groups requires a strong model of community development principles, true consultation, engagement, ownership, partnership to understand barriers to service and then working together to redress those as much as possible.

The need for a translator adds another dimension of difficulty whether that is for a person of non-English speaking background or someone who is deaf. The confidentiality of therapy is compromised by the presence of the translator who is privy to all that is said. In a large city a deaf person may be able to source a trusted signer but in some smaller communities there may be only one choice of translator who may know, or be known to, the victim and their family. Similarly in some language groups there may be a very restricted range of choices.

3. What would better help victims and survivors in correctional institutions and upon release?

Topic C: Geographic considerations

1. What challenges do service providers face when trying to respond to the needs of victims and survivors outside metropolitan areas (e.g. those living in regional, rural or remote areas)?

Most community service organisations operate on a very small budget. Travel requirements (cost and time required) limit the availability of services to rural and remote areas. Professionals often travel from the nearest regional centre and some of the areas covered are vast. Services vary but

they often only occur on a monthly basis which provides little continuity for the client. Follow-up in between sessions can be done by phone or, if available, internet.

In some regional and remote areas, weather can also play a big part. Seasonal flooding, impassable roads, storms, snow or ice can limit access.

Often regional and remote communities are small. There is still a lot of stigma attached to talking about sexual assault issues so care needs to be taken to arrange outreach sessions in a venue that does not easily identify who you are there to see. Community Health Centres that have a lot of visiting professionals have proved the best choice in the Northwest and West Coast of Tasmania.

2. What would help victims and survivors outside metropolitan areas?

Are there innovative ways to address the geographical barriers to providing and receiving support?

The advances in technology can be harnessed to overcome some of the geographical barriers. Where internet access is available, technology such as Smartboards, personal computers, Skype & iPads can provide contact that is nearly as good as face to face contact and certainly much better than phone support.

Topic D: Service system issues

1. There is a range of terminology used to describe advocacy and support as well as therapeutic treatment services for victims and survivors of child sexual abuse. We provided our current working definitions in the introduction to this paper. Are these terms adequate and have they been defined appropriately? If not, what terminology and definitions should we consider using?

2. Given the range of services victims and survivors might need and use, what practical or structural ways can the service system be improved so it is easier for victims and survivors to receive the advocacy and support and/or therapeutic treatment services they need?

What type of service models help victims and survivors to receive the support they need?

3. How can we ensure practitioners and workers are sufficiently skilled to provide advocacy and support and/or therapeutic treatment for adult and child victims and survivors, including those from diverse backgrounds?

The National Association of Services Against Sexual Violence (NASASV) has drawn up a Standards of Practice Manual for Services Against Sexual Violence. The second edition was released in 2015. These standards have been accepted by the Tasmanian government as the minimum standards for services receiving government funding to provide sexual assault care.

Survivors are vulnerable people. It is very important that practitioners and workers are sufficiently skilled and work within ethical guidelines. PACFA is a peak body set up to monitor and promote that level of skill and accountability. To quote from their website:

“PACFA is a national peak body for professional associations within the Counselling and Psychotherapy profession. PACFA provides a forum for professional associations to unite in providing professional identity, research support and public accountability for the profession.

PACFA promotes the development of the practice of Counselling and Psychotherapy and represents the profession to the community and government while respecting the diversity of approaches within the profession.

PACFA is made up of 25 Member Associations which have adopted rigorous ethical and training standards developed by consensus through the PACFA Council, PACFA’s peak governing body. This body reflects the diversity of the profession by including representatives of all PACFA Member Associations.”

Most but not all practitioners are required to belong to a professional body where ongoing registration is required to remain a practitioner. Registration requires the professional to work within the Code of Ethics of their professional body and undertake a required minimum level of ongoing professional development. At present there is no requirement for someone who calls themselves a counsellor to have such registration when they hang up their shingle. It would be advisable to close this loophole so that only counsellors registered with a PACFA approved professional body could practice.

Topic E: Evidence and promising practices

1. What promising and innovative practices (including therapies, interventions, modalities and technologies) for victims and survivors of institutional child sexual abuse are emerging from practice-based evidence?

The resurgence of interest in and the recognition of the brain’s neuroplasticity, along with the role of the polyvagal nervous system have led to many new and innovative ways to address the effects of trauma. New possibilities are emerging all the time as researchers and clinicians apply these principles in new and innovative ways.

Some of the authors who have published work in this area are Norman Doidge, Sebern Fisher, Bessel Van der Kolk, Dan Siegel, Lou Cozolino, Steven Porges, Pat Ogden, Peter Levine, Babette Rothschild Ellert Nijenhuis, Cathy Steele, Onno van der Hart, John Briere, Colin Ross and Bruce Lipton. This is only a very small snapshot of the body of research work available. A very small sample of their work is included in the reference section.

The Boston Trauma Centre has been instrumental in conducting research into emerging innovative practices. Their website contains an extensive list of further research and discussion papers at:

<http://www.traumacenter.org/products/publications.php>

Some of the newer and diverse therapies and treatment modalities specifically addressing neuroplasticity include yoga, neurofeedback training, EMDR, EFT (Emotional Freedom Techniques), mindfulness, martial arts, psychodrama and The Listening Project.

Some of the results in these newer therapies are remarkable.

Bessel van der Kolk stated in his March 2015 workshop in Melbourne that only rarely does a new treatment present that truly warrants the investment of years of his time to research that but it has happened on four occasions. The first was Prozac, the second EMDR, the third yoga and the fourth is neurofeedback therapy. He has carried out research to prove or disprove those observations and his findings have been published for the first three. Research into Neurofeedback therapy is currently ongoing.

In the 2007 randomised clinical trial for PTSD patients that compared EMDR with Prozac and placebo (v.d. Kolk 2007). At the end of the 8 week trial period the Placebo group showed “a 42% improvement which is greater than many other treatments that are promoted as evidence based.” (v.d. Kolk 2014) The Prozac group did slightly better than the placebo but the EMDR group did substantially better. But it is not as straightforward as choosing the best therapy and using that for all clients as the following excerpt shows:

“After 8 EMDR sessions one in four were completely cured (their PTSD scores had dropped to negligible levels), compared to one in ten of the Prozac group. But the real difference occurred over time: When we interviewed our subjects eight months later, 60% of those who had received EMDR scored as being completely cured. As the great psychiatrist Milton Erikson said, once you kick the log, the river starts flowing. Once people started to integrate their traumatic memories they spontaneously continued to improve. In contrast, all those who had taken Prozac relapsed when they went off the drug.

This study was significant because it demonstrated that a trauma-specific therapy for PTSD like EMDR could be much more effective than medication.

Another key finding of our study: Adults with histories of childhood trauma responded very differently to EMDR than those who were traumatised as adults. At the end of 8 weeks almost half the adult onset group that received EMDR scored as completely cured, while only 9% of the Child-abuse group showed such pronounced improvement. Eight months later the cure rate was 73% for the adult-onset group, compared with 25% of those with histories of child abuse. The child-abuse group has small but consistently positive responses to Prozac.

These results reinforce the findings that I reported in Chapter 9: Chronic childhood abuse causes very different mental and biological adaptations than discrete traumatic events in adulthood. EMDR is a very powerful treatment for stuck memories, but it doesn't necessarily resolve the effects of the betrayal and abandonment that accompany physical or sexual abuse in childhood. Eight weeks of therapy of any kind is rarely sufficient to resolve the legacy of long-standing trauma.” (van der Kolk 2014 p.254-255)

The last paragraph highlights that EMDR is a useful part of therapy for childhood trauma survivors but that it cannot replace the traditional modes of counselling. It is sad to note that van der Kolk goes on to say that despite this study having the most positive outcome of any published study up to the writing of his book in 2014, “many of my colleagues continue to be sceptical about EMDR – perhaps because it seems to be too good to be true, too simple to be so powerful.”

Whereas EMDR is a treatment to integrate traumatic material, yoga is a means by which the survivor can learn self-regulation skills. To initially test the perceived effectiveness of yoga's effect on physiological functioning, the Boston Trauma Centre advertised for volunteers.

"Ultimately we selected thirty-seven women who had severe trauma histories and who had already received many years of therapy without benefit. Half the volunteers were selected randomly for the yoga group, while the other would receive a well-established mental health treatment, dialectical behaviour therapy (DBT), which teaches people how to apply mindfulness to stay calm and in control. Finally we commissioned an engineer at MIT to build us a complicated computer that could measure heart rate variability (HRV) simultaneously in eight different people. (In each study group there were multiple classes, each with no more than eight participants.) While the yoga group significantly improved arousal problems in PTSD and dramatically improved our subjects' relationships to their bodies ("I now take care of my body"; "I listen to what my body needs"), eight weeks of DBT did not affect their arousal levels or PTSD symptoms. Thus our interest in yoga gradually evolved from a focus on learning whether yoga can change HRV (which it can) to helping traumatised people learn to comfortably inhabit their tortured bodies." (v.d. Kolk, 2014 p.269-270)

Van der Kolk goes on to describe what aspects of the yoga have become the essence of their trauma-sensitive yoga:

"Many of our patients are barely aware of their breath, so learning to focus on the in and out breath, to notice whether the breath was fast or slow. And to count the breath in some poses can be a significant accomplishment.

We gradually introduce a limited number of classic postures. The emphasis is not on getting the posture "right" but on helping the participants notice which muscles are active at different times. The sequences are designed to create a rhythm between tension and relaxation – something we hope they will begin to perceive in their day-to-day lives.

We do not teach meditation as such, but we do foster mindfulness by encouraging students to observe what is happening in different parts of their body from pose to pose. In our studies we keep seeing how difficult it is for traumatized people to feel completely relaxed and physically safe in their own bodies. We measure our subjects' HRV by placing tiny monitors on their arms during 'shavasana', the pose at the end of most classes during which practitioners lie face up, palms up, arms and legs relaxed. Instead of relaxation we picked up too much muscle activity to get a clear signal. Rather than going into a state of quiet repose, our students' muscles often continue to prepare them to fight unseen enemies. A major challenge in recovering from trauma remains being able to achieve a state of total relaxation and safe surrender." (v.d.Kolk 2014, p.270-271)

One thing survivors of ongoing childhood abuse have in common irrespective of diagnosis is an overwrought, amygdala-driven dysregulated nervous system. Neurofeedback is an emerging therapy that is able to decrease reactivity and promote affect regulation in survivors whose problems can stem from attachment problems or developmental trauma. It does so by providing the brain with "real-time" feedback of the brainwave activity and then providing a reward when the brain produces a more desirable brain wave pattern. The brain wave activity tries to find equilibrium. In trauma this equilibrium has been "bumped out of orbit" so to speak and as a result a new and less desirable equilibrium has been established.

Sebern Fisher is one of the leaders in this field. In the introduction to her book “Neurofeedback in the Treatment of Developmental Trauma” (2014) she says the following:

“Just as emotion regulation is the first task of good parenting, it is also the first task of effective therapy. All too often, however, the severe states of the patient prevail and despite the effort of both the therapist and the patient, despite even the most judicious use of pharmacology, the therapy fails. Through training the brain to seek its own stability, we can ease these terrible sequelae to early childhood neglect and abuse, regardless of the diagnosis given. The fact that these things happened never goes away, but the person’s reactivity to them can diminish dramatically. In talking about how early traumatic events had stolen her life, one of my patients said, ‘I don’t know exactly where this is coming from but, somehow, it just doesn’t seem important anymore.’

Several important core assumptions are the foundation of this book:

1. Neurofeedback changes the focus of our attention from the mind to the brain.
2. The brain organises itself rhythmically in the frequency domain, and it is there that brain plasticity resides.
3. We can access these rhythms through a type of computerised biofeedback to the brain called neurofeedback.
4. Fear is the core emotion and the primary dysrhythmia in developmental trauma. Without addressing the brain’s fear circuitry directly, developmental trauma remains highly resistant to treatment.

My aim in writing this book is to share with readers what I have learned about the intricacies of attachment problems and developmental trauma and the role that neurofeedback can play in ameliorating them.

What makes neurofeedback therapy even more exciting is that gains made through neurofeedback are retained over time just as they are for EMDR.

Where are these available and who can access them?

Availability of these newer treatment modalities will depend on the size of the population centre and particular interests of practitioners. EMDR and Mindfulness based practices would be the most commonly available. Yoga and martial arts are commonplace but programs specifically tailored for trauma survivors less so.

For many survivors the cost would be prohibitive. Many of these modalities have no Medicare rebates. Those that do are limited to a certain number of sessions. Currently in Tasmania there are no free services that provide these newer therapies with the exception of trauma informed yoga in the North West.

2. What evaluations have been conducted on promising and innovative practices? What have the evaluations found?

The Boston Trauma Centre’s website (below) contains research papers of controlled trials of some of these promising and innovative practices. Unfortunately it is very difficult to source research

funding for innovative practices that do not have the potential to be converted into significant income streams if successful.

<http://www.traumacenter.org/products/publications.php>

The same site also has a wealth of information that has not been formerly peer-reviewed.

3. What other learnings are emerging from practice-based evidence or from grey literature (i.e. published reports and papers that have not been formally peer-reviewed, such as government reports) about supporting adult and child victims and survivors?

References

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You do not need to answer every question. The Royal Commission encourages you to answer the questions relevant to your expertise, interests and experiences. Your submissions will be made

public unless you request that it not be made public or the Royal Commission considers it should not be made public. That will usually only occur for reasons associated with fairness.

Submissions should be made by 13 November 2015, either

- Electronically to advocacyandsupport@childabuseroyalcommission.gov.au,
- By completing an online submission form at www.childabuseroyalcommission.gov.au/policy-and-research/issues-paperssubmissions/have-your-say
- In writing to GPO Box 5283, Sydney, NSW, 2001.

Submissions can be anonymous. If you have participated in a private session and would like your session to be recognised as a formal, confidential submission to this Issues Paper, please contact the Commission at advocacyandsupport@childabuseroyalcommission.gov.au.