



DOCTORS FOR SEXUAL ABUSE CARE

PO BOX 90 723, 5/4 WARNOCK STREET, GREY LYNN, AUCKLAND
PHONE: (09) 376 1422 FAX: (09) 376 0790 email: dsac@ihug.co.nz

NATIONAL NEWSLETTER

EDITORS: ANN PEARL & CAROL SHAND ISSUE No.42 DECEMBER 1999

President's Report 1999 "Commitment pays off"

Whenever we read the papers or just look at statistics on sexual abuse, it would be easy to become overwhelmed by the problem and decide "this is too hard". Some in the community appear to be prepared to exploit the truth in order to get public opinion on their side. Our message by comparison often seems dull and un-newsworthy.

More and more it appears that working in this area is full of such potholes and mine fields that it feels like one false move and "all will topple".

However, if we look at what DSAC has achieved and continues to achieve, then I think that dedication with good sound common sense and a commitment to achieve excellence continues to pay off.

This past year alone, DSAC has been able to have its statement on memory with respect to past sexual abuse accepted by the NZMA National Policy Council and disseminated by way of the NZMA newsletter. Although we had wanted it adopted as a national policy by this council, it was clear that the acceptance it received was as full an endorsement as could occur and that this acceptance was in spite of some very strong anti-DSAC lobbying.

ACC, a constant source of frustration, agreed to meet with us and discuss their new claiming procedures for sexual assault. They came, they listened and immediately saw sense. As a result they not only instituted a change in their claiming process but are keen to look at provision of service with DSAC. How how many years have we battled with ACC with seemingly little progress?

Pharmac, another seemingly incomprehensible, unmovable decision-making machine, has come to the party with its provision of azithromycin to sexual assault victims.

Funding. Now if ever there was an area where we could be forgiven for throwing our hands up in horror and saying its getting too hard, then this would be it. I mean it's not as if we want to hire our own planes and go to popular tourist destinations for our next regional coordinators' meeting. DSAC achieves a huge amount on what is really a shoe string budget. Mostly because our members are volunteers. Traditional funding sources are increasingly drying up. But, again, years of continued dedication and

keeping our sights fixed on DSAC's aims have paid off with generous funding or our secretariat for three years from the Geddes Philanthropic Trust.

In Wellington, just as the adult roster service appeared to have "foundered" funding arrived in the form of the WIPA sexual health contract. Hopefully, this may mean the inclusion of funding for sexual assault will become an essential part of the provision of service specifications for sexual health if contracting becomes standard.

It seems like just yesterday that I presented my first annual report in September last year and only last week that I took over from Ros Gellatly as President.

When preparing this report it was amazing to see all that has been achieved over the last twelve months. But then when one looks at the organisation, skills and energy of our Project Co-ordinator, Claire Hurst, coupled with the seemingly endless vision and dedication of the "volunteers" on the executive and at the coal face that make up DSAC throughout NZ, I guess the answer lies in front of us. DSAC's success is its members.

Once again DSAC has had a busy and very successful year. The secretariat and some executive members in particular were very busy with ISPCAN and I think were relieved to find that they could forge ahead with DSAC work once that had passed.

There have been a number of new initiatives and moves to modernisation that will keep DSAC abreast of the times.

DSAC started this last year by recognising that active members of our ranks need to move on. But we came up with a clever ploy to maintain access to their several expertise. To this end the executive recognized a new category of DSAC members known as the senior advisors and agreed to co-opt them to DSAC executive as specific needs arose. We welcomed Robynne Milford, Robin Fancourt, Carol Shand, Juliet Broadmore and Dawn Elder in this category and went straight on to involve them in projects which I will mention as we go.

DSAC moved to new premises which are larger more permanent and actually cheaper. We have also updated computer equipment in the office. And Claire

has discovered the joys of the internet.

As mentioned before Kel and Ann Geddes have yet again showed their commitment to aiding those working in the field of Child abuse, by funding DSAC's office and running expenses for the next three years. They have also been assisting with the printing of our newsletter as well. By providing this funding they hope to allow DSAC to concentrate less on fund-raising and more on getting our work done.

Thank you to Ann Pearl and Carol Shand for their editorial work on the newsletter and to Elsbeth with the database and journal club. Thank you to Dawn, Christine, Janet and Kristen for your work on the reviews of articles for the club members and again to Ann Pearl for her financial portfolio.

This year we are not having a national regional co-ordinators' meeting but hoping to meet with as many as possible during the Laura Slaughter seminars. Thank you Linda for being our executive regional coordinator.

Training projects and Seminars;

Once again DSAC has organized and held a number of very successful seminars this year.

The understanding Sexual Offending Seminars in Wellington, Dunedin and Christchurch were very well received and attended by over 270 registrants.

Dissociation, DID and Trauma Therapy seminars in April with Constance Dalenberg and Judith Armstrong attracted over 540 registrants and were held in the four main centres. An imminent disaster became apparent when on the eve of Constance Dalenberg's first seminar she had to return back home because of a family bereavement. However, our Claire kept her head and coolly continued the seminars with Judith Armstrong alone. It was with much relief that of the over 500 registrants only one felt let down, the rest giving glowing appraisals.

In June DSAC departed from its usual seminar topics and agreed to help organize and run a seminar on Domestic Violence. After an amazing effort in diplomacy and organization, a very successful conference attended by over 90 people was held with wonderful feedback and indications that more of this type of seminar is wanted. I might add here that Claire was away overseas during this conference presenting a paper of her own at an international congress. This left Vivienne to step into the breach. She worked admirably and helped to ensure a very smoothly run conference which attracted a very wide range of people from many different professional spheres.

In July Constance Dalenberg was called to NZ to provide expert evidence for the Peter Ellis appeal. She offered two excellent seminars on complex PTSD which were attended by over 200 people.

John Briere offered to do a seminar on Therapy for male victims while he was in NZ for the NZ Psychological Society. This attracted over 100 registrants in August.

Two forensic training weekends have been held this year – one in March in Wellington and one just gone held by Caroline in the South.

Achievements and projects

Apart from the memory project, ACC, azithromycin, and WIPA mentioned previously, DSAC members have been busy achieving elsewhere.

Carol Shand presented the DSAC role to the newly appointed Police Co-ordinators. The appointment of 23 of these co-ordinators of sexual assault throughout NZ seems a very positive step, but they have raised concerns about the availability of DSAC doctors in some areas.

As part of the medical waiting list projects throughout NZ various doctors have been on working parties looking at referral guidelines to medical outpatient clinics. We have been able to get sexual assault/ abuse referral guidelines included in the sexual health referral guidelines.

DSAC as you know has been accepted as a special interest group for CME provider and Claire attended the annual CME provider workshop in Wellington in March this year.

Watch this space :

Work continues on the updating the manual and also on the regional co-ordinators' liaison directory.

The DSAC web site is closer to fruition. It is thought that this is the best place to publish the liaison directory so that it can be continually updated.

Clarification of the Paediatric accreditation process and work on re-accreditation process is also underway. This is essential to DSAC continuing to maintain its professional standards.

A number of DSAC members are involved in a one-stop-shop pilot project being set up by Emma Davies consisting of project groups from CYFS, health, counsellors and mental health to decided how best to integrate and set up multi-disciplinary advocacy centres for children and adolescents who have suffered abuse. These are still in the planning stage but may help stop the "falling through the cracks" syndrome many of these children and adolescents suffer.

The move towards some nurses becoming Sexual abuse Examiners has been supported by the DSAC doctors and looked at with keen interest by the nurses themselves. There are a number of issues to be addressed and we will watch the progress with interest.

We have just had the first in a series of combined seminars on Adult Sexual Assault – Doctors and lawyers – crossing the great divide.

DSAC ran a series of half day seminars trying to address issues between doctors and lawyers with Dr. Laura Slaughter as guest speaker. She is a recognized expert on the forensic evaluation of sexual assault victims. This is the first time DSAC has brought a recognised expert in acute adult sexual assault to NZ. As well, it is timely to address the role of the expert witness in adult sexual assault court cases in particular issues of neutrality of findings and our role as advisors to both prosecution and defence. We are making full use of Laura's visit by piggybacking these seminars with peer review and regional coordinators' meetings in the various centres.

Finally, it is with much pleasure that I commend to you Caroline Corkill your next president. Caroline I know will bring to the position a much-needed peripheral centre perspective with the associated difficulties of providing sexual assault services in smaller communities. I hope you find your two years as president as satisfying as I have.

- Selina Green, DSAC President 1997-1999

(Address given to the DSAC AGM, Auckland October 18, 1999)

DSAC PRESENTATION ON ADULT SEXUAL ASSAULT

GUEST SPEAKER DR. LAURA SLAUGHTER

DSAC brought Dr Laura Slaughter to New Zealand with the aim of focusing on adult and adolescent acute sexual assault, the area that most of us were originally involved in when the formation of DSAC was first conceived. DSAC's aim to continue to research and develop medical management of sexual assault means that we must continue to look at our protocols and state of knowledge both in NZ and internationally.

Dr Laura Slaughter's papers on medical findings with the use of the colposcope in acute sexual assault coupled with recommendations from those who have worked with her, made her an obvious choice as a speaker. Her recognition as an expert witness as well as her work in the field of rape/homicide also made her an appealing speaker for the Police and Justice. Laura's ability as an engaging and compelling speaker was well founded.

Her visit to NZ has left DSAC with a number of challenges to meet. DSAC has already set up a working party to develop policy on the use of the colposcope as a tool in acute sexual assault evaluation and the use of photography of injuries both on the body and parts of the genitalia as an aid to evidence giving in court. We hope to develop a consensus and policy on these issues but at this point in time DSAC has written to all the registrants at Laura Slaughter's seminars including the Police and Legal representatives and are advising them that DSAC is not going to be advising its doctors to change their current examination techniques or evaluations.

Below is an overview of what I found very useful and interesting in Laura's seminars and some take home messages for me.

LAURA SLAUGHTER SEMINARS

1. Useful review of anatomy and physiology and the normal sexual response (Masters and Johnson)
2. Relationship between the anatomy and physiology and what we may or may not find with non-consenting sexual intercourse.
3. It is becoming widespread practice in North America to use a colposcope and photography to assess and record injuries in acute adult and adolescent sexual assault. Injuries on all parts of the body can be examined and recorded in this way.
4. Dr. Slaughter has not had a problem obtaining consent for the use of these photos in court.
5. The medical examiner along with the police, victim's support and social worker and/or nurse do a combined interview of the history of the assault with the victim. This is the police statement.
6. Often the examination is done by a sexual assault nurse examiner. - SANE
7. Follow up examination again with photography to show resolution or healing is routine procedure.
8. Follow up exams allow use of the patient as her/his own control, to distinguish lesions the patient "owns" from acute lesions.
9. A lot of useful courtroom presentation including "what makes a good expert witness"

- Show you have considered and discounted other possible causes for the injuries.
- If self injury is suggested, ask if there is any evidence of significant psychiatric history
- Differentiate between what is possible and what is medically probable
- Do not use the word "alleged" in history taking as doctors do not describe "alleged chest pain".
- Point out if asked a hypothetical question how it differs from what you know in this case?

10. Rape homicide: Laura Slaughter's discussion of rape homicide led to the suggestion that the pathologists should consider using DSAC trained doctors expertise in the medical evaluation.
11. Ensure peer review of all statements done for court.

Below is a list of points raising issues to be discussed. DSAC welcomes its members views and opinions around these issues.

COLPOSCOPY

ADVANTAGES

- ◆ More precise and greater clarity
- ◆ Prolongs the window of opportunity for finding injury
- ◆ Photography allows presentation of the findings indefinitely and will allow the victim to be used as her own control when follow up is done to show resolution of the findings.
- ◆ Allows good peer review and support by colleagues for our findings
- ◆ Allows the injury to speak for itself rather than just our description in words

DIFFICULTIES

- ◆ Issue of informed consent
- ◆ Training/expertise
- ◆ Expense
- ◆ Protocol needed to protect the slides and their use in court and by defence etc.
- ◆ Addressing the issue of "genital" photography — i.e. photos of injuries that happen to be on the genital area.
- ◆ Lack of availability in smaller isolated areas.
- ◆ Requires experience to become competent and confident in its use and requires ongoing use to maintain expertise. This may raise difficulties in smaller areas.

- Selina Green

Comments from the *LAURA SLAUGHTER SEMINARS*

From Queenstown:

Judge P A Moran, District Court

At DSAC's invitation I offer the following necessarily superficial observations on the above subject.

1. Use of colposcopes

The case for the use of colposcopes in forensic medicine is unanswerable. It affords a means of discovering material evidence that would otherwise remain insensible to sight.

The only limitations that I can see arise from the availability of money and of personnel prepared to enter this field of expertise.

2. Impartiality of experts

It seems there is some disquiet among DSAC doctors over their being perceived as partisans for the prosecution. That disquiet should be dispelled.

The trial process is not a search for truth. It is a contest between prosecution and defence in which the prosecution bears the burden of proving its case beyond reasonable doubt.

In cases of sexual assault the central issues are usually whether the sexual assault occurred at all or whether the sexual encounter was consensual. Evidence of trauma is directly relevant to both these issues and, naturally, that evidence will invariably be called by the prosecution.

Experts in the field should not feel tender about that fact of life. They should always keep in mind that they are not advocates for one side or the other but expert witnesses whose integrity demands that they remain true to their science.

3. Second medical opinions

The paper prepared for the Auckland meeting raised the question "how should a second medical opinion be obtained?".

I am not sure what issues were envisaged but it may be observed that the defence's obtaining its own expert opinion would be facilitated by the existence of photographs of a colposcopic examination.

In the context of a trial, the ordinary rules of disclosure require such evidential material to be made available to the defence, a fact which, arguably, a complainant should be made aware of before submitting to examination.

4. Use of genital photographs in Court

I do not share the sensitivity of some of my legal friends who caution against the use of graphic photographs in Court.

Jurors are more robust than given credit for and the prejudicial effect of graphic photographs on juries is, I think, more imagined than real. Initial shock and revulsion becomes dulled as the trial proceeds.

Admissions of such photographs is in the discretion of the trial Judge. If the photographs are substantially helpful to the expert in explaining his or her findings to the jury then the photographs should be shown.

5. Absence of findings in an acute case

The expert witness should be able to say to the jury whether, from the account of sexual assault given by the complainant, the expert would expect to find evidence of trauma. If it be the expert's opinion that evidence of trauma would not necessarily be present then he or she should say so and back it up with reasons.

In this context the lack of colposcopic examination might well justify the expert in saying that significant trauma insensitive to the naked eye might well have been present.

6. Consistent v Diagnostic

I have no problem with the formula that evidence of trauma is consistent with but not diagnostic of sexual assault. There is no need to resort to weasel words such as "neutral".

Defence counsel will always seek a concession that some innocent cause for trauma is "possible". Given that the Crown's standard of proof is beyond reasonable doubt, defence counsel is likely to pose an innocent explanation for trauma as a "reasonable possibility".

Either way I see no harm in the expert witness conceding possibility or even reasonable possibility of innocent cause if that is appropriate but it would also be as well to qualify the concession that given the totality of the injuries observed the innocent causation of any of them is unlikely or may even be reasonably ruled out.

By way of parting shot may I be permitted the observation that any witness (expert or not) who is prepared to make concessions where appropriate is a more effective witness than one who circles the wagons and concedes nothing.

Thank you for the opportunity of participating in Dr. Slaughter's presentation.

From Wellington:

Hon Justice J W Gendall

In closing may I express the thanks of Chair and the appreciation of all participants at this seminar for the outstanding presentation given by Dr Laura Slaughter. I also thank and express appreciation to Dr McDonald, Mr Burston and Mr Davidson for their valuable contributions. I have no doubt that the expertise and experience of Dr Slaughter and the other members of the panel have provided valuable insight and information to all present. The audience is representative of many disciplines. Today's presentation has been particularly valuable to doctors present to assist in their techniques of examination, history taking and presentation of

evidence in Court. Senior Police officers and detectives present will have received considerable benefit to assist them in future investigations of crimes and complaints of serious sexual assault. How they liaise with medical professionals is crucial. The Crown and Police prosecutors will now be better informed so as to present submissions, lead evidence and prepare their cases, through careful briefing of medical witnesses, effectively. Finally defence counsel, represented here by leaders of the Wellington criminal bar, will have had their knowledge enhanced. We must remember that whilst justice requires that accused persons are properly tried with evidence that is properly

given, relevant and tested, on the other side of the coin medical expert evidence may well assist counsel in defending clients. Knowledge on the part of defence representatives is as important to the process of justice as is knowledge held or acquired by prosecution counsel, investigators and doctors called on behalf of the prosecution. Knowledge gained by all present today will be invaluable to the process of the law. All aspects of the different professional disciplines that those here today represent will greatly benefit from the presentation of Dr Slaughter to whom we are indebted, we extend our warmest congratulations and appreciation.

Message from the new DSAC President

Dr Caroline Corkill writes:

DSAC has been improving medical management of sexual abuse for ten years now. Six dedicated presidents, an energetic core of members and enthusiastic supporters like Claire urging us on have kept DSAC going over this time. I have accepted the job of president in the hope that I can do my bit for an organisation which has supported me professionally and personally over those years.

Selina Green has been a member since DSAC's early days and president for the last two years. Thank-you Selina for all your hard work - for the victims of sexual assault you care for, for encouraging the provision of sexual assault rosters around the country, for developing our role as expert witnesses, for making some progress in the negotiations with ACC, and for developing DSAC as a bicultural organisation. In other words, Selina, for achieving the goals you set yourself as incoming president in 1997.

My goal as president is to keep on with the good work of my predecessors. We still need to encourage more doctors to train and share the medical care of sexual assault victims. This

is our basic role and needs to be continued as long as sexual abuse happens. The new edition of the manual will help this.

We learned much from Laura Slaughter about being expert witnesses but we will have to debate and decide how we implement her suggestions in New Zealand.

I think we will be asked to become more involved in the care of those affected by other forms of violence and neglect, as happened in this year's Domestic Violence Workshop. We will have to work out how best to do that within our goals and organisational rules.

I hope to encourage those members of DSAC who are interested in research. Sexual assault/abuse is international but NZ information is particularly helpful in working out what is most appropriate for NZ.

Thanks to all of you for your hard work in 1999 and my wishes for a peaceful Christmas and a good start to the New Year.

AZITHROMYCIN

Remember that supplies of Azithromycin (Zithromax[®]) are available for STI prophylaxis for any patient who is at risk of infection as a result of a sexual assault. The regime is absolutely simple 1G. stat. (2 x 500mg tablets)

PHARMAC is fully subsidizing this drug through DSAC and supplies are available from:
DSAC National Office,
P.O.Box 90 723, AUCKLAND.

You can write, E-mail (dsac@ihug.co.nz) or Fax: (09) 3760790 to order your supply for the next 6 -12 months.



Erratum

The editors apologise for errors in printing in the last newsletter No.41. Copy was produced in Microsoft Publisher and sentences from two articles were lost in the process of sending it to the printer.

This issue is produced in Adobe Pagemaker software. To enable ease of publishing we are making use of modern technology and electronic transfer of copy, including the final version to the printer. We are inexperienced at this and hence the lost copy last time. We hope it will work better this time in Adobe.

Carol Shand and Ann Pearl

ACC SEXUAL ABUSE CLAIMS

NOVEMBER 1999

When you suspect a patient may have been sexually abused and that they may be entitled to an ACC claim follow this sequence of questions:

1. DOES THE EVENT MEET SECTION 40 CRITERIA?

Check against relevant sections of Crimes Act - see Extracts from the Accident Insurance Act 1998. (Note the addition of two new crimes in the 1998 Act - 194: Assault by a woman on a child under 14 years old and 204a & b : Female genital mutilation.) If the event is definitely outside these criteria - then do not bother with an ACC or other insurance claim.

2. DID THE EVENT HAPPEN IN NEW ZEALAND, OR WAS THE PATIENT ORDINARILY RESIDENT IN NZ AT THE TIME?

Only eligible for ACC claim if the answer is yes.

3. IS THE PATIENT SELF-EMPLOYED?

If the patient is self-employed, then find out if they are insured by ACC or by a private insurance company. If they have a private insurer then this claim has to be done on the private insurer's forms - Accident Treatment Certificate - and processed by the private insurance company regardless of whether the abuse happened at work or elsewhere. DSAC is finding out what special processes and training private insurance companies have in place for handling these claims.

4. IS THERE ANY PHYSICAL INJURY?

(e.g. bruises, grazes, cuts)

If there are injuries then fill out an ACC M45 for the physical injury and an ACC M40 Bulk-billing claim. The date of the injury should be the date of the accident/abuse. These forms should both be sent to your local ACC SERVICE CENTRE.

5. IS THERE ANY MENTAL INJURY?

The Act defines "mental injury" as

"a clinically significant behavioural, cognitive, or psychological dysfunction." (e.g. Acute stress reaction, Post Traumatic Stress Disorder -PTSD -, Depression, Phobia etc.).

If there is no mental injury then an ACC claim will not be accepted.

If there is mental injury then

- (i) Complete an ACC 45
 - The date of the injury is the date of first presenting for treatment
 - Part E - In the Diagnosis code - Put Z***
 - Under Additional Comments put "mental injury that is caused by rape/sexual violation/incest"
 - Part H - 'I certify that....' Cross out "accident" and write in "Event listed in the Third Schedule of the AI Act 1998".
 - If a physical injury ACC45 has also been done, then make a note of this on the sexual abuse ACC45.
- (ii) Complete an ACC 290
- (iii) These should be posted together to
THE SPECIAL CLAIMS UNIT,
 PO BOX 1426,
 WELLINGTON
- (iv) Fill in a M40 Bulk Billing Claim (if not already done for physical injury) This can be sent with the other forms to the Special Claims Unit or to your local office. If claiming on Police 175 for forensic examination, you can still claim ACC \$27 for filling out these forms as long as you deduct time from police claim.

6. DOES THIS PATIENT NEED REFERRAL?

If so provide appropriate referral e.g. counsellor.

Accident Insurance Act 1998

Third Schedule

Cover for Mental Injury caused by Certain Criminal Acts

Crimes Act 1961

- S. 128 - Sexual violation
- 129 - Attempt to commit sexual violation
- 129a - Inducing sexual connection by coercion
- 130 - Incest
- 131 - Sexual intercourse with girl under care or protection
- 132 - Sexual intercourse with girl under 12
- 133 - Indecency with girl under 12
- 134 - Sexual intercourse or indecency with girl between 12 and 16
- 135 - Indecent assault on woman or girl
- 138 - Sexual intercourse with severely subnormal woman or girl
- 139 - Indecent act between woman and girl
- 140 - Indecency with boy under 12
- 140a - Indecency with boy between 12 and 16
- 141 - Indecent assault on man or boy
- 142 - Anal intercourse
- 142a - Compelling indecent assault with animal
- 194 - Assault on a child, or by a male on a female (to the extent that the assault is by a female on a child under 14 years old)
- 201 - Infecting with disease
- 204a - Female genital mutilation
- 204b - Further offences relating to female genital mutilation

DSAC negotiations with ACC for recognition of DSAC accredited doctors as preferred providers of medical services to victims of sexual assault are proceeding. DSAC is hopeful that this will result

in an appropriate payment for services provided to victims when there is no police involvement, services which until now DSAC doctors have provided largely as a charitable service.
MORE NEWS IN THE NEW YEAR



Barbara Morris leaves DSAC EXEC

Barbara has been a long term member of the DSAC executive. She served as Secretary for many years, an onerous job that is the linchpin in any organisation. Barbara has worked on many DSAC projects and has always been willing to do the work that is needed.

As well as the administrative work that Barbara has done for DSAC, she has been the backbone of the Auckland roster. For the last few years Barbara has done a wonderful job of roster co-ordination and getting doctors onto the Auckland roster.

Barbara, your participation and contribution to DSAC has been greatly valued and you will be sorely missed.

ANGST COLUMN

The Auckland ANGST has been busy lately doing some serious writing.

We have produced a nursing chapter for the soon-to-be-revised DSAC manual. We are pleased to have the opportunity to officially recognise the nurse's role and we hope we have reflected the diversity of the role in the chapter. We have circulated it to Wellington, Christchurch and Dunedin and hope that it is acceptable south of the Bombays.

We are working hard on writing clinical pathways for our roles. In the new year we hope to produce a program for training new nurses and upskilling those of us who are ready to become Sexual Abuse Nurse Examiners. DSAC is planning a Basic Paediatric Training in the New Year and we hope to offer a nurse training in conjunction with it. We are unsure what level to aim this at, so any feedback from the regions would be appreciated.

Whakaruruhau now has two full-time nurses and Karen Togi says she is settling in well. Karen is already a valuable contributor to the ANGST group and we look forward to picking her brains more!

That's all for now.

Kathy Lowe

Selina Green pays tribute to Vivienne Coyle

Vivienne joined as an assistant for Claire in March 1997. She has more than lived up to the promise that was seen when she was taken on and we are very aware of her total commitment to DSAC and its progress. Sadly I guess one of the downfalls in taking on someone with many skills, energy and promise, is that they will outgrow the job and move onto bigger and better things.

Vivienne, I know that sometimes sitting in the office at DSAC you felt isolated and unappreciated, but because of the smooth running we often had no reason to be in contact. Your easy and friendly approach certainly made my job as President much easier and on behalf of DSAC I would like to wish you every success in teaching and hope we can continue to keep in contact.

ACSHP WORKING PARTY ON SEXUAL ABUSE

At its last executive meeting the Australian College of Sexual Health Physicians (ACSHP) approved training in sexual assault care as part of the core training to be required of all applicants for fellowship of the college.

Carol Shand and Juliet Broadmore have subsequently agreed to help on an ACSHP Working Party on Sexual Assault Medicine along with Australians Jacki Mein (Darwin) and Margaret Mobbs (Melbourne.)

This working party has been asked to:

- 1 Collate and critically review existing sexual assault training packages NZ and Australia-wide
- 2 Amalgamate a short training and reference manual appropriate for Australasian trainee use
- 3 Keep regularly updated lists of sexual assault medical practitioners Australia/NZ with contact details
- 4 Keep regularly updated lists of sexual assault medical and counselling education options Australia/NZ with course and contact details
- 5 Disseminate the lists and reference manual through appropriate means - college secretariat, contact people/groups in different States/Territories, email listings, websites.

It is anticipated that this working party will function through teleconferences. There will be progress reports to the College for publication in the College Newsletter.

Carol Shand and Juliet Broadmore would like to hear from any of you who have ideas about any of these topics. We will also provide DSAC with updates on progress.

Julietb@paradise.net.nz or cshand@braithwaite.wn.planet.gen.nz

TREATMENT OF MALE SURVIVORS OF SEXUAL ASSAULT IN CHILDHOOD AND ADULTHOOD

Auckland 30th August 1999

This review of the workshop presented by John Briere, Ph.D., has been written by Andrew Moskowitz, Ph.D., psychology lecturer at the University of Auckland.

As those of you who have previously attended his workshops can attest to, trying to take notes on a John Briere workshop is like – forgive me for paraphrasing *The Sound of Music* – trying to catch a snowflake in your hand! This was my first contact with John, and I must say that it was exhilarating. Part raconteur, part entrepreneur, and part seasoned guide, Dr. Briere is a pleasure to listen to. He has an unparalleled wealth of knowledge about trauma, is clearly a very careful thinker and researcher and, most importantly, has the capacity to convey complex and difficult information with humour, grace and pizzazz. Unfortunately, what made Dr. Briere thrilling to listen to made trying to take coherent notes exhausting. On more than one occasion I was unable to find in my notes parts ‘three’ or ‘four’ of the “five aspects of such and such” he was poised to give us before another fascinating tidbit leapt to his forebrain! Nonetheless, the breadth and depth of what he conveyed, and the clarity of his thought, particularly in conjunction with the wonderfully detailed handout, more than made up for any fleeting longings for structure I may have had. So please bear with me as I try to convey the essence of this wonderful workshop.

John Briere, Ph.D. is Associate Professor of Psychiatry and Psychology at the University of Southern California School of Medicine, and a clinical psychologist at the Division of Emergency Psychiatry of LAC-USC Medical Center. Dr. Briere is a fellow of the American Psychological Association and a member of the Board of Directors of the International Society for Traumatic Stress Studies (ISTSS). He also sits on the Advisory Board of the American Professional Society of the Abuse of Children (APSAC). Dr. Briere is author of a number of research papers, chapters and books in the areas of child abuse, psychological trauma and interpersonal violence. Recent books include: *Psychological assessment of adult posttraumatic states* (1997), and *Therapy for adults molested as children: beyond survival*, rev.edition (1996).

In reviewing my notes, I found that John Briere’s workshop could be broken into four overlapping sections: 1) gender differences which have implications for how men respond to sexual abuse and assault, 2) differences between how men and women respond to having been sexually abused or assaulted, 3) an overview of PTSD and trauma treatment as conceptualised through Dr. Briere’s “self-trauma” theory, and 4) considerations for treating men who have been sexually abused or assaulted.

With regard to gender differences, Dr. Briere commented on the well-documented predilection for men to “externalise distress,” and to respond to problems with instrumentality, that is, a desire to “do something” to “solve” the problem. Due to sex-role pressures, men are allowed limited expression of “soft” emotions such as sadness and grief, and encouraged to express only “hard” emotions such as anger. Dr. Briere used the expression “funneling” to describe this process. For men, particularly violent men such as ‘batterers’, almost every affect gets “funneled” into anger. Likewise, sex becomes a funnel for men, as a range of “soft” emotions/issues, such as intimacy and vulnerability get linked closely with it. Dr. Briere argued that, while women are allowed (and indeed encouraged) to express/

experience non-sexual intimacy, men are not; intimacy/vulnerability is sexualised for men, which has implications for the contexts in which they can express distress or hurt. Dr. Briere stated that, for many men, the expression of pain/distress in the context of therapy violated sex-role norms, and stimulated intolerable feelings of being “one-down,” or “weak.” He noted that, because of this, many men can only express distress, if at all, to a female sexual partner.

Dr. Briere also noted that men embrace an “ideology of imperturbability” (another wonderful phrase!), which does not allow them to acknowledge pain, such as from an injury, in public, but does allow them to “whine” in private to their partner when, for example, they get the flu. Since men cannot openly acknowledge distress or hurt, they may somatise as an acceptable way to get support. Related to this, Dr. Briere argued that men actually dissociate far more than has been realised, though primarily in the form of intellectualisation (perhaps also described as ‘dissociation of affect’?).

Much of the workshop was spent in this next area, characterising how men and women differentially respond to sexual abuse/assault. Dr. Briere first reminded the audience that men are viewed differently by society after sexual assault than are women, because sexual abuse/assault violates males’ gender roles in different ways than women. He noted that studies have shown that women are seen as less intelligent and powerful after a rape, but not less “feminine.” In contrast, men are seen as less masculine. Rape violates men’s gender role to such an extent that men are seen as either “weak” or “gay” after such a trauma.

Dr. Briere did talk about how childhood sexual abuse impacts men’s sexual identity. He noted that men sexually abused in childhood were more likely to consider themselves gay or bisexual as adults (although noting that homosexuality was most likely “normally distributed” in societies), but were likely to carry the scars of the abuse in one of two tragic ways. Some boys are actually aware from a very early age of being “gay” or attracted to men (however they might characterise it). Dr. Briere noted that, when boys with this awareness were sexually abused, it can lead to a cognitive distortion he characterises as “gayness-caused abuse.” Since perpetrators almost always claim that this was the “first time” or “only time” they committed such an act, the child may conclude that it is something about “them” which caused it. For boys who are aware of feeling gay before the abuse, they may think of themselves as an “abuse magnet” of sorts, concluding that they must have given off some kind of “signal” by their sexual orientation that led the abuser to them. Such cognitive distortions lead to tremendous amounts of self-blame and low self-esteem, and self-identity as a “seducer.”

In contrast, boys who had no awareness of being gay or homosexual prior to the abuse, but go on to develop sexual interests in men after being abused, sometimes see the abuse as *causing* their sexual orientation, which Dr. Briere characterised as “abuse-caused gayness.” In this equally destructive cognitive distortion, the male sees his homosexuality as a “symptom” of the abuse, thus his very identity becomes a “symptom.” This distortion leads to tremendous amounts of shame, self-loathing, and much pathologising about the self. Of course, there is no doubt a significant number of gay men who were sexually abused as children, but whose identity is not affected by either of these patterns.

Not all men who were sexually abused as children consider their

sexual orientation to be homosexual or bisexual. Among men who were sexually abused and who develop a heterosexual orientation, some respond to their abuse in stereotypical ways. One very common pattern is what Dr. Briere referred to as “hyper-masculinity.” These men become very “macho” in orientation, turning to bodybuilding or other traditionally masculine pursuits, in an attempt to convince themselves and all those around them that they could not possibly be gay. Dr. Briere characterises this as a fear of latent homosexuality. While some men who were sexually abused have no obvious difficulties in heterosexual relations, others become hyper-sexual (as a form of self-soothing, re-enactment, or distraction), while others become phobic or avoidant of sexual activity.

Men not only respond to sexual abuse differently, they are much more reluctant to admit it, as consideration of such an admission stimulates fears of being seen as “gay” or “weak.” Studies now suggest that 12-15% of men in the community have been sexually abused as children, which Dr. Briere thinks is an underestimate. He speculated that, in clinical populations, the prevalence was probably 25-35%. This compares to 25-30% for women in the community, and 50% for women in clinical settings.

As difficult as it is for men to report childhood abuse, it is almost impossible for men to acknowledge being sexually assaulted as adults. I found this portion of the workshop shocking and mesmerising. Dr. Briere claimed that over 10% of rapes were actually perpetrated on men, and that many of these men did not consider themselves gay or bisexual. (Almost invariably, the *perpetrators* characterised themselves as “straight.”) Compounding the overwhelming shame of being raped is the reality that, for the few men with the courage to report rape, few appropriate venues exist to take such reports. Rape crisis centres are almost invariable designed for women, and often have difficulty responding appropriately to men who have been raped. Dr. Briere reported that men almost never go to rape crisis centres. It is the gay and lesbian outreach centres which typically respond to such crises, but that is probably the *last* place a straight man who has just been raped would want to go. Clearly, this is a problem that needs to be addressed on many levels.

Before commenting on some other ways in which men respond to being sexually abused/assaulted, it may be useful to consider Dr. Briere’s unique and stimulating characterisation of posttraumatic stress disorder (PTSD). In the first place, Dr. Briere argued that PTSD is better thought of as a point on a dimension, rather than as a discrete disorder. As many others have said, Dr. Briere noted that people who just miss the diagnosis of PTSD may still be in significant psychological pain. Secondly, he argued that the reexperiencing symptoms, such as flashbacks, should actually not be considered symptoms at all, as he claimed they are actually “attempts to heal.” As evidence of this, Dr. Briere noted that soldiers in Vietnam developed flashbacks only after they had returned from the war, not while they were over there and still in danger (this appears to be consistent in other traumas as well). He argued that this was because flashbacks and other reexperiencing symptoms were actually the mind’s attempt to heal; by re-experiencing aspects of the trauma in a “safe” environment, the mind is actually attempting to break the link between the memory and the physiological response, to desensitise or habituate. Further evidence for this is the fact that many people have symptoms of PTSD shortly after a trauma which dissipate in the ensuing weeks, and do not go on to develop PTSD (a month’s duration of symptoms is required). He describes this process as trying to “trim” a “conditional emotional response” (or CER), which we will hear about more in his description of trauma therapy.

The difficulty occurs with the development of avoidance symptoms, which are more prominently used by men than women. Too much avoidance, whether through dissociation, substance abuse, or cognitive distortions, leads to an inability to process or habituate the traumatic event. Dr. Briere characterised behaviors such as substance abuse as

“tension reducing behaviors,” or “TRB’s,” which he defined as “any external activity someone engages in as a way to regulate painful internal states.” TRB’s, which can distract from pain or self-soothe, can also be used to alleviate guilt, as in self-punishment rituals such as self-mutilation. Dr. Briere noted that self-mutilation, which he defined as “intentional self-effected bodily harm of a socially-inappropriate nature (and non-suicidal in nature)”, was equally as common in men and women. (I have certainly found this to be true in prisons). He also indicated that aggression can be a TRB, and commented on the common pathway from childhood abuse to prison for men. Socialised to externalise their distress, men are deprived of opportunities to learn how to regulate affect by means other than TRB’s. Dr. Briere commented that this incapacity to modulate and tolerate affect, along with “acting out” behaviours, was perhaps the most crucial difference between how men and women responded to abuse trauma.

Finally, Dr. Briere turned to the topic of treating men who had been sexually abused or assaulted. First he gave an overview of his approach to trauma treatment, which had several important concepts. As with other approaches, he started with a strong emphasis on support and safety between client and therapist. He then highlighted the importance of constructing a coherent narrative of the trauma, with as much detail as tolerable and emphasising appropriate levels of responsibility, starting initially in the past tense and then moving to the present tense. These graduated recountings (“context-reinstatement”) help the client to “trim” the ‘conditional emotional responses’ (CER’s) developed from the trauma. By telling the story of the trauma in the relative safety of the therapy session, the memory of the trauma ultimately loses much of its terrible power. However, Dr. Briere noted that these recountings had to be carefully titrated, kept in what he referred to as the “therapeutic window.” He emphasised the importance of getting the right balance between too little exposure, which would be ineffective in “trimming” the “CER’s”, and too much (in time or intensity), which would stimulate between-session avoidance techniques (such as substance abuse, etc.). He also noted that there were individual differences in how much pain could be tolerated, and that men appeared to have a “narrower” therapeutic window than women. The old concept of abreaction was reintroduced, with Dr. Briere indicating his belief that “emotional discharge,” in the form of crying, could be “curative,” particularly when it was paired with exposure. He also spoke of the crucial importance of helping the client develop affect regulation and affect tolerance, through staying present in the session despite being in pain. Finally, Dr. Briere emphasised the importance of bringing positive closure to each narrative, to keep clients from “hitting the wall,” in a beautiful phrase, so that a “failure experience” will not become “built in” to the session.

With regard to men in particular, Dr. Briere cautioned that the therapist needed to understand their male clients’ greater need for control over the process of treatment in general, and their own internal experience; as men are more likely to use avoidance strategies and TRB’s, the therapist should always talk about the potential impact of the sessions and what it might cause the client to do over the ensuing week. Dr. Briere further argued that sexually abused men experience greater levels of shame, blame, and guilt than women, and that corresponding levels of dissociation (intellectualisation), which could undermine the therapeutic work, should be carefully monitored.

All in all, a most entertaining and stimulating workshop, on a very timely topic. I believe this to be a crucially important area; we may see a significant decrease in male violence if we can only find a way to impact gender role socialisation to allow men less violent ways of expressing their distress.

THE TREATMENT OF COMPLEX PTSD

Constance Dahlenberg PhD

Review of Auckland workshop written by Kim McGregor, PhD student based in the Injury Prevention Research Centre, Department of Community Health, University of Auckland

Dr Dahlenberg's research on the recognition and treatment of complex post traumatic stress disorder (CPTSD) provides clinicians with a new and deeper level of understanding of this intricate and complicated work. As Director of the Trauma Research Institute and Associate Professor of Psychology at the California School of Professional Psychology, she has a wealth of experience in both clinical practice (as a therapist) and as a researcher in experimental psychology. The way she combines her exceptional skills in both spheres means that her work has immense practical value for therapists. Until recently therapists have not been well served by research. To date most research in this area has focused on identifying symptoms rather than assisting, in a practical sense, those of us who work day after day with survivors of various traumas, including child abuse and neglect.

For me Dr Dahlenberg's workshop was inspirational. Being so impressed, I am left feeling that it is difficult to do justice to the complexity of her work - particularly in such a short article. However, for those who wish to hear more of her workshop, DSAC has cassette tapes available for hire.

Dr Dahlenberg began the workshop discussing some of the difficulties arising when applying Diagnostic and Statistical Manual (DSM) diagnoses to symptoms of trauma. She gave an example of survivors of trauma who exhibited classic PTSD symptoms and who, according to the way the various DSM's have defined trauma over the years, were not entitled to the diagnosis of trauma.

In recent years, Dr Dahlenberg and her colleagues have found Herman's (1992) definition of CPTSD useful. However, even this definition has been regarded as limited because it states that, in order to receive the diagnosis CPTSD, a person must have survived severe and prolonged trauma rather than a single trauma. Dr Dahlenberg states that CPTSD is not just severe PTSD. In fact, people can have CPTSD but not PTSD. For example, a study of Vietnam

veterans exposed to a "potential" trauma resulted in approximately equal numbers who manifested symptoms of PTSD only, CPTSD only, and those who experienced both PTSD and CPTSD.

Difficulties with diagnoses become even more complicated when those with symptoms of CPTSD display not only the more severe aspects of PTSD but also other diagnoses such as obsessive compulsive disorders, depression, suicidality, and personality disorders. In practice then, because CPTSD is highly associated with a collection of other diagnoses, the survivor of trauma is often given multiple diagnosis such as: PTSD, major depression, major anxiety disorder, and/or a personality disorder. It is as though the person is suffering "a DSM disorder". Dr Dahlenberg suggested that diagnoses are only useful if they assist the clinician in matching the presenting condition with appropriate treatment. Current inadequacies in definitions of trauma mean that clinicians faced with such multiple diagnoses find it difficult to know how to proceed.

Dr Dahlenberg offers the clinician a way through this gap. She reduces CPTSD to its simple biological messages:

- 1) **Remember this moment** (leading to intrusive thoughts)
- 2) **Never go this way again** (leading to avoidance)
- 3) **Be prepared** (leading to the development of hyperarousal)

Put simply, CPTSD leads people to generalise symptoms of PTSD. An example of this generalisation is when a trauma survivor not only becomes anxious when seeing someone with a 'similar look' to the attacker, but almost 'anyone' causes a similar level of anxiety. In addition, with CPTSD there is a lot of repetitive preparation by the trauma survivor to ensure that no-one ever hurts them again. Hence, a trauma survivor may avoid any interactions that may in any way trigger feelings similar to those created by the trauma,

such as shame, rejection, or abandonment. Unfortunately, any interpersonal intimacy creates the risk of triggering parallel feelings. The trauma survivor is therefore currently potentially reactive to a unique cocktail of triggers. The specific meaning of each of these triggers may be found within the traumatic event(s) that occurred in the past. To avoid experiencing feelings similar to the trauma, the survivor may resort to self-harming as a way of avoiding another person hurting them. Self harming can represent the trauma survivors taking control of the situation by inflicting the pain on themselves.

The purpose of CPTSD treatment is:

- to re-regulate the biological system
- to compartmentalize the trauma
- to recreate the possibility of a safe, rewarding and approachable world through exposing the client to circumstances that contain elements sufficiently similar to activate the emotion/trauma and sufficiently different to allow for change.

Working at an interpersonal level with a person struggling with CPTSD is tremendously difficult. The intimacy of psychotherapy can trigger invisible trauma related pain in the survivor. Dr Dahlenberg shared a sobering quote that resonated with a number of the audience: "*Practicing psychotherapy is a difficult - if also rewarding - way to earn a living. It is no profession for the individual who likes certainty, predictability, or a fairly constant sense that one knows what one is doing. There are few professions in which feeling stupid or stymied is as likely to be a part of one's ordinary professional day, even for those at the pinnacle of the field.*"

Dr Dahlenberg provided some basic guidelines for this work. In general, a therapist should :

- Shout their attachment to their client
- Whisper comments on disturbing and distancing behaviours
- Try not to shift boundary rules

suddenly

- Respect the magnitude of the client's pain
- Help the client to reframe "over-reaction"
- Explain as you treat.

When commenting on a therapist's attachment to their client, Dr Dalenberg referred to the meaning and purpose of involvement in therapy. She highlighted several benefits to positive countertransference:

- Positive counter-transference facilitates positive transference, as well as the foundation for the acceptance of therapist interventions within either cognitive or analytic theory
- The therapist's involvement, particularly in long-term therapy, is a sign to the client of his or her inherent likability
- Involvement will increase the capacity of the therapist to empathically understand the feelings of the client.

Dr Dalenberg discussed a number of difficulties that occur in therapy. Due to space considerations only the first two of these can be addressed here.

1) Problems in therapy occur when the therapy goes too fast.

Before the therapist leads the client to re-experience aspects of the trauma they must assist the survivor to achieve sufficient safety and stability in their world so that approaching aspects of the trauma will not overwhelm. Before this work commences, it is of vital importance that the trauma survivor also feels safe with the therapist. In her study, Dr Dalenberg found that therapists often expected too much of their clients too soon. Clients complained of feeling overwhelmed when therapists "wrenched" out of them all of their traumatic symptoms and pushed for a very quick disclosure. In the workshop, Constance recommended that therapists have to move "very slowly" with people who have CPTSD "in order to get reasonable change from them."

2) Difficulties arise when therapists avoid discussion of the trauma.

Discussing trauma is difficult for both parties. Dr Dalenberg's study found that some therapists attempt to protect their clients from feeling the pain of the trauma by helping them to "forget". Clients felt a corresponding "pressure to avoid" the trauma to protect their therapist from feeling overwhelmed. Dr

Dalenberg commented that this impasse was made even more difficult because many of the useful descriptive words had been "used up". For example, in every day language we say: I was "terrified" on the rollercoaster, I was "horrified" at the sight of my teenager's room. Therapists are left with comments such as "That sounds like it was hard". Knowing the inadequacy of this description, therapists often feel stuck in silence.

Dr Dalenberg's presentation of these everyday clinical issues and impasses was refreshing and normalising for therapists to hear. Listening to the tapes of this one day workshop reminded me of common transference and countertransference difficulties and solutions and assisted me to feel more confident in my work with traumatised people.

I have been lucky enough to have Dr Dalenberg as a consultant involved in the design of my PhD research. Early to mid 2000 I will be advertising for participants for my study which will be a partial replication of Dr Dalenberg's research asking survivors of trauma about their therapy experiences- particularly what they found helpful and not so helpful.

Report from Wellington DSAC - Jane MacDonald

As everyone now knows since 1/7/99 sexual assault has been included in the sexual health contract managed by WIPA (Wellington Independent Practitioners Association), the same organisation running maternity services in the Wellington area.

There is some discrepancy about area of coverage for sexual assault examinations as the Hutt Valley has its own doctors' roster and is co-ordinated by Rape Counselling Network in the Hutt Valley; but the Porirua and Wellington call outs continue to be co-ordinated by the Wellington Help Foundation and the doctors carry out the examinations in the Afterhours / Sexual Health Clinic in Newtown, Wellington. This clinic is central, well equipped, well lit and staffed 24 hours a day.

Wellington DSAC has the support of Cathy O'Malley, CEO of WIPA, Craig Tamblyn, manager, and the staff of the sexual health clinic. We encourage the sexual health staff to be involved with callouts during the day. We also have to rely on them to adjust their clinics to accommodate the emergency callouts. This has caused a bit of hassle for everyone concerned, but we are sorting these teething problems out as we go and in the main everyone is working together well.

Night times and weekends are still covered by the old faithful!! Our DSAC nurse, Rachel Broom, also works as a nurse at SHC. Since the move we have been very busy, partly because we

are now funded for non-forensic callouts but the forensic side of things has been busy too.

We are training 2 doctors and we have 2 new nurses on the roster. Ann Simmons and Karen Simcox. Both these nurses have been involved in maternity, women's health and abortion services for many years and we are delighted to have them both on board!

We have Azithromycin now, which is kept separately from the SHC pharmacy stores - thank-you Claire!

The main problem we have is adjusting to the new computers at the SHC for printing our labels.

We were all stimulated and challenged at the recent seminars by Laura Slaughter, and we plan to review our anatomical knowledge and terminology at our December meeting in Wellington as well as discussing the colposcope issue.

Over Christmas and New Year medical cover will be thin, as some of the doctors (mainly me) will be overseas. Our friends at Wellington Central Police station are unfortunately expecting a busy time over the New Year.

Lets hope it is not.

Happy Christmas and a Good New Year to you all from Wellington DSAC.

DSAC

Diary of Events - 2000

Dr John McCaan, MD

Advanced Teaching Seminar on Evaluation of Child Physical and Sexual Abuse

VENUE

Marion Davis Library Auckland Hospital
Park Road, Grafton

COST

\$150.00 + GST

DATE

21 February 2000 (*All Day*)

"Dr John McCaan is a Clinical Professor of Paediatrics and the Medical Director of the University of California, Davis Medical Center Child Protection Center. He is Chairman of the American Professional Society Against Child Abuse's (ASPAC) Committee on the Interpretation of Anal/Genital findings in Child Sexual Abuse. He is widely regarded nationally and internationally as a master anatomic diagnostician in the field".

Whakaruruhau & Te Pua Pohutukawa Teams

Basic Paediatric Training Medical Assessment of Sexually Abused Children & Adolescents

Followed by

1 Day Nurse Practitioner Training

VENUE

Marion Davis Library Auckland Hospital
Park Road, Grafton - (to be confirmed)

DATE

22-24 February 2000
Saturday, 25 February 2000

For all events

Apply to DSAC National Office

PO Box 90 732, AUCKLAND

Tel: (09) 376 14422

Fax: (09) 376 0790

email: dsac@ihug.co.nz

Dr Christine Courtois, PhD

**Healing the Incest Wound:
A Treatment Update for Adult Survivors**

VENUE

Auckland - Location to be confirmed
Wellington - Location to be confirmed
Christchurch - Location to be confirmed

DATE

Last 2 weeks of March
(1 Day Seminars - dates to be confirmed)

"It has now been over a decade since treatment models for incestuous abuse have been published. Much has changed in the knowledge base and in the treatment model during this decade. This workshop is designed to present recently published information regarding the characteristics and dynamics of incestuous abuse. This information is used to inform and update the treatment model. The expanded treatment model includes increased attention to: developmental consideration and attachment, diagnostic formulations, comorbidity, memory and delayed/repressed memory issues as well as the sequencing and pacing of treatment and recommended strategies and techniques".

"Dr Christine Courtois is the Clinical Director for The Centre, Post Traumatic & Disassociative Disorder Program, the Psychiatric Institute of Washington, Washington DC".

DSAC NATIONAL NEWSLETTER - Editor Carol Shand

Published quarterly by DSAC, P.O. Box 90 723, Unit 5/4 Warnock Street, Grey Lynn, AUCKLAND

E-mail: dsac@ihug.co.nz

©DSAC 1999

The views expressed in this newsletter are not necessarily those of the Editor or Publisher

ISSN 0114-4340