



DOCTORS FOR SEXUAL ABUSE CARE

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NATIONAL NEWSLETTER

EDITORS: SANDRA RHIND & CAROLINE CORKILL ISSUE No. 76 NOVEMBER 2008

Manager's Report - Hayley Samuel

This report is devoted to the work of the DSAC Domestic Violence Intervention Sub-Committee whose eight dedicated members continue to provide training, primarily to Primary Healthcare professionals, throughout New Zealand on the *Recognition and Response to Partner Abuse*. The work of the sub-committee is by way of a contract with the Ministry of Health, which DSAC has held since April 2002. This contract enables DSAC to offer this training programme to General Practice team members, Sexual Health Clinic staff and some Obstetricians and Gynaecology professionals plus other health groups not covered by a different contract. Whilst the training sessions themselves are free to groups of eight or more attendees, we do seek a contribution towards travel and accommodation costs if a trainer is required to travel outside of their region.

The article "Treating family violence as a health issue" in the June 2008 (Ministry of Health produced) issue of *Public Health Perspective* reported that, "More than 4500 health professionals, including midwives, have completed training in family violence intervention". Given that DSAC, as of December 2007 (the last data that the Ministry of Health had received prior to publication of this article), had trained 3238 health professionals i.e. nearly three quarters of the reported total of health professionals trained, it is encouraging to know that the eight DSAC trainers have played a large part in this success!

One of the major barriers that we continue to face is the lack-of Primary Healthcare Organisation (PHO) management/leadership buy-in. This means that the training programme is not taken up by the PHOs, or has limited attendance. DSAC has requested Ministry assistance to access the key PHO contacts in order to facilitate training uptake and to encourage internal policy change to reflect PHOs' commitment to recognising and responding to family violence.

Dr Faye Clark, one of the key domestic violence intervention trainers, was approached by the College of Practice Nurses National Conference Committee to provide a plenary session on Family Violence, and the importance of this being addressed in Primary Health Care, on a recommendation by Hilary Graham-Smith, the Clinical Nurse Director of Pinnacle Health. Faye delivered this session at the nurses' annual conference in May to 200+ delegates. The DSAC Office has consequently received five requests for more detailed information on the DSAC Training Programme with one firm booking to date.

The one reporting area which we have not delivered on under this contract is that of follow-up audit data post-training. This has been a continuous struggle despite paper and online post-training surveys being developed in conjunction with the Auckland University Family Violence Evaluation Team (AUT FVET). DSAC have been consulted by the AUT FVET regarding the development of a PHO family violence responsiveness tool which may be more effective in data capture and may ultimately assist with the provision of hard data on the implementation of the Family Violence Intervention Guidelines within primary healthcare practices.

I would like to thank all of the DV Trainers for their commitment to delivering this training.

Continued on page 2

WHAT'S INSIDE.....

	Page No.
Manager's Report (<i>continued from page 1</i>).....	2
DSAC Advanced Paediatric Training Course	3 - 6
Carol Shand's Investiture Ceremony	7
An Evening With Dr Jan Jordan	8
Shari Barkin Workshop	9 - 11
DSAC Diary of Events 2009	12

Continued from page 1

Visiting Speaker Update

Marylene Cloitre, Ph.D. – October 2008

It has been wonderful to see the registrations for the Marylene Cloitre seminars continue to roll in. I am very much looking forward to her three 1-day seminars entitled “*Psychotherapy for the Interrupted Life: Treating Adult Survivors of Childhood Abuse*” as follows:

Auckland - Waipuna Hotel & Conference Centre
– Monday, 20th October 2008
Wellington – Mercure Hotel Willis Street
– Wednesday, 22nd October 2008
Christchurch – Holiday Inn City Centre
– Friday, 24th October 2008

Ellert Nijenhuis, Ph.D. – February 2009

DSAC was first recommended Dr Nijenhuis in 2003 by two independent sources and we have spent the last five years trying to encourage him to come to New Zealand so we are thrilled that he has accepted! Dr Nijenhuis will be delivering three 2-day workshops on “*Dissociation of the Personality and Childhood Traumatization: Theory, Research, and Treatment*”

Auckland – West Lounge, Eden Park
– Friday, 13th & Saturday, 14th February 2009
Wellington – InterContinental Hotel
– Wednesday, 18th & Thursday, 19th February 2009
Christchurch – Holiday Inn City Centre
– Monday, 23rd & Tuesday, 24th February 2009

Dr Nijenhuis is a Psychologist in The Netherlands who is one of the most recommended speakers on the treatment of complex PTSD currently internationally. He is known by other experts working in this field for grappling with some of the most complex and perplexing phenomena that therapists are likely to encounter. His work provides a unifying theory that identifies a disturbance of the self as the core problem for the whole spectrum of trauma related disorders. This theory is then closely linked to a highly sophisticated understanding of assessment and treatment.

These intensive 2-day seminars will be useful for all mental health care professionals working with chronically traumatized individuals including those who have experienced severe abuse and neglect. The seminars will present the theory of structural dissociation and a psychology of action, and their application in the various treatment phases of chronically traumatized individuals.

Both theory, and the phase-oriented treatment model based on it, provide the basis for effective treatment. Among other things, they describe each treatment phase in terms of overcoming specific trauma-related phobias.

- Phase 1 is geared toward overcoming phobias of trauma-derived mental and behavioral actions, of dissociative parts of the personality, and of attachment and attachment loss with the therapist.

- Phase 2 is directed toward overcoming the phobia of traumatic memories, and phobias related to insecure attachment to perpetrator(s).

- In Phase 3, treatment is focused on overcoming phobias of normal life, healthy risk-taking and change, and intimacy.

The phase orientated treatment model aims to integrate a range of different perspectives including: Janet’s psychology of action, affective neuroscience, attachment theory, developmental psychopathology, evolutionary psychobiology, learning theory, cognitive theory, psychobiology of traumatization and sensorimotor psychotherapy.

Dr Gillian Mackay, Psychiatrist and Psychotherapist (ACC Registered), highly recommends Dr Nijenhuis’ work as follows:

“This training is an opportunity not to be missed and we are very very lucky DSAC has finally managed to bring Ellert to NZ. He is a rare master educator, communicator, therapist and researcher, with the additional quality of genuine compassion. I would travel across the world to hear Dr. Nijenhuis again.

Ellert has presented his work on the neuropsychology of trauma throughout the world and is a leading light in the trauma field. He skillfully conveys complexities of trauma dynamics from both a theoretical and clinical perspective. Moving videotapes of his work with clients demonstrate how he combines solid research with humanity and compassion in effective clinical intervention.

Ellert R S Nijenhuis, Ph.D., is a clinical psychologist, psychotherapist and researcher. He works at the outpatient department of psychiatry of Mental Health Care Drenthe, Assen, the Netherlands, where he engages in the diagnosis and treatment of severely traumatized patients, and chairs the trauma committee.

Ellert is the recipient of multiple International awards and Honours for his outstanding contributions to the diagnosis, treatment, research and education in dissociative disorders. He has published numerous clinical and scientific articles and authored many books and book chapters.”

For more about Dr Nijenhuis’s work visit:
www.enijenhuis.nl

Hayley Samuel
DSAC National Manager



DSAC Advanced Paediatric Training Course and 4th Combined Australia and New Zealand Meeting on the Medical Assessment of Sexually Abused Children and Adolescents

1 - 3 August 2008, Christchurch

Report by Dr Sandra Rhind, Invercargill, New Zealand

The weekend's activities began when doctors met with lawyers and counsellors to hear Dr Suzanne Blackwell, Clinical Psychologist, report on the findings of her PhD thesis, "Child Sexual Abuse on Trial – The Jury Research Project". This 5-year research project has provided insight into the jury system, raised questions on its relevance and suitability for use in sexual assault trials and given rise to suggestions for improvements.

Dr Blackwell's interviews of jurors from 23 child sexual abuse trials brought to light common misconceptions.

- A child will immediately report an assault.
- Retraction of an allegation implies it was untruthful in the first place.
- A continued relationship between the alleged perpetrator and victim means no abuse occurred.
- Children are highly susceptible to suggestion and easily influenced so that they will believe they have been abused even if they haven't been. They are easily coached to give evidence.
- Children's memory is fallible so they have difficulty differentiating between reality and fantasy.
- Children are more likely to lie than are adults.
- The average person can tell by someone's body language whether or not they are lying.
- Children will be upset when giving evidence if they have been sexually abused.
- Sex education has implications on a child making sexual abuse allegations.
- People who offend in this way are probably easily recognised by appearance and manner.
- Sexual abuse cannot happen in close proximity to other people.
- Inconsistencies in a child's testimony imply the child was not truthful about the main event.
- Teenagers are vindictive and are more likely than adults to make false statements.

She noted that defence lawyers often used these misconceptions as part of their defence.

In several instances judges had told jurors to look at the witness's manner and how they said things, not just what they said. Unfortunately, studies have shown that observing body language is a poor way of finding the truth.

Doctors who appear in court proceedings should be aware of the features jurors found important when deciding to trust expert witnesses. In descending level of importance they were:

- relevant professional experience
- lack of bias
- clarity of evidence
- confidence
- eye contact with the jury
- academic qualifications

I will be interested to read the papers (likely to be 7-8) Dr Blackwell will publish using this research.

The next day we moved to the Oncology Lecture Theatre at Christchurch Public Hospital, which provided an effective, comfortable venue for the rest of the course.

Dr Lori Frasier gave us an update on current literature and controversies in the medical evaluation of child and adolescent sexual assault victims. We know that normal anatomy is highly variable, that the hymen changes configuration during growth and development so that the same child examined several years apart may have a quite different looking hymen with different notches that are totally normal and not trauma-related. Studies that have followed injuries through to healing have shown that the hymen heals without scarring.

Adams et al have updated their classification of anogenital findings. These are now presented as guidelines with the note that findings must be evaluated in the context of the medical history and the statement from the child. The current three categories are:

- findings documented in newborns and commonly seen in children who have not been sexually abused,
- indeterminate findings – those that can support a diagnosis of trauma and/or sexual assault,
- findings that are diagnostic of trauma and/or sexual contact.

Continued on page 4

**With special thanks to
Image Centre,
34 Westmoreland Road West
Grey Lynn, Auckland
(09) 360 5700**



There is still a lack of 100% consensus on several findings. Remember that most examinations won't show injury, and other unrelated conditions can cause unusual findings.

Our clinical observational and diagnostic skills were put to the test with a variety of slides of these anogenital conditions that commonly mimic those of sexual abuse. This was a good reminder of the variety of changes seen (bleeding, blistering, redness, apparent bruising, discharge, bumps, lumps and protuberances) and their wide range of causes other than sexual abuse. Be systematic in your observation and approach. Remember lichen sclerosis!

Dr Frasier's stamina showed as she continued presenting with an update on STIs. We were reminded the incidence of sexually transmitted diseases in children who are suspected of having been sexually abused is low (1-2% in most studies), so routine testing is not advised, but testing should be done in those who are symptomatic and those at higher risk of infection ie having a sibling with an STI, a perpetrator with an STI, evidence of penetration, or multiple perpetrators. Whether we like it or not, sensitivity and specificity are important to understanding STI tests and their applications! She reviewed the research on the results of using NAATS, culture and combinations of these for identifying those infected with gonorrhoea and Chlamydia trachomatis.

Following lunch Lori reviewed some papers that looked at the effect experience and/or the availability of history had on the interpretation of findings. These highlighted the need to ensure our findings and conclusions are not influenced by our expectations. Less experienced clinicians are more likely to over call findings than under call them. Look at as many 'normals' as you can and always question what you see. The need and benefit of peer review, be it face-to-face or by some other method, was reiterated. She demonstrated a method she and others employed that used web based applications. It certainly looked user-friendly and informative.

When DSAC members say "How long is a piece of string?" we know what they are talking about – the long awaited update of the Medical Examination Kit (MEK). Dr Clare Healy has spent many hours, which has been a true test of her patience, working with ESR and Police staff to finalise this. She let us into a few "secrets" of the new look kit that is expected to make its debut later this year; reminders of important history to elicit, better layout for recording of drug and alcohol history, improved instructions on sampling and more body diagrams and spare swabs!

Suzanne Alliston, Associate Clinical Team Leader of STOP Adolescent and Children's Programmes in Christchurch, explained these programmes to us. STOP provides a residential treatment programme in Christchurch and community-based programmes in other centres of the South Island for adolescents between the ages of 12 and 18 who have engaged in sexually abusive behaviour.

Sexual abusing by adolescents accounts for a significant proportion of all sexual abusing in society. (The USA figure of 30-50% of child sexual abuse being perpetrated by adolescents was quoted.) However, less than 40% of people who engage in sexually abusive behaviour have themselves been sexually abused.

Adolescents take a long time to engage in treatment and, indeed, are unlikely to unless there are significant negative consequences for them not doing so. It is partly for this reason that there is a 3 month period of assessment and education for both the abuser and their family/caregivers before the treatment programme of 3 to 36 months begins. Intervention is individually tailored to a point and involves individual, group and family work.

Dr Dawn Elder showed us, with her usual humour, that the experience of sexual assault can affect any part of the sleep cycle, as can a lot of other (often fairly innocuous) things in a child's life. So again, it is important to be systematic in your approach to the problem, and don't jump to conclusions.

As usual, the peer review session was an opportunity for each attendee to present a brief overview of a case, highlighting a particular issue or concern that arose from it. Improvements have made this streamlined so the most can be made of what never seems to be enough time. It is always a good learning experience and having the input from Dr Lori Frasier and the Australian attendees was an added bonus.

Congratulations and thanks are given to Hayley Samuel, Christine Foley, Clare Healy and Dawn Elder for the time and effort they gave to put together this informative yet enjoyable update and to the guest presenters Suzanne Alliston and Dr Lori Frasier. We are fortunate to be able to benefit from the knowledge of such highly qualified and approachable experts.

Dr Sandra Rhind
DSAC Doctor

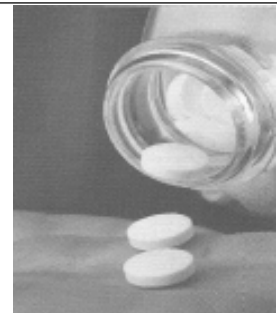


Azithromycin

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 tabs)

PHARMAC is fully subsidizing this drug through DSAC and supplies are available from:
DSAC National Office, PO Box 90723, Victoria Street West, AUCKLAND 1142

To order your supplies for the next 6-12 months you can either write, email: dsac@ihug.co.nz or
fax: 09 376 0790



Report by Dr Angela Williams, Australia

After having attended the Initial Paediatric Training Course in April this year I decided to cross the Tasman for a second time this year and attend the Advanced Training Course held in Christchurch in the first weekend of August. What an impressive course, with a fabulous international speaker and a great opportunity to peer review with and meet so many colleagues dedicated to advancing their knowledge and practice relating to child abuse.

On the first evening I was inspired by a presentation by Dr Suzanne Blackwell, a Clinical Psychologist of the University of Auckland, who spoke to her PhD – Child Sexual Abuse on Trial: The Jury Research Project. There were two fundamental parts to her research; jurors knowledge of child sexual abuse and a survey of all sexual offence trials over one year.

After taking copious amounts of notes (after one or two NZ reds and a long trip over to NZ) I have deciphered the following insights:

- Jurors are not necessarily representative of the general population
- Jurors subscribed to many of the myths and misconceptions surrounding child sexual abuse including that children are suggestible or easily coached, that if the allegations were real they wouldn't have delayed in reporting, that if there was a strong relationship there couldn't have been abuse, that children lie, children will be distressed and cry if they are telling the truth in court, that paedophiles are identifiable ie look a certain way, sexual abuse can't take place in close proximity to other family members, that peripheral inconsistencies mean the child is lying, teenagers can be vindictive and so too can mothers (who coach their children to make the allegations), child sexual assault is rare and those affected will always exhibit behavioural problems... (to mention more than a few).
- Many jurors will judge the behaviours of the witnesses, assessing truth by body language. In particular they note the absence of distress, eye contact, crying and other emotion.
- Characteristics of the expert witnesses were rated and appeared in the following order:
 - o Relevant professional experience
 - o Lack of bias
 - o Clarity of evidence
 - o Confidence
 - o Eye contact with the jury
 - o And academic qualifications of the expert

Gender of the expert was largely irrelevant and there was a perception that the group were not impressed by 'hired guns'.

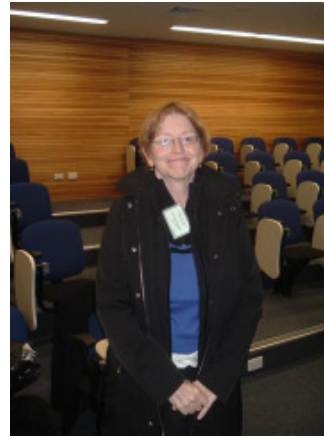
- There was increased likelihood of conviction if:
 - o the child was backed by >2 adults (mother must believe child)
 - o physical injury was present – hard medical evidence
 - o the jury didn't think they were lying but not enough evidence
 - o there were witnesses
 - o there were 2 or more complainants
 - o there was a confession or video footage.

- CSI effect – the police and prosecution are pressured to provide more forensic evidence in criminal trials
- The defence was often based on promoting the misconceptions i.e.:
 - o Focusing on the delayed reporting
 - o Demonstrating ongoing contact with offender
 - o Demonstrating continued affection with offender
 - o Highlighting where the child had 'peripheral' inconsistencies (i.e. can't remember what colour the curtains were)
- o Accusing the child of lying.
- Prosecution were noted to only have met with the child on average on one occasion, for less than one hour, an average of three days before the trial. They rectified the misconceptions at closing and often attributed no conviction as being secondary to the complainant's behaviour or inconsistencies.
- Judges were also noted to have given jury directions less often than was probably appropriate, interfered where necessary in less than half of cases, used inappropriate language, missed giving the notes of evidence (or the videotaped evidence transcript) to the jury on some occasions.
- Predictive variables for convictions were as follows:
 - o If the child was <12 years of age at trial
 - o Similar fact evidence was led (i.e. offender had similar behaviours before)
 - o Recent complaint
 - o Penile penetration
 - o 2 or more complainants
 - o 4 or more charges
 - o accused admitted part but not to being guilty
 - o positive medical evidence or DNA
 - o witness to actual sexual offence.
- The predictive variables did not apply for adult cases (for the most part the defence is consent where there is positive medical evidence or DNA).
- Story model of decision making – this is a process that jurors go through in their determination. Jurors will fill in the gaps with their own experience or misconceptions where there are 'holes' in the story.
- Defence counsel focus on peripheral rather than central aspects of the alleged incident.
- Jurors felt they were at trial to 'find the truth'.
- Jurors defined 'beyond reasonable doubt' in terms of mathematical certainty.

Saturday was a day full of interesting lectures given predominantly by Dr Lori Frasier from the United States of America. She attended the University of Utah College of Medicine and completed a paediatric residency at the University of Washington. She was a fellow at the Harborview Sexual Assault Centre under Dr Carole Jenny. Dr Frasier was on the faculty of the Department of Paediatrics at the University of Iowa, establishing the sexual abuse evaluation clinic there, and participating in evaluations of physical abuse and neglect. From 1995-2002 she was on the faculty of the Department of Child Health at the University of Missouri Columbia, Director of the Child Protection program there, and from 1994-2002 was the Medical Director of the Missouri

Continued on page 6
page 5

SAFE-CARE Network, a network of medical providers trained to provide medical evaluations of abused and neglected children. She is currently the Medical Director of the Medical Assessment Team at the Centre for Safe and Healthy Families, Primary Children's Medical Centre, Salt Lake City Utah, and a Professor in the Department of Paediatrics at the University of Utah School of Medicine. She has published many articles and chapters in the field of child abuse and has lectured locally and nationally. She is the immediate past Chairman of the Executive Committee for the Section on Child Abuse and Neglect of the American Academy of Paediatrics and on the board of Directors of the American Professional Society on the Abuse of Children (APSAC). Dr Frasier has been appointed to the American Board of Paediatrics first sub board in Child Abuse Paediatrics.



*Dr Lori Frasier
Advanced Paediatric Training Course 1-3 August 2008*

Saturday was an intense day of lectures and had many important points worth sharing. These points are my interpretation of what Dr Frasier was saying and again, for ease, I will pop them in dot point form:

- Inexperienced practitioners tend to over interpret findings.
- How many examinations make an examiner competent?
- Developmental issues of childhood are fundamentally inconsistent (anatomical variations, age, influence of hormones) – no wonder findings are inconsistent with respect to ‘what is the norm’.
- We should be aiming for 100% review rate of our videocolposcopies and reports.
- The congenital absence of a hymen has never been reported in medical literature.
- The ‘normal findings on examination’ is by far the most frequent finding in literature.
- Most injuries to the genital area heal without obvious findings. All except complete transections and beyond, healed without evidence, and then some of those healed without evidence too. Petechiae were gone by 48 hours.
- The hymen changes in configuration with age.
- Lori felt that no scar tissue has ever been found on the hymen.
- All findings should be taken in context of the history from the child.
- Anal tags are usually associated with conditions other than past anal trauma, therefore over-interpretation should be discouraged in the absence of seeing the trauma that preceded the anal tag.
- Lichen sclerosis never involves genital mucosa.
- The commonest cause for phimosis requiring circumcision in adult males is lichen sclerosis.
- STIs in children are rare.
- Antibiotic prophylaxis in prepubertal children is not common practice.

The importance of peer review was reiterated to the group, however Dr Frasier chose the term ‘quality review’ as there is a risk in peer review of ‘group think’. It is therefore very important to have external review of our practice, and reports also.

***Dr Angela Williams
President FAMSACA
Forensic Physician
Victoria, Australia***



*Dr Min Lo and Dr Angela Williams
Advanced Paediatric Training Course 1-3 August 2008*



*Dr Christine Foley, Dr Clare Healy, DSAC National Manager
Hayley Samuel, Dr Lori Frasier and Dr Dawn Elder
Advanced Paediatric Training Course 1-3 August 2008*

Carol Shand's Investiture Ceremony

On Friday, 5th September 2008, I was privileged to represent DSAC as one of Carol Shand's four invited guests to her investiture ceremony at Government House. Carol was invested as a Companion of the New Zealand Order of Merit (C.N.Z.M.) by His Excellency The Governor-General, The Hon Anand Satyanand, for Carol's services to women's health. I was incredibly proud to share this moment along with Carol's daughter Claudia, son Karl, and friend Anne Munz.

Carol then hosted a celebration, a "gong party", at her home on the Saturday evening. As I wandered through the house I heard a number of people remarking that "it was about time" that Carol had been acknowledged for her many years of commitment to women's health across New Zealand. The biggest disappointment that Carol's friends shared was that the Honour did not include a title for Carol to include in her name – apparently one can no longer be 'Dame-d'! The party atmosphere was entrenched with pleasure and pride for Carol's acknowledgement by the New Zealand honours system.



Congratulations Carol!

Hayley Samuel
DSAC National Manager



Hayley Samuel and Dr Carol Shand
at Carol's Investiture Ceremony, Government House

THE MEDICAL MANAGEMENT OF SEXUAL ASSAULT SIXTH EDITION 2006

The DSAC training manual is a resource for medical health professionals who provide medical care for victims of sexual assault. It is a supplement to the DSAC training courses in medical management of sexual assault and represents a collation of current thinking in this field of medicine, from both local and international sources.

The 6th edition is significantly different from the 5th edition and has been reorganised into 3 main sections. Not all subsections have been fully updated for this edition and these will be added to the online manual as they emerge. Until all sections have been updated, some cross referencing will be inaccurate.

Section A contains practical guidelines for forensic examination and medical care of adult victims of sexual assault. For ease of use, references have been kept to a minimum. Forms and templates that can be used in your clinical situation are marked with a printer icon.

Section B contains guidelines for children and adolescents.

Section C contains important reference material.

Note that previous appendices are now included in the main body of each individual section.

The technology of the Web will allow DSAC to regularly up-date sections in response to new knowledge. Users can browse and download in print individual chapters as they wish.

Visit www.dsac.org.nz

Access to it is by purchasing an individual user name and number through the DSAC office.

Annual access fees include GST.

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Individual non DSAC Members	\$100.00	\$140.00
Medical Institution	Price on Request	\$140.00
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* postage not included - please contact the DSAC Office for postage costs

An Evening With Dr Jan Jordan

In August 2008 the Government announced the release of a discussion document in relation to aspects of the law on sexual violation. In particular the document considered aspects of the law of consent and the extension of the rape shield, as well as seeking general input on alternative ways that sexual violence could be handled within (or alongside of) the criminal justice system. Public submissions were sought (deadline was 30/09/08).

29 August 2008

Re: Discussion Document on Sexual Violence Legislative Reform

Tonight I'm going to speak briefly about one issue raised in the discussion document that our work at HELP leads us to believe is a key law change that must be made if our legal system is to keep pace with, or more accurately catch up to, the social and sexual environment in which we live.

That issue is the defence of reasonable belief in consent. This is an automatic defence that is the focus of most rape trials. Before we had DNA evidence, most rape trials were defended on the basis of identity – in other words, “it wasn't me, I wasn't there”- and the prosecution's job was to prove that it was him and he was there. With the advent of DNA, identity is the issue in the smaller proportion of cases where the rapist is a stranger attacker. When the attacker is identifiable the issue is almost always consent.

As the law currently stands the prosecution is required to prove, beyond reasonable doubt, that the defendant did not believe on reasonable grounds that the victim was consenting. That's a negative construction of the concept of consent – in other words it assumes that consent exists unless...

The problem with this assumption of consent is that it leaves the doors of the court and its antecedent systems wide open to rape myth and gendered notions of normal sexual behaviour.

In a world in which women's greater sexual freedoms are in collision with the mainstreaming of pornography and prostitution, juries, and statutory agents and indeed much of the public, have come to interpret the wearing of certain clothing, drinking, flirting or even just being in a social environment as a reasonable indication that she “wanted it”.

Is that any wonder, when the law currently gives different messages to men and women about consent. To women it says, you need not say no to refuse sex – in the words of section 128A – “a person does not consent to sexual activity just because he or she does not protest or offer physical resistance to the activity”.

But to men it says, if you have a reasonable belief in her consent then you're good to go. That second message matters much more than the first, because what has come to stand for “reasonable belief” in our courtrooms and in the minds of juries, is almost any sexual interest or interchange.

Here's an example: a young woman is at a party, she's been drinking and meets a man with whom she goes to the bedroom, lies down on the bed and engages in kissing and touching with him. When things progress past her comfort zone, she pushes him off, gets off the bed, pulls up her pants and goes to leave the room. He grabs her, throws her on the bed, pulls her pants down and rapes her.

consent existed.

Unusually that case went to trial; most often cases like that don't make it to court, or even to investigation, because the reasonable belief defence influences not only what happens in court, but also what happens at almost every point from the decision to make a police report onwards...., and backwards.

Because consent culture and the commonly understood rules of sexual interchange between men and women rest on the assumption of consent, adding more guidance to the reasonable belief test – perhaps by requiring the jury to consider the steps the accused took to ascertain consent - as suggested in the discussion document, is likely to have little effect on the outcome of most trials. It certainly doesn't reflect the realities of our sexual and social culture.

What we need to do is remove the assumption of consent and make the point of choice to freely engage in sexual activity, conscious and visible.

There really is little point in freedom and choice in the context of a legal system and a society that assumes consent anyway.

In paragraph 90 of the discussion document there's a hint of how we think the law can be reformed to resolve this conundrum.

That is, that the law must require people to take reasonable steps to ascertain that there is clear and uncompromised assent to the sexual activity in question.

In simpler words:

JUST ASK:

And only YES means YES

Not “maybe later”, not “I'm not feeling great”, not “I'm a bit drunk”.

It's really not that hard, and it could change our world. Imagine the increased intimacy that comes from communicating desire and assent in every sexual interchange, and the mutuality that results from the equal exercise of freely given choice.

Surely that's not just the standard we want for ourselves and our loved ones, but one which is demanded by the world in which we now live.

This is an issue that deeply affects us all and you can help make change happen. This public discussion is a specific opportunity for us to come together and demand a world without rape and violence, and a legal system that refuses to allow rape myths to thwart justice for survivors.

So please take up this opportunity to have your voice heard and join with us again in making change happen.

Thank you.

Speech from: Paulette Benton-Greig, Agency Development Manager, Auckland Sexual Abuse HELP

Brainwave Trust Workshop: Shari Barkin

Key Findings in Family Violence Prevention and Strategies for the Workplace - Dr Faye Clark

Early Friday 28th March saw me on a ferry to Auckland from Beachlands for these very well presented sessions and some small group time hosted by Professor of Paediatrics, Shari Barkin, from Monroe Carrel Junior Children's Hospital at Vanderbilt. Professor Barkin was brought to New Zealand by the Brainwave Trust. Clearly an enthusiast for education, practical intervention and planned motivational interviewing, she carried a full room of attendees along for a very intense day of information giving and encouragement.

The first section, dealing with brain development, anatomy and physiology (which might have been sleep inducing), was well pitched to engage interest and provide digestible information that, for me, was a very neat summary of lectures I dimly remembered from medical school. We were reminded that brain development in the foetus begins 25 days post implantation, that the increase in complexity and size in the 3rd trimester is approximately 3 times that of the previous 6 months gestation, and that only 15% of brain development occurs before birth. 85% of development occurs postnatally, predominantly in the first 3 years, to a lesser degree in the 3rd to 5th years followed by much slower growth up to year 25, when myelination is completed.

Different skills are learnt with absorption of stimuli at different times - the human brain appears to have a timetable or peak window of opportunity to acquire various functions i.e. sensory pathways 0-6 months, receptive language 6-12 months and higher cognitive functions peaking at 9 months to 6 years. Of course, these all continue to age 25 years. Those of us a little older than that were reassured that novel learning by association, a "secondary" process, does continue lifelong. However, not everyone gets to abstract thinking levels.

All of us pretty much rely on our midbrain (reactive) - that is about a 3 year old level of functioning - when crises arrive!

The key message was that the foundations built early in life, which depend on both experiences and genetic inheritance, affect the architecture of the developing brain, and the quality of that architecture establishes a sturdy or weak base for all the learning and behaviour of that individual for his/her lifetime. The early months and years MATTER - advanced skills depend on basics being properly acquired. We were reminded that the ability to change behaviour decreases over time... better to get it right first time than to require remediation. None of the

comments above are rocket science, but are very good reminders of the basics we need to keep constantly in mind when dealing with children experiencing or at risk of abuse.

Relationships provide the context for learning. This occurs best when a child is in a nurturing, secure environment with adults who provide loving care and healthy stimulating experiences, which "grow" new neural connections. Shari called relationships "external neurotransmitters".

She commented on early childhood stress influencing developmental outcomes. The stress can be positive if mild/moderate and short-lived, tolerable if significant but manageable with support, or toxic and likely to be damaging if strong and prolonged. An example of toxic stress is physical abuse, which leads to an increased perception of anger, with the child unable to distinguish it from other emotions and unable to stop paying attention to "angry" cues. A child may respond to a smile as if it is an angry grimace, and may constantly be asking, "Are you angry with me?" Neglect produces some similar responses, with decreased ability to perceive emotional states and to discriminate between them. Physical changes have been observed in these situations. She quoted a study published in 2006 that looked at the prolonged release of the stress hormones epinephrine and norepinephrine - both toxic to brains when present over time - in maltreated/neglected children arriving from orphanages overseas. Cortisol was also measured. High levels over time inhibit the ability of dendrites to make connections and once damaged, those dendrites cannot be repaired. She showed an extraordinary slide of CT brain scan slices of two 3-year-old children, one from a "normal" environment and one who had experienced extreme neglect. The smallness and reduced ratio of brain tissue to ventricular space of the neglected child was obvious.

The Adverse Childhood Experiences Study also tied together those with longer/worse experiences and their increased risk for cardiovascular disease in adulthood, so linking environment and stress to poorer physical outcomes.

The second session started with discussion of the Ecological Model of the child encapsulated in the family, the community and the society and then reviewed interventions by health providers, day-care/preschool teachers, parents and policy makers towards preventing youth violence.

She listed as more effective: pregnancy prevention (avoiding rapid repeat pregnancies), home visitation

Continued on page 10

Continued from page 9

(similar to Plunket home visits), parenting programmes, early childhood education, problem-solving skills teaching, marital and family therapy, and supervised after school recreation.

Less useful in general were mentoring (with the qualification that, depending on how they were done, some programmes were good) violence prevention curricula, peer mediation or counselling, drug abuse prevention, vocational training and employment programmes, neighbourhood cleanups and curfews, gun buy-backs and antiviolence campaigns. All had exceptions. She also stressed that marital therapy was contraindicated in situations where violence was involved, as it was likely to increase the homicide risk.

Time was then spent talking about the role of the media, going over the well documented research linking violence on TV with aggressive behaviour, poorer educational outcome increasing with increased time watching TV, and reviewing an RCT (random controlled trial) that revealed a reduction in time spent with TV, video tapes and games use resulted in decreased aggressive behaviour.

It appeared that 75% of American 12 year olds have a TV in their bedroom, and have an average media use of 4-6 hours a day - probably not news to current parents of 12 year olds in NZ.

Discipline was seen as a central element of parenting. She noted that parents regard discipline as punishment as opposed to teaching, and that there is an association with corporal punishment and child aggression and emotional and behavioural problems. Evidence cited included a US National Family Violence Survey, which found that children who were hit were four times as likely to repeatedly assault a sibling, and that parents who recalled being hit as a teen were three times more likely to have hit their spouse.

Firearms access and violence were linked to both unintentional injury and suicide risk.

A study conducted in the United States on 5000 2-11 year olds being seen by paediatricians for well child checks compared the change in media use in those whose parents/caregivers were provided with brief interventions (familiarisation with community agencies, listing of parents areas of concern, patient centred plans for changes, skills training e.g., time out, being given timers to use for cool down periods, dispensing of cable locks to disengage firearms, plus referrals where agreed) and those whose parents/caregivers were advised to read to their children for 15 minutes a day. Media use dropped to less than 2 hours a day in 7.2% of the intervention group and 3.2% in the reading only group. By extrapolation, this would reduce exposure to TV for 1.6 million children in the USA and in

New Zealand the same intervention could affect 36,000 children. Likewise the reduction in exposure to unsafely stored firearms by a gun-locking device being given to parents in the USA would mean that 152,000 people (some of them children) would be safer.

Shari suggested that using motivational interviewing techniques would help identify patient-centred solutions to change and help assess the interest and confidence of parents in changing behaviours. It is also useful to check on media use and firearm risk.

Research on the preschool environment and its impact on high-risk children were reviewed with two studies in particular being remarked upon. The principal positive elements were highly skilled teachers, small classes with high adult to child ratios, age-appropriate curricula, stimulating materials, a safe language rich environment, warm responsive interactions between children and staff, and high and consistent participation levels by children. Again, not rocket science, but it reminds us of the long-term value of good preschool educational environments on later learning and life outcomes.

The sentinel paper, published in 1998, on the randomised controlled trial, "The Promise of Home Visitation" i.e. visits by paediatric community nurses, equivalent to Plunket in New Zealand (that should be compulsory reading for all Ministers of Health - Clark Opinion!) was reviewed. This presented the outcomes 15 years on of low income families who were visited weekly or monthly by professional nurses teaching health-promoting behaviours for the first 2 years of the child's life (intervention group), compared with those receiving visits during pregnancy only, and those just provided with free transport to health checks for the mother and child. The intervention (visited) group showed an 80% reduction in child maltreatment (inversely related to maternal sense of control), 54% fewer arrests and 69% fewer convictions among 15 year olds, a 56% reduction in days consuming alcohol for 15 year olds, 58% fewer sexual partners in this age group, and a 44% reduction in problems related to drug or alcohol use. Hard to argue with those outcomes! This study basically demonstrated that interventions that included home visits by nurses in early childhood were extraordinarily effective.

Another study looking at parenting education for parents in substance abuse programmes appeared very promising also, but longer-term outcome data is awaited.

In summary, sustainable change works best when all levels of a child's environment are addressed – family, community and society.

Session 3 was a great review of how to change behaviour, looking at several theoretical models and then rolling that into motivational interviewing and "Stages of Change"

assessment - what most GPs spend half their waking hours doing! This session covered familiar material but was well crafted and a good reminder of the complex skills required to elicit change and to accurately respond in the most fruitful way to patient issues.

Part 4 looked at the inputs from various levels that go in to preventing violence in our communities and societies. Shari noted the fact that spending on early life has the best outcome for brain development and on adult outcomes for society as well as for individuals, quoting a 16 fold reduction in expenditure on criminal related costs for every \$1 spent in early childhood programmes, a reduction in special education needs and welfare dollars, and an increase in economic outcomes from increased earnings.

Dr Barkin pointed out that one secure adult in the life of a child can increase resiliency and reminded us that children live in an environment of relationships.

“In order to develop normally, a child requires progressively more complex joint activity with one or more adults who have an irrational emotional relationship with the child. Somebody’s got to be crazy about that kid and that’s number one. First, last and always.” - Brofenbrenner

Policy should mirror core developmental concepts, taking into account the nature/nurture context – the feedback loop between environment and genes. Limits and boundaries are important, with children being active participants in development, human relationships being building blocks and emphasis put on the development of the individual, taking account of transitions, sensitive periods and continuities and discontinuities of change in the lifecycle process.

A reminder was given that prevention is better than intervention and looking at the chronological timeline of when things can go wrong allows opportunities for prevention and intervention to be identified and plans made to address them.

Child development is thus seen as the foundation for community development. The promotion of supportive relationships and learning opportunities beyond literacy – that is social learning – are of great importance. This includes things such as co-operative work, conflict resolution, identifying and developing support systems for new parents, for working parents, for parents in poverty and for those with mental health needs.

Attention to healthy pregnancies by stopping smoking, minimising exposure of the foetus to drugs and alcohol, the reduction of environmental exposure of mother to toxins e.g. lead, mercury, was suggested as essential.

The recognition of poverty as a toxin, and non-standard work hours as a family stressor affecting a child’s environment, were both seen as useful elements to address in policy at community and government level.

A plea was made for early identification of maternal depression, for evidence based services, and use of methods to address vulnerable children in a family-centred way. Human development is the connection between social competence, emotional well-being and cognitive function. It was pointed out that IQ tests are a limited and often misused tool for assessment of individual development as they ignore the other important aspects.

A discussion on the need for the careful application of science was entered into, with the warning that interventions must be thoughtfully designed, have clear outcome measures and a means of evaluation because resources are hard to come by and so need to be applied where both best results are likely and the highest risk areas addressed.

Professor Barkin suggested that Haddon’s Matrix approach was a good framework to use for policy considerations. By considering the host (person affected), agent (cause of the problem), environment (physical and social context), and the event phase – pre event (prevention), injury (secondary prevention), and post event (rehabilitation) – potential solutions can be sought to address each part of the problem.

Participants worked in groups to review or develop an issue or policy that was within their area of interest or expertise. I participated in a police group from Hamilton looking at proposing legislation to develop a new criminal charge of attempted strangulation as a separate charge from assault, with particular reference to partner assault in domestic violence and sexual assault, and perhaps to attempted murder.

Policies that were achieved or promoted in New Zealand in 2007 were highlighted – notably the replacement of s59 of the Crimes Act 1961, which protects children from assault in a manner comparable to adults; the CYPF Amendment Bill (6) promoting information sharing between agencies; and the movement towards reframing the perception of custody as a right rather than a duty, and that to have this right actually means that parents must bear responsibility for their children. Rights are given to them in trust to enable responsibilities.

Impression? A very stimulating day!

Resource website: www.developingchild.net

Dr Faye Clark
DSAC Domestic Violence Intervention Trainer
Auckland



DSAC Diary of Events 2009

DSAC is a RNZCGP CME Registered Special Interest Group

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DSAC INITIAL PAEDIATRIC TRAINING COURSE in the *MEDICAL ASSESSMENT OF SEXUALLY ABUSED CHILDREN AND ADOLESCENTS*

Dates: 28 April - 1 May 2009

Venue: Marion Davis Library
Auckland



MEDICAL/FORENSIC MANAGEMENT OF ADULT SEXUAL ASSAULT TRAINING WEEKEND

Dates: 3 - 5 April 2009

Venue: Marion Davis Library
Auckland



The DSAC Office will be
closed for the holidays from
19th December 2008 - 12th January 2009

Season's Greetings
to you all



OVERSEAS SPEAKER

Dr Ellert Nijenhuis

*"Dissociation of the Personality
and Childhood Traumatization:
Theory, Research and Treatment"*

Auckland

West Lounge, Eden Park
Friday 13th & Saturday 14th February 2009

Wellington

Intercontinental Hotel
Wednesday 18th & Thursday 19th February 2009

Christchurch

Holiday Inn City Centre
Monday 23rd & Tuesday 24th February 2009

Dr Nijenhuis is known by other experts working in this field for grappling with some of the most complex and perplexing phenomena that therapists are likely to encounter. His work provides a unifying theory that identifies a disturbance of the self as the core problem for the whole spectrum of trauma related disorders. This theory is then closely linked to a highly sophisticated understanding of assessment and treatment.



LETTERS TO THE EDITORS

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