



DOCTORS FOR SEXUAL ABUSE CARE

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NATIONAL NEWSLETTER

EDITORS: SANDRA RHIND & CAROLINE CORKILL ISSUE No. 79 NOVEMBER 2009

Manager's Report - Hayley Samuel

The last few months have been as busy as ever for DSAC. Both the Accreditation Sub-Committee and the Family Violence Intervention Sub-Committee have held productive face-to-face meetings in this time. DSAC largely functions by way of teleconferences and emails, so it is always such a pleasure to meet up with the sub-committee members and collectively tackle the ambitious meeting agendas that have been set. I am always astounded at how much we are able to achieve in an 8-hour meeting and yet still be able to leave at the end of the day feeling inspired and energised by the shared commitment and energy of all involved.

The Accreditation Sub-Committee has been busy designing mock cases for re-accreditation applicants who may not have enough cases for purposes of completing the re-accreditation process. The accreditation application forms have also been reviewed and will be reformatted in time for the next Medical/Forensic Management of Adult Sexual Assault Course. The accreditation requirements remain the same but we hope that the forms may be more user-friendly.

The Family Violence Intervention Sub-Committee have already met the output requirements for the current contract with the Ministry of Health (MoH). The trainers have delivered 34 sessions to over 600 people in the last year. This is a significant achievement given the fact that the vast majority of attendees are not mandated to attend this training and are required to do so in their unpaid time. The MoH are now supporting DSAC to develop a more formalised partnership role with GPs developing systems approaches for identification,

assessment and referral that will align with and support the Violence Intervention Programmes in District Health Boards.

At the August face-to-face meeting held in August, the Family Violence Intervention Sub-Committee acknowledged the extraordinary commitment and achievements made by Dr Faye Clark. Faye has really been a pioneer in promoting the role of the health professional in identifying and responding to family violence in New Zealand. I suspect that Faye has lost count as to how many years she has been training health professionals on how to Recognise and Respond to Family Violence. However we at DSAC do know that for the last seven years Faye has delivered over 80 sessions to over 1600 people within the context of the DSAC/MoH Contract. Attendees at Faye's sessions have said:

- "Thanks for giving me the confidence that I can possibly make a difference."
- "Faye is amazing! Wonderful energy, thank you."
- "Absolutely wonderful – keep up the great work – we need lots more people like you!"
- "Faye, you are an excellent presenter. This is probably the best course I have been to for ages."
- "The best presentation at a cell group we have had at any meeting."
- "Thank you Faye; you're an amazing example and ambassador."

Faye officially retired as a DSAC trainer, in addition to her many other roles, in October 2009. It is difficult to imagine the DSAC Family Violence Training without Faye however fortunately she has agreed to be our on-call advisor. That is, if she is actually available, as Faye is now being sought after by the United Nations to deliver training in the Pacific which may become part of her retirement plan!

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Dr Kalash Deva, DSAC National Manager Hayley Samuel, Dr Faye Clark, Dr Clare MacGougan, Dr Clare Healy, Dr Rita Middleton

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On behalf of the DSAC Family Violence Intervention Sub-Committee and the DSAC Executive, I extend our enormous gratitude to Faye for her enduring commitment to this work. We wish her well in her retirement and much joy in the time that she will now have available to relish playing Grandmother.

The series of three 1-day John Briere seminars in Wellington, Christchurch and Auckland were a great success. The feedback was overwhelmingly positive for each of the centres with an overall average rating of 4.1 out of 5. Attendees always appreciate John's presentation style which weaves good humour throughout the delivery of the informative material. DSAC are grateful to the New Zealand Psychological Society for providing the opportunity for us to jointly host John at each of our respective seminars.

Dr Min Lo, editor of the DSAC Manual, has been immersed in the process of reviewing and updating a number of key sections of the manual. The manual requires constant review in order to keep up-to-date with current thinking and international literature in this field. It is certainly in very capable hands with Min driving this project. Thank you Min for your time and attention to this.

Lastly, many of you will be aware of the Accident Compensation Corporation's (ACC) intention to significantly alter the management of Sensitive Claims by way of the proposed new Clinical Pathway. The Pathway was implemented on the 28th October and Providers were sent a "Provider Information Pack" outlining the "Change to new Clinical Pathway for sensitive claims clients – alternative clinical diagnostic tools now considered with appropriate supporting information". This pack includes a brief description of the two minor changes that had been made to the Pathway.

1. The word 'reasonable' has been inserted into the disclosure of information description. How "reasonable" will be defined and applied in practice has not yet been released.

2. ACC have also agreed that "mental injury" does not have to be restricted to DSM IV diagnosis. "ACC will consider diagnoses using

other relevant clinical tools where that is appropriate to the clients needs. For ACC to consider a diagnosis of mental injury using an alternative clinical tool, information on why it is reasonable to use that tool should be supplied." Details about what tools will be acceptable, are not yet available.

DSAC and the other professional bodies on Te Ohaakii a Hine - National Network for Ending Sexual Violence Together (TOAH-NNEST) and the Sensitive Claims Advisory Group (SCAG) were not consulted in the development of the initial Clinical Pathway.

DSAC sent letters of concern to ACC on 30 September and 9 October. Copies of these letters and Dr Peter Jansen's replies are included in the Newsletter for your information. DSAC also released a media statement regarding the Pathway which follows this report.

DSAC, TOAH-NNEST and SCAG requested an opportunity to have a workshop with ACC to critique the proposed Clinical Pathway from clinical and cultural perspectives prior to the release of the revised pathway. This request was declined but ACC have indicated that they would like to "meet twice in workshops before Christmas with professional bodies and TOAH-NNEST" and that they "will separately set up hui to talk about improving services for Maori" i.e. once the Pathway had been implemented.

We are therefore entering a time of uncertainty about what this means for doctors caring for people who have been sexually assaulted. Please let me know your questions, as we hope to be invited to discuss these with ACC at some future date. I will provide an update on this matter in a future newsletter issue once further information is made available.

I wish you all a safe and joyous festive season.

Hayley Samuel
DSAC National Manager



DSAC Media Release dated 19th November 2009

Media Release

Thursday 19 November 2009

For immediate release

Attention: Health and Social Issues Reporters

Doctors for Sexual Abuse Care (DSAC) supports ACC's overall intention to improve the quality of its funded services for individuals who have a mental injury arising from sexual assault/abuse. However, DSAC does not support the implementation of ACC's new Clinical Pathway for Sensitive Claims as it currently stands.

This Pathway is a selective implementation of some parts of the Massey Guidelines. It was designed by ACC and introduced abruptly (design completed 19 October, effective from 28 October 2009) and without effective consultation and input from expert clinicians working in the area or with patient advocacy groups. It thus has some predictable flaws.

DSAC's main concern is that the new Pathway has removed the ability of many individuals to access, in a timely manner, psychological support as a consequence of the crime committed against them/sexual assault.

DSAC does not support the new narrow definition of a DSM-IV diagnosed psychiatric illness as a requirement for cover. ACC has chosen this as its "preferred diagnostic tool." Thus individuals have to see a New Zealand Registered Clinical Psychologist or Psychiatrist for a DSM-IV assessment prior to commencing counselling. ACC have indicated that "other registered health professionals" with "specific training and experience in mental health diagnostics" may be acceptable to ACC to provide a DSM-IV diagnosis. ACC also state that "competency in this and other domains of practice is a matter for registration authorities." This leaves the professional bodies to solve a problem that ACC could have averted had they invested in a collaborative approach in the design of the Pathway.

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Section 27 of the IPRC Act does not limit mental injury to a DSM-IV diagnosis. Instead it defines “mental injury” as “a clinically significant behavioural, cognitive or psychological dysfunction.” ACC have therefore recently indicated that they are open to using “alternative diagnostic tools.” Which alternative tools will be acceptable to ACC have not yet been defined. This means many mentally injured distressed patients who cannot access a DSM-IV diagnosis, or do not fit these limited criteria, are unable to receive ACC-funded psychological support in a timely manner.

As yet there are no guidelines in place indicating how children and adolescents who have been sexually abused, and who require intervention, will access psychological support. The DSM-IV classification system has severe limitations for children and adolescents.

DSAC also has significant concerns about the informed consent and the new procedures ACC is using to request

disclosure of additional information by doctors immediately after a claim is lodged.

These concerns have been communicated to ACC on several occasions.

Meanwhile DSAC is fielding enquiries from doctors seeking advice on what to advise patients alleging sexual assault as to how they are supposed to safely navigate the complex bureaucracy which is the “new pathway” in order to access psychological support. This advice is particularly needed for those doctors working in rural areas and small towns where local support agencies may not have the necessary “qualifications” which ACC require in order to make a DSM- IV diagnosis.

Statement Ends

Letter to Dr Peter Jansen, Senior Medical Advisor, ACC dated 30th September 2009

Dear Dr Jansen,

RE: Proposed changes to ACC Sexual Abuse Counselling entitlements – Request for clarification of proposals

DSAC represents the doctors who provide acute and other medical services for people who have been sexually abused.

These doctors who work on Sexual Abuse Assessment and Treatment Teams want the best outcome for the patients they see, and can be expected to have informed opinions on the topic of access to treatment services for these patients. It has come to our attention that ACC may be proposing some significant changes to funding for counselling for people who have been sexually abused. We would appreciate receiving written clarification of what is proposed.

DSAC have received the following:

1. An email copy of the “ACC4451 Sexual abuse and mental injury practice guidelines for Aotearoa NZ” (March 2008)
2. An electronic version of “ACC5226 Clinical framework for the ACC Sensitive Claims Unit” (June 2009), including an invitation to workshops about the counselling guidelines.
3. An email from Emma Zorn dated 4 September 2009, which included an updated outline of the proposed clinical pathway.

There was nothing in the first or second document to alert us to impending major changes, but there were some indications of possible significance in Ms Zorn’s email and attachment.

No DSAC representatives were able to attend the workshops, but we understand that no further documents were distributed at these meetings.

The documents mentioned outline the proposed changes to the process for accepting claims and monitoring treatment. Some of these changes may adversely affect our patients and impact on the work of SAATS Teams. This raises concern for us. However none of the documents include specifics, such as limiting treatment to 16 sessions, as has been mentioned in the public media (e.g. National Radio, NZ Herald). If the specifics are contained in one of these documents, then please direct us to the relevant pages. On the other hand it is possible we have not received the communication that contains these details. We therefore need to see any material, additional to that referred to above, containing them. This will enable us to provide you with feedback.

DSAC is a member organisation of the ACC Sexual Abuse Advisory Group. This group is due to meet for the first time in six months on Friday this week, and we would like to view the relevant information prior to this meeting.

Yours sincerely,

Dr Min Lo
Executive Chairperson
Doctors for Sexual Abuse Care

Cc Kendra Sanders, Programme Manager, Early Interventions, Rehabilitation Service Development, ACC

Letter to Dr Peter Jansen, Senior Medical Advisor, ACC dated 9th October 2009

Dear Peter,

RE: PRIVACY CONCERNS ABOUT PROPOSED CLINICAL PATHWAY AND CHANGES TO MANAGEMENT OF ACC SENSITIVE CLAIMS

DSAC would still appreciate a response to our letter dated 30 September 2009. Meanwhile, here is an outline of some issues that we request urgent attention to.

At the SCAG meeting on Friday 2 October DSAC verbally expressed concern about the proposed new pathway. This letter expands on some of our concerns and responds in part to your letter of 6 October 2009.

Our members are aware of the benefits for many patients of timely counselling interventions that have assisted patients to recover from the effects of rape and sexual abuse. We are also aware of negative consequences when the quality or timing of the counselling has been counterproductive for some patients. We therefore share ACC's concern that access to appropriate counselling is efficient, and that the counselling itself is as effective as possible for the patients we refer.

Our comments on the proposed New Clinical Pathway – as per the 4 September 2009 email from Emma Zorn – follow:

1. Will this pathway or any provisions of this pathway (e.g. the privacy waiver) apply to acceptance of a claim for medical therapeutic management after sexual assault, or only to a subsequent claim for treatment for mental injury with a separate M45?

2. Re: Step 2 - Clinical Triage: The consent form for collection of additional information – ACC 167

DSAC does not support the use of **this** form for this purpose. The invasion of privacy that it could allow is quite contrary to the principles in the Massey Guidelines. People who have been sexually abused or assaulted have significant concerns about informed consent, and these concerns extend to informed consent regarding information about them.

DSAC understands how and why ACC may want to gather further information in relation to some claims; however this is a potentially damaging way to go about this at this stage. These are not Lump Sum compensation claims; they are claims to allow access to recovery services.

The latest version of the Clinical Pathway – 4 September 2009 – does not state which consent form will be used, but the previous versions of the Clinical Pathway proposed using ACC167. In the absence of a copy of any new proposed form we can only comment on the ACC167.

The most serious problems with ACC167 are:

2.1. The client is asked to sign that “I understand that.... this consent applies to all aspects of my claim and includes external agencies and service providers such as general practitioners, specialists, employers, etc from whom ACC asks for information”

People who have been sexually abused have genuine and often soundly based fears about their story being shared with people who will not understand, and who may increase their mental suffering. This is one reason that sexual abuse claims are called “Sensitive Claims.”

These patients may choose to go to a doctor other than their GP, and specifically do NOT want their GP to know about the abuse at that time for valid reasons. (They may be comfortable about telling their GP after treatment, but not before.) Anxieties about employers finding out are often even more of an issue, and the word “etc” at the end of the list leaves the people ACC might contact unlimited. ACC could contact family members, friends, acquaintances, or even the alleged abuser, and all without prior discussion with or preparation of the client.

2.2 The timing of presentation of the form to the patient is not suitable for people who are making a claim for recovery services for mental injury following sexual assault.

The proposed Clinical Pathway states this form will be posted to the client after the claim is lodged with ACC. The client will have seen a counsellor for 2 sessions for assessment, diagnosis, and formation of a treatment plan, but will be without any counselling support while ACC determines if the claim will be accepted. The proposed Clinical Pathway, 4 September 2009, does not indicate how long this will be.

This could be a very vulnerable time for some clients, and a time when they will not have ready access to an independent person to explain the implications of the form to them.

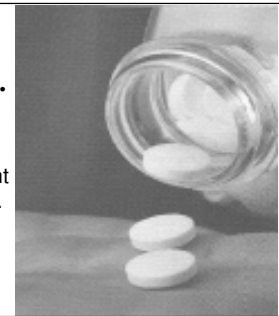
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Azithromycin may now be obtained via MPSO therefore DSAC is discontinuing provision of this drug.

DSAC still has a small supply remaining so this is the last opportunity to order from the DSAC Office.

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 has fully subsidised this drug through DSAC. To order from DSAC's remaining supplies, email: dsac@ihug.co.nz, or fax: 09 376 0790



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We would like ACC to redesign this process and this form and consult with us and other members of SCAG, and TOAH-NNEST about how and when to obtain informed consent from these clients in order to obtain specific information from specific people in relation to the claim.

3. We share the concerns of other groups on SCAG and TOAH-NNEST regarding the narrowing of acceptable mental injuries to DSM –IV TR diagnoses.

4. “Longer term management” is not defined in the proposed Clinical Pathway of 4 September 2009. This definition would be of interest to our members.

5. The new processes for Treatment Completion Review and Recommendations (Step 5); Decisions on Treatment Completion (Step 6); and the Multidisciplinary Assessment Panel (Step 7) - are each problematic because of the ever increasing number of people the client may have to interact with, or disclose details to about their sexual abuse. This could be perceived by the client as another invasion of personal privacy, and loss of control of sensitive information, and this may set back their recovery.

Details about the pre-requisites for appointees to these various roles are not included in the document, or on ACC’s website.

This may be of interest to our patients, and we look forward to this information being available prior to introduction of the new Clinical Pathway.

These are not the only concerns that DSAC has about the proposed changes, however some of the features that might be of interest to us on behalf of our patients, are only loosely described in the ACC documents and at this time we do not wish to try to address all the issues in detail because the potential problems with the privacy waiver are especially urgent.

Please let us know if we can help ACC address this privacy issue, which is completely unacceptable for people who have been sexually abused or sexually assaulted.

Yours sincerely,

Dr Min Lo
Executive Chairperson
Doctors for Sexual Abuse Care

Cc Kendra Sanders, Programme Manager, Early Interventions,
Rehabilitation Service Development, ACC
SCAG Members
TOAH-NNEST Secretariat

Letter to Dr Min Lo from Anne Aitchison, WorkStream Leader, ACC dated 19th October 2009

Dear Dr Min Lo

Re: The Proposed changes to ACC Sexual Abuse Counselling Entitlements

Thank you for your letter of 30th September asking for clarification of proposals.

The documents you reference in your letter have been the documents we have released so far. A final Pathway document is being released today 19th October 2009.

There is no intention to cap or limit treatment to any specific number of sessions for a client. We will be planning treatment based on the individual needs of the client. There has been a lot of attention to this in the media but ACC’s final position has not been released until now.

It may be simpler for you to read the information we send today and then respond to Peter Jansen with any outstanding queries

Kind regards

Anne Aitchison
WorkStream Leader

Letter to Dr Min Lo from Dr Peter Jansen, Senior Medical Advisor, ACC dated 19th October 2009

Dear Dr Min Lo

Thank you for your letter of 9th October 2009. It raises a number of issues about which we share concerns.

In relations to the particular issues you raise I can respond.

1. The Pathway relates to a claim for treatment for mental injury.

The consent form ACC uses is the ACC167. The consent form ACC167 is used in addition to the consent given on the ACC45. ACC may need to collect additional information for the purposes

of reaching a diagnosis and continuing entitlements and this is critical to our managing processes appropriately for clients.

Any contact with employers is negotiated with the client as part of determining any work related package or weekly compensation claims. Our Case Managers all recognise the sensitivity of this process. This process is explained in the existing SCU form IS01 **“How we can help after sexual assault or abuse”**.

We expect that those therapists who assist a client to lodge a claim will understand the process and the need for ACC to receive information. An informed therapist can explain this to the client and can also identify for ACC any privacy issues.

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I agree that the clients will feel vulnerable at the time that a claim is lodged. However, I do not expect that clients will not be without support while ACC receives information and considers the claim. The therapist who has assisted in lodging the claim will no doubt have explained the process, the range of support available and the costs, if any, for counselling and other support.

2. ACC has determined to use DSM IV diagnosis for all mental injury. The decision has been supported by the courts. Importantly it is not appropriate for ACC to fund treatment without a diagnosis and a treatment plan appropriate to that diagnosis. As we require a diagnosis we need to use a recognised system or tool – the DSM IV.

3. Longer term management refers to those clients for whom it is obvious at the outset that they will require long term intervention or for whom such a situation becomes evident during the initial treatment period. This group will be managed with a Case Manager, with different reporting requirements and regular input from a multi-disciplinary panel within ACC. Using information received by ACC

the multi-disciplinary panel will advise the case manager on appropriate support or treatment for the individual client.

4. One aim of the Pathway is to reduce the number of assessments. Wherever possible the person completing the Treatment Completion Review (TCRR) will be the same person undertaking the initial assessment. For most clients this should mean contact with only 1 assessor. The multi-disciplinary panel has contact with the Provider(s) and not the client.

The assessors are those currently holding DATA contracts.

The issue of informed consent is currently under review within ACC. I would be happy to discuss with you further.

Kind regards

Dr Peter Jansen
Senior Medical Advisor

Monash Learning - Dr Clare Healy

Thoughts from a brain, slightly strung out after catching up on missed assignments...

Here I am, coming to the end of a five year project culminating [I hope!] in obtaining a Masters of Forensic Medicine from Monash University, Melbourne. The first three years were spent studying topics such as Medical evidence, Medicine, science and the law, Injury interpretation, Adult sexual assault, Custodial medicine and the Elements of forensic science. This resulted in a Diploma of Forensic Medicine but I was persuaded into continuing my studies in order to complete a Masters. One further paper through Monash [Paediatric Forensic Medicine] and two others taken through Auckland University [Clinical Epidemiology and Evidence based Healthcare, Child & Adolescent Psychopathology] brought me in view of the finishing line. A small “project” was required so, in my project, I have described the content and process of development of a web-based tool to assist general practitioners manage patients who present with sexual or physical assault, including family violence. Sometimes I am worried in case any information falls out when I shake my head too vigorously....

Overall, I have really enjoyed the chance to take part in post-graduate education. I have developed computer skills [some, less well recognised such as third digit typing] and involved the family [i.e. used my children to teach me how to write satisfactory essays]. Friendships have formed and proved very useful when trying to sort out complex problems or get second

opinions on an idea. I have loved going to Melbourne for the “residential” parts of the Monash papers- a chance to explore the city and catch up on family there. The forensic papers, in particular, have sharpened my thoughts and expanded my knowledge in the field of forensic medicine. At times the assignments have proved challenging in terms of time management but their content has always interested me.

This year’s subject of Child and Adolescent Psychopathology, a distance learning course offered by Auckland University, has always attracted me. Working in general practice as well as seeing adolescents and children referred for evaluation after alleged sexual assault provides a wealth of psychopathology. Taking this paper has enabled me to put a framework around relevant observations and provided a semblance of coherence to referral letters, when seeking further help for these patients. It is possible to take “weeks off” during the academic term but it does put pressure on, upon return!

Thus I can thoroughly recommend post-graduate study, particularly in an area which interests and enthralls you. I would be happy to talk to anyone who is considering doing one of the excellent Victorian Institute of Forensic Medicine [Monash] papers or those papers I have taken through Auckland University.

Dr Clare Healy
Christchurch



Accreditation Sub-Committee Activity

The annual face-to-face meeting was held in Christchurch in August. This meeting enabled us to:

1) Streamline aspects of the accreditation process and costs. The application packs have been given a more professional touch and bound into a booklet. The previous supervisor report forms have also been reduced to two, in line with the minimum requirement.

2) Consider templates for use in our dealings with the courts. The templates included:

- A brief of evidence template – primarily developed by Min Lo this has been substantially reviewed and added to the DSAC manual. It provides an example of a Formal Written Statement and has already been extremely helpful in giving structure to the presentation of evidence in a logical manner.

- A court feedback form – this can be used for getting some sort of evaluation of the strengths and weaknesses of aspects of your evidence delivery on the day. The form can be taken by the doctor to the hearing and given to someone possibly

a police officer in attendance to fill out as you give evidence. ESR have used a form to gather feedback for their expert witnesses for some time with the aim of improving their service to the court. ESR have allowed DSAC to adjust this form for use by sexual assault clinicians. This version will be given a trial and made available from the DSAC office.

- A defence opinion template – this is also being developed.

3) Review mock cases for adult and adolescent age groups to the point of readiness for a trial use by the committee in particular circumstances for re-accreditation purposes.

More recently a decision was reached on a new alert system for accreditation expiry. This will mean a letter will notify doctors of their impending accreditation expiry at 6 months and 1 month pre-expiry and then finally 3 months post expiry. Hopefully this third letter will not be necessary!

Dr Jane Batchelor

Chairperson

DSAC Accreditation Sub-Committee



Expert Witness Programme

Australian College of Legal Medicine - Expert Witness Intensive for Doctors, Dentists & Other Health Professionals. 5th September 2009, Wellington.

I attended this programme on the recommendation of several colleagues who had attended past similar seminars.

It was run by Dr Roy Beran, President of the Australian College of Legal Medicine and involved a full day comprising several presentations from lawyers and judges in the morning and a moot court in the afternoon. Also – de-identified briefs of evidence had to be submitted before the seminar and these were “marked” by Dr Beran and returned to us during the moot court session.

I found the day busy but very helpful – not least the networking at morning tea and lunchtime. It is not often you get a chance to ask a high court judge a lot of questions!

The morning focussed on what the expectations are of expert witnesses – from solicitors, barristers and high court judges.

Justice Williams’ comment that courts are interested in facts not opinions, unless you are an expert witness and therefore can be of substantial help is a good starting point for what is expected. This substantial help rule is under the judge’s discretion. To be an expert witness you must have knowledge and skill based on training, study or experience. You must also be aware of the code of conduct of expert witnesses and more importantly have read it and agree to abide by it (it is available here <http://www.nzma.org.nz/journal/117-1190/807/>)

Expert witnesses have a duty to provide reports (in clear, accurate properly spelled language!) and also to present to the court. They

can be challenged on their expertise, impartiality, accuracy or inadequacy of foundation for opinion.

Justice Fisher said in the 1990s that “experts do not enter the witness box in order to present a case – that is the lawyer’s job.”

Several themes running through the presentations were that medical language needs to be explained well in reports and jargon should be avoided especially in court. Meeting with the Crown or Defence (depending on who you are giving evidence for) before going to court is important – I usually find out from the police who the Crown Prosecutor is and then phone them to ask when/where can we meet – it is preferable to do this before the day as it then gives you more time and is less stressful than trying to have a quick meeting minutes before you go to into court.

Appearance is important – look professional – it means you are more believable (Justice Williams’ comment was that you need to look and act in a way that we would believe you and trust you). Talk slowly (difficult if you are a motor mouth like me)! Use pictures/diagrams – it makes things easier to explain. Address the Judge and/or Jury – it is them you are there for.

The moot court was somewhat intimidating but educational and even a little fun – thanks to being able to practise what you would not normally get a chance to do in a real court. For the record, only use humour if you are very experienced!

I ended the day feeling I had gained some insight into the legal vs. the medical process and also had reinforced what my job as an expert witness is (and is not). Very worthwhile.

Dr Marie Burke

Christchurch



John Briere Ph.D.

Working with Complex Childhood Maltreatment Effects in Adults: Treatment advances, new techniques and mindfulness issues in integrated trauma therapy

Auckland, 4th September 2009

John Briere, Ph.D. is Associate Professor in Psychiatry and Psychology at the Keck School of Medicine, University of Southern California. He is also the Director of the Psychological Trauma Program at LAC-USC Medical Centre, and Co-Director of the MCAVIC-USC Child and Adolescent Trauma Program. He is a past president of the International Society for Traumatic Stress Studies (ISTSS). Dr. Briere is also the author of over 70 articles, 20 chapters, 10 books, and 8 psychological tests in the area of child abuse, trauma and interpersonal violence. His most recent book (co-authored with colleague Catherine Scott, MD) *Principles of Trauma Therapy- A Guide to Symptoms, Evaluation and Treatment* (Sage Publications 2006) has been described as the “definitive resource on the treatment of all types of trauma” and “an essential reference for all clinicians”.

This daylong seminar continues Dr. Briere’s ongoing commitment to training New Zealand clinicians and professionals in the provision of well-integrated, evidence-based, trauma therapy.

THE WORKSHOP- an overview

John Briere is a raconteur. He tells stories about himself, his trainees and his clients, notwithstanding his successes and failures - stories we can all relate to. At one moment the trickster, jostling and joking with his audience; the next, a wise sage, appreciating deeply the human struggle to understand the harm we, as a species, inflict upon others. He honours the toil involved in both healing our own interpersonal injuries and trauma and helping others to survive and heal theirs. He playfully chided the images we as therapists might wish to hold of ourselves as “the happy healthy people who have no issues and are doing just fine”, encouraging us instead to view ourselves more “like our clients than different from them...as bozos on the same bus...simply trying to get by”. In another way, without hiding his debt to his ever-deepening immersion in Buddhist philosophy and mindfulness practice, “we too are them”, suggesting that therapists as a profession are increasingly “closet meditators”. He prompted us to hold with gratitude the privilege it is to work with those at their most vulnerable and encouraged us to be patient and to persevere with helping the injured particularly in the face of the current climate, funding cutbacks, and the wider political context. Burnout, he suggested to a roomful of nodding heads, comes not from “doing trauma work with clients, but from doing this work in the agencies and organisations we work within”.

Complex Post-traumatic outcomes

Dr Briere began his workshop material from an evolutionary biological perspective of human beings as highly socially organised primates with a requirement for love, care and attention, trained by our parents to survive through the provision of a protective environment. Our bodies, he says, reinforce togetherness yet punish us for separateness. Being at the mercy of adults and parents, what happens when they are the very ones who abuse, neglect and maltreat us? The drive to connect, to love and be loved, to need people is, we know, distorted by traumatic experience and as John teaches us, it becomes absolutely central to its recovery.

Dr Briere drew attention initially to the characteristic set of complex presenting issues for those who have been traumatised early in life (either by ‘acts of commission’ or by ‘acts of omission’). Essentially these issues occur as:

- self-capacity disturbances and impairment involving identity, affect regulation and relatedness
- the imbalance between the level of potentially activate-able distress and our capacity to tolerate or regulate it
- avoidance and chronicity involving cognitive avoidance, dissociation, substance abuse and tension reduction behaviours (TRBs).

The first involves the inability to access an internal sense of self. Instead, trauma and maltreatment create a sense of “other-directedness”. Here young people learn that it “doesn’t matter what you think because reality for you is defined by others”. People presenting with these issues will have an over-emphasis on meeting your needs rather than having a sense of their own. They have learnt to protect themselves and survive getting hurt by meeting other’s needs. This leads children toward externality, or hyper vigilance, and an empirally validated, increased susceptibility to be harmed further. When they “go inside” they feel pain. These young multiply-traumatised clients we see may present with a sense of “no one home” and Briere notes three reasons for young people not being able to identify what they think or feel; dissociation, post-traumatic numbing, and simply never getting a chance to develop a self. As a victim of boundary violations and boundary blurring these may be recreated and, in many cases, passed on.

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Recovery from Complex Trauma

John Briere's general philosophy of intervention is about not pathologising trauma or its complex symptomology but rather viewing survival and recovery as a growth enhancing human experience.

No two trauma survivors are the same. In trauma recovery the factor most clinically indicated to (should this be "indicative of") outcome is simply what one "brings to the trauma"- one's "relative ability to regulate internal emotional states: the ability to calm oneself down". When we experience a trauma and go into hyper aroused states (fight/flight/freeze) our neurobiological compensatory systems act to calm us down. For those who have been traumatised in childhood the ability to develop adequate regulation mechanisms has been seriously hampered. Instead of learning then how to calm our aroused states we learn to avoid those states and places that trigger us. Affect regulation can be defined as the ability to bring down your aroused internal states without using an avoidance strategy or behaviour. Thus chronic posttraumatic outcomes occur from the imbalance between the level of "activate-able distress" and our affect regulation capacity. Briere's Self- Trauma model speaks to our capacity to bear pain being overwhelmed by the level of the pain. When the pain exceeds our capacity to cope with it we find ways to decrease our awareness of the pain and thus bring our pain down. If the pain is huge and our ability to tolerate it is very low we can do "anything" to reduce it – denial and dissociation, drinking and drugging, chronic masturbation or sexual impulsivity, bingeing/purging, cutting etc. This is where the essential dialectic of trauma treatment comes in. Awareness increases pain but the only way to get over the terrible things that happened to you is to re-experience them over and over WITH awareness. Sacrificing awareness for pain relief ensures we never get free of the trauma and suffering becomes chronic because it never gets processed.

Trauma focussed Therapy

What is it then that psychotherapy can do to assist in chronic trauma? John Briere nailed home that "it is relationship that hurts us and relationship that heals us". While considerable clinical training, techniques, and skill is important in treating



*DSAC National Manager Hayley Samuel with
Dr. John Briere at the Auckland Seminar*

complex trauma ("...and the more training the better") the "necessary precondition" is the relational nature of the professional relationship - a caring, safe, and supportive therapeutic relationship that activates attachment dynamics in which the past can be explored and processed interpersonally. Therapists, Dr. Briere reminds us, are simply "people who have the ability to be present with other people without their own stuff altering how they relate to other people so that they don't hurt them or exploit them".

Buddhist philosophy and mindfulness practice is not just for clients and trauma survivors, but is intrinsically linked to the therapeutic use of self. When we change our own relationship to pain and suffering as a therapist and stop being acutely sensitised to other's pain, stop wanting to try and change it, we are more able to be with another, "to sit with you and view your pain not as something bad but as you being on the road to recovery because you are allowing yourself to feel bad in the presence of safety".

The qualities present in an effective therapeutic relationship include: safety, acceptance and support for introspection. These are easily said, reminds Dr. Briere, but much harder to practise - both for helper and help seeker. Presence and attention are essential to creating safety and unconditional positive regard. Again these are supported by the clinician's own mindfulness practice. Introspection is aided by being able to speak about oneself in a context with someone who is not judging you or likely to harm you, which then allows for a wider perspective on one's self view and experience ('cognitive reconsideration').

No longer is treatment a question of psychology vs. psychotherapy or CBT vs. psychodynamics. No longer an "either or" dialectic but "both and". The goal of psychotherapy with complex trauma John says is "that one has to feel painful, unhappy feelings in the presence of safety... and not only in safety but in a loving environment". In therapy we are "asked to remember" for it is not the actual memory that hurts but the associated emotional states triggered by the memories. When the memory is talked about in therapy it triggers the feelings and thoughts that occurred at the time of the original trauma which rush back in the present as if we are in the past (called reliving 'experiences'). However this is now being done in an environment of relatedness and safety providing exposure to the memories but not reinforcing the emotional experience that goes with the memories. This is called 'counter-conditioning.' Over time the lack of reinforcement then extinguishes these negative states.

The three empirically verified pathways to healing trauma involve:

1. Therapeutic exposure – reducing the painful emotional associations to memory
2. Affect regulation training- increasing one's capacity to tolerate the painful associations connected to memory
3. Mindfulness- changing one's relationship to the experience of the memory and its cognitive-emotional associations

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In other words, we change the amount of the pain, change the ability to tolerate the pain and change the relationship one has with the pain. For Dr. Briere, the first two ways are based on the premise that pain or suffering is a bad thing and that that in itself may be flawed. "What if", he prompts, "we could change our experience of the pain so that it didn't hurt so much...? What if we could embrace our pain, without rejecting it, without judging it, basically accepting the pain as part of our experience; how bad would it hurt then?"

An important point Dr Briere makes relates to memory-recruitment and complex trauma. "If you've been raped on 17 occasions, sexually abused 53 times, neglected and abused as a child" there is no chance that you can isolate memory to a specific situation. "There is no such thing as a discreet trauma memory." This points to the possibility that treatment funders such as ACC allowing only treatment of the specific remembered rape, for example, is out of step with the science of memory. This is quite apart from what is clearly regarded as best practice involving the necessity of the relational professional relationship to activate the attachment systems in clients. Dr Briere did not hide his criticism of the long term effectiveness of "16 session CBT" therapy stating that he could train us in 3months to provide effective CBT interventions for trauma but that a more full training in psychodynamics and the use of the therapeutic relationship still takes years of training and years of experience. He condemned what he called the purely "Western notion that we can fix complex things in simple ways".

Buddhism and Mindfulness practice

Briere talks about the spread of Western Buddhism. Buddhist philosophy and the practice of meditation teach people how to get through adverse experiences, what causes suffering and how to get through it. This has led to large numbers of survivors finding peace in meditation where they may not be able to change the experiences of their life but can "change their experience of their experience". In other words meditative practice enables us to sit with our experience and develop greater affect regulation skills including the ability to learn breathing techniques to calm oneself down.

Dr Briere defines mindfulness as "the capacity to enter a state wherein one is aware of current experience on a moment to moment basis without any judgement and with acceptance". He suggests that life is "constantly triggering us" and proposes, "enlightenment is the cessation of triggering". When we are triggered it is very difficult for us to let go of the trigger activation - the "monkey-mind". Things in the present are triggering past associations, despite the fact that we are unable to figure out what the trigger is. Mindfulness is a cultivated practice, a skill any of us can learn. This is, he says, an excellent affect regulation skill because we learn to watch our arising thoughts, emotions and sensations as simply phenomena with less attribution of meaning to our experience and in this way it becomes less

catastrophic and less powerful over us. Dr. Briere's programme uses mindfulness training assist people to experience the feeling, note it, and let go of it without it hurting further, and to experience the cognitions, note them and let go of them without them becoming accepted as truth.

John Briere is in the process of writing a new book on the philosophy and practice of mindfulness in trauma treatment. Around the world there are more and more empirical studies and research being done in this area. He even suggested that the next time he comes to NZ he may well offer a day of Mindfulness for Clinicians. This is integral practice for clinicians, he says, to become more aware of notions of compassion, acceptance, loving kindness, equanimity, concentration and attention but also for learning more about and recognising their own transference and countertransference issues, vicarious traumatisation and stress reduction and self care needs. When we are more able to be aware of ourselves and others, moment by moment our experience of ourselves, our clients and our work (and similarly, our client's experience of themselves, of us and of the work) is that much richer.

This is a radical challenge to us as therapists and professionals working with those who suffer from complex trauma outcomes as a result of childhood injury and maltreatment at the hands of those who are supposed to care for them. Treatment involves more of us than simply the application of empirically validated techniques. The therapeutic relationship requires more of us than training and experience, but as Dr. Briere has found in Buddhist practice, a guiding philosophy of the causes, prevalence and continuance of human suffering, and the practice of a path to its cessation.

*Martin Putt
Senior Therapist
SAFE Youth Programme.*



DSAC National Manager Hayley Samuel with Dr John Briere and Dr. Cheryl Lanktree in Wellington



**With special thanks to Image Centre,
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A Tribute To Dr. Faye Clark

DSAC Family Violence Intervention Trainer

My first memory of Faye — oh, about 20 yrs ago was her smile. When we started working on the Family Violence Workshops, it was such a relief to have someone who actually knew what they were talking about! It was quite a daunting task formulating the training, and Faye was our guiding light.

Her never ending enthusiasm and hard work certainly kept me going when there were times when I felt like packing it in.

The other quality she had was never complaining about her taking on the lion's share of presentations to my sometimes meagre offerings.

She was also a fantastic host when I stayed at her home. I will miss her very very much, but promise that she'll be hearing from me, whether she likes it or not!

All the best, Faye, and good luck with being a Mainlander
Dr Clare MacGougan, DSAC Family Violence Intervention Trainer, Nelson

I would like to say how inspiring a colleague and teacher Faye is. She has great skills as a group facilitator also. She has been very generous sharing her knowledge and presentation material. I would like to ask her if her DV presentations could be kept on a DSAC DV archive and if she would mind being contacted for advice from time to time!

Dr Penny Kagan, DSAC Family Violence Intervention Trainer, Dunedin

Faye is a fantastic person with oceans of energy and empathy for others, and never does anything half-pie. What does one say about people like that?

I have known Dr Clark for over 20 years as a General Practice colleague and have worked with her as a co-presenter delivering Partner Abuse Recognition and Response training to Primary Care health providers for the last 15 years.

She has demonstrated her passion in the area of Family Violence and Partner Abuse as evidenced through her long association (over 10 years) with Doctors for Sexual Abuse Care (DSAC), her work over 15 years as a DSAC accredited forensic medical examiner for the Police Department dealing with victims of partner abuse and rape at all hours of the day, published many journal articles on the subject, was a driving member of the working parties developing the Recognition and Responding to Partner Abuse Resource Handbook for General Practice which is on the working shelf of many of my colleagues in General Practice, and many other good works that are too numerous to add here.

She has excellent communication skills as evidenced by her popularity in her multicultural practice in Otara (the Pacific Capital of Auckland), and her long service with the local high school and the Manukau Technical Institute facility. Dr Clark's work with local communities also includes being a founding member of the Otara Diabetes Project Trust – this group comprises various local ethnic group community leaders, healthcare

providers and District Council members which demonstrates her ability to communicate with others of different ethnic, economic and educational backgrounds, and her ability to focus on reducing inequalities in the general community and her ability to think about issues from individual and population based perspectives.

Her extensive involvement in teaching and presenting on the subject of Family and Partner Violence to wide and varied audiences including Primary and Secondary Healthcare Providers both in New Zealand and internationally is testament to her status as a well known, knowledgeable and sought after person in this field.

Dr Kalash Deva, DSAC Family Violence Intervention Trainer, Auckland

I admire Faye for her dedication to the cause. I first met her when we were developing the training package for the Partner abuse program. At the time, she seemed the most focused of us all. I suspect that it had been an area she had put considerable effort into already. She had really good ideas of how the training should go and of what the important issues were. She was also brimful of empathy, and seemed to be able to express this with a look or a gesture, putting others at ease.

To review the statistics of the training she has delivered over the years, is mind boggling. I might be wrong, but I suspect that she has been responsible for 75% of the training delivered. She seems to be tireless in her willingness to do the work. She has also managed to stay sane through out, to have maintained her sense of humor, and continues to have a clear direction of where she is going. I have never known her to be negative or to express feelings of being bogged down by the emotional baggage that can be draining with this type of work.

I wish her well for the years ahead and hope that she has time for family and fun!

Dr Rita Middleton, DSAC Family Violence Intervention Trainer, Masterton

Our heartfelt thanks to Faye for the energy and commitment she has put into DV work over the years. She has been a truly inspirational woman in this field. Thank you again, Faye.

Dr Terry Wyatt, DSAC Executive Member



DSAC Administrator Meagan Kerr, Dr. Faye Clark, and DSAC National Manager Hayley Samuel

DSAC Notices

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**The DSAC Office will be
closed for the holidays from**

24th December 2009 - 18th January 2010

**Season's Greetings
to you all**



LETTERS TO THE EDITORS

Letters to the Editors can be submitted, although publication, editing and abbreviation are at the Editors' discretion. While the principle of 'right of reply' to articles and letters published in the Newsletter is accepted, this right is not automatically granted and is subject to Editorial discretion and the limitations of space - DSAC news and information have priority. All letters submitted must include appropriate contact details and email submissions are preferable so as to reduce the possibility of error in transcription.

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.

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