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CDFV Re@der

Pilot of accredited Course in Responding to Domestic and Family Violence commences

Engaging traumatic stories of violence and abuse: Vicarious trauma in helping professions

Adolescent to parent abuse: an overview

Queensland Indigenous welfare reform agenda

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Director's message

On the 12th September I had the honour of participating in a one-day symposium titled *Understanding and Preventing Domestic Violence*, convened by Griffith University's Key Centre for Ethics, Law, Justice and Governance. Under the direction of Professor Paul Mazerolle, the Key Centre has established a Violence Research and Prevention Program, constituting a coalition of Griffith University academics and PhD students conducting work in this area, which provided the impetus for the symposium. I had the privilege of representing both Griffith University, as a PhD candidate, and CQUniversity in my role as Director of Centre for Domestic and Family Violence Research and was delighted that Paul had asked me to present my work on strategies to address Indigenous family violence. Paul is to be congratulated on pulling together such a varied and stimulating symposium and it was great to see it well supported by my Queensland Domestic Violence Services Network colleagues and others from the domestic violence prevention field.

Some presenters, notably Julie Stubbs, Robyn Holder and Heather Douglas are particularly well known to the domestic violence sector across Australia, while most of us would have met for the first time Canadian academics Dr Elizabeth Blaney and Dr Carmen Gill from the Muriel McQueen Fergusson Centre for Family Violence Research, University of New Brunswick. Dr Blaney and Deputy Chief Leanne Fitch, Fredericton Police Force, New Brunswick discussed their Train-the-Trainer curriculum for police to improve their response to intimate partner violence. Of particular interest to me was the presentation by Dr Gill about the development of the Canadian Observatory on the justice system response to intimate partner violence. In 2007, the Canadian Observatory received funding of $2.1 million from the Social Sciences and Humanities Research Council of Canada for its seven year project. The Observatory is developing standardised national and international data sets on the justice system's response to intimate partner abuse, with particular emphasis on civil legislation and specialised responses within police, prosecutions and the courts. This will enable a consistent examination of the justice system's response to intimate partner violence from different jurisdictions, and provide evidence of critical ingredients for successful justice system responses through rigorous analysis. This is a fantastic initiative and one I wish had commenced much earlier to provide evidence for the development of Australia's national plan of action to reduce violence against women and their children, currently being undertaken by the National Council.

Paul Mazerolle spoke about his current ARC-funded research on developmental pathways to intimate partner homicide to better understand the individual, social and situational pathways to intimate partner homicide, and to improve risk assessment and the responses of police and social services. Betty Taylor also addressed the need for better understanding of pathways to intimate partner homicide and outlined the discussion paper she is developing on behalf of the Queensland Domestic Violence Death Review Action Group (DVDRAG). Dr Brian Sullivan discussed the patchy state of programs for male perpetrators of domestic violence in Queensland, citing a lack of adequate funding and support as the reason for the inability of most existing programs to meet the State's Minimum Standards of Practice and for the difficulties of recruiting and retaining staff.

The session on emerging PhD research on intimate partner research was extremely interesting and diverse. Silke Meyer discussed early outcomes of her work on understanding help-seeking behaviour of women experiencing domestic violence. Her work finds support for Gondolf's Survivor Theory, with women more likely to seek help as experiences of violence increase, as opposed to Walker's Learned Helplessness Theory, which predicts that the more women are abused the less likely they are to seek help. Marion Tower's research on health and healthcare for women affected by domestic violence demonstrates the limitations of health responses that operate within a de-gendered policy context and which are focused on diagnosis, treatment and cure, rather than addressing the complex needs of women affected by domestic violence. Significantly, Marion's research has found that this limited response has negative impacts on women's health and well-being. Her research findings should make a very valuable contribution to nurse education. Finally, Nada Ibraham presented her doctoral studies on intimate partner violence in the diverse Australian Muslim community. Her research will address the absence of evidence on the prevalence of intimate partner violence within the Muslim community, and explore the particular beliefs and attitudes that contribute to it, in order to develop effective intervention strategies.

As CDFVR stakeholders know, we value highly opportunities for academics and service providers to come together to discuss research and its implications for practice, and CDFVR provides such opportunities as much as possible. I'm very pleased that Randall Ross, from James Cook University, has agreed to present his work on 'Red Dust Healing' as a Distinguished Visitor's Seminar for CDFVR on 31st October. Further details can be found on page 18.

Heather Nancarrow

Inside this Issue

Centre News

Welcome to CDFVR's new-look publication!

The Centre is pleased to launch the first edition of our new-look quarterly publication, CDFVRe@der. The CDFVRe@der was designed and developed as a result of the Centre's recent external evaluation which included a review of the format and content of the quarterly newsletter and resulted in a recommendation to increase content consistency by introducing regular content areas. This also created an ideal opportunity to revamp and rename the publication. The new design and format is the creation of CDFVR's talented Multi Media Officer, Clinton Rawsthorne, who is also responsible for the designs featured on many of the Centre's resources and products.

Each quarter, the CDFVRe@der will feature articles in the following content areas.

- From the Director
- Centre news
- Research summaries
- Policy initiatives
- Evidence based practices
- Database highlights
- Resource reviews
- Conferences & workshops

The Centre will publish articles from guest contributors, when available, and encourages readers to consider writing an article. If you know of any new research, policy or practice that you'd like to see featured in the CDFVRe@der, or if you'd like to submit an article, or share your feedback about the new design and format, please contact us, we're keen to hear from you.

Sincere apologies to Verelle Cox who was incorrectly referred to as 'Narelle' in an article about the Ministerial Advisory Council on Domestic and Family Violence in the last edition of the CDFVR newsletter (June 2008). Verelle represents the Wide Bay - Burnett Region on the Council.

Training update

Celebrating successful partnership – Launch of pilot Course in Responding to Domestic and Family Violence (30629QLD)

History was made in August when CDFVR, in partnership with the Queensland Health and Community Services Workforce Development Council, launched the pilot of Queensland's first nationally accredited domestic and family violence course titled: *Course in Responding to Domestic and Family Violence (30629QLD).* Twenty-six participants from government and non-government organisations that respond to women who have been subjected to domestic and family violence, signed up to participate in the pilot. The Course's first unit of competence, *Recognise and Respond to Domestic and Family Violence* was delivered in New Farm, Brisbane, by training consultant and domestic violence advocate Betty Taylor.

Shirley Slann and Karina Henaway discuss the effects of violence on Indigenous women, families and communities.

Content of *Recognise and Respond to Domestic and Family Violence* includes the following elements:

- Work within a domestic and family violence framework
- Promote confidence with clients affected by domestic and family violence
- Identify client needs
- Respond to client needs

During the training for this first unit of competence, participants were invited to participate in role plays, brain storming and team information sharing to demonstrate a variety of work practices. These included demonstrating a shared understanding of domestic and family violence, safety for clients and self, managing stress in the workplace, interpersonal skills required to work with women who have been subjected to domestic and family violence and risk assessment strategies. Di Mangan, Manager of dvconnect and Caroline Fernandes from Immigrant Women's Support Service presented an overview of their services and participants with expertise in a specific area were encouraged to contribute their experience and knowledge.

Course participants during a brainstorming session

Training consultant Betty Taylor

The Course's second unit of competence, *Referring Appropriately and Effectively in Response to Domestic and Family Violence*, will be delivered in Brisbane on October 15, 16 and 17 and the third unit, *Reflecting on Work Practice when Responding to Domestic and Family Violence*, on November 25-27. Participants successfully completing the Course will receive a nationally recognised qualification, "Statement of Attainment in Course in Responding to Domestic and Family Violence (30629QLD)". All places in the pilot are now filled, but we are hoping to continue working with the Health and Community Services Workforce Development Council in 2009 to plan further Course delivery in Queensland, utilising a Recognition of Prior Learning (RPL) Tool for the Course, which is due to be completed in early 2009.

Further details about *Course in Responding to Domestic and Family Violence (30629QLD)* can be found on CDFVR's website at: www.noviolence.com.au or by emailing Annie Webster on a.webster@cqu.edu.au.

Research Summary

Adolescent to parent abuse: an overview

By Annie Webster, Education Project Officer, CDFVR

Recent Victorian Police statistics showing a 26 per cent increase in domestic violence incidents involving a perpetrator under 19 years has led to increased media attention and Victoria's Police Commissioner, Christine Nixon, calling for further research into the problem of adolescent-to-parent abuse. Internationally, research on adolescent to parent abuse commenced over 30 years ago, however, there is still inadequate measurement of the incidence of this type of family violence, and no incidence studies have been conducted in Australia. A range of studies published from as early as Harbin & Madden's work (1979) to the more recently published work by Cottrell and Monk (2004) use a range of different sampling techniques and measurement scales, which subsequently deliver a breadth of results. The focus of this article is to provide an overview of what is known from the literature and the limited Australian data on the nature and extent of abuse of a parent by a child (predominantly adolescents).

Definitions

The World Health Organisation defines *adolescence* as being between 10-19 years and *youth* between 15-24 years. Given the transition of this life stage, together with the biological and socio-cultural conditions, both these age groups are often combined in the group 'young people' (WHO 2006). The literature and available data sets related to child-to-adult violence indicate incongruence in the way this population is defined.

To define young people's violence toward their parents as "challenging behaviour" is to locate it outside of the spectrum of family violence (Downey 1997). Cottrell (2001, p.3) makes clear that adolescent to parent abuse is "not normal adolescent behaviour" and defines it as "any act of a child that is intended to cause physical, psychological, or financial damage to gain power and control over a parent". Australian definitions of adolescent to parent abuse are broader and suggest "behaviour [of one family member] is considered to be violent if others in the family feel threatened, intimidated and controlled"(Patterson et al 2002 cited in Stewart et al 2004, pp.199-210). What is clear is that there is a range of similarities between domestic and family violence and adolescent to parent abuse; however, because the violence is perpetrated on the person considered to be the most powerful in the relationship (the parent), the balance of power is less clear than it is in adult relationships.

Prevalence

Data from the USA estimates the frequency of child to parent violence for two parent families at between 7 – 18% and around 29% for one-parent families (Peek et al 1985). Canada, which has comprehensive research on adolescent to parent abuse, reports an estimated incidence of between 9 – 14% (Cottrell & Monk 2004). There are no Australian statistics on the prevalence of child-to-parent violence. However, during a recent interview with ABC television's 7.30 Report, Victoria's Police Commissioner Christine Nixon said that she and her fellow police commissioners around the country are concerned about what they believe to be an increasing trend of adolescents using violence against family members, including parents. Statistics released in 2006 indicate that of the 30,000 annual family violence call-outs in Victoria, 3,500 (11.7%) involved perpetrators under the age of 19 years (ABC 2008).

Data from CDFVR's Domestic and Family Violence Database, provides some indication of the extent of the problem in Queensland. The Domestic and Family Violence Database is comprised of information pertaining to all new client matters presenting to one of 29 domestic and family violence support services across Queensland. Of the total 46,433 new client matters recorded for the 18 month period from 1 January 2007 to 30 June 2008, 5.5 percent concerned the abuse of a parent by a "child" (noting that the age of the child is not known, and would include adolescent and adult children), compared to other family members which include siblings, grandparents, and other family members such as uncles and cousins, as shown in Table 1, below.

For just over half (51.38%) of the parents attending a domestic and family violence support service because of abuse by an adolescent or adult child, the abuse had been reported to the police (not necessarily by the victim). Thirty-one percent of cases had not been reported at the time a support service was sought, and it is not known whether the remaining cases were reported to police or not.

Types of abuse

Adolescent to parent abuse fits into three categories – verbal, emotional and physical. Eckstein's (2004) study revealed that parents were easily able to identify the type of abuse they had experienced and readily assigned a hierarchy to the severity of the abuse. Parents were relieved to be able to apply a low rating on the type of abuse they experienced (verbal and emotional as opposed to physical) and that by doing so they could justify that their children loved them. However, parents surveyed identified that verbal abuse was often the first episode of adolescent-to-parent abuse experienced, which later escalated to physical abuse.

Table 1 Frequency of reported abuse by a child against a parent

Type of relationship	Frequency	Percent
Parent/child (where the child perpetrates the abuse)	2542	5.5%
Other family member	2653	5.7%
Total	5195	11.2%

Source: Domestic and Family Violence Database Queensland Centre for Domestic and Family Violence Research, CQUniversity.

This report is supported by Jackson's (2003) qualitative study examining the experiences of six women abused by their adolescent children. Four out of the six women interviewed experienced an escalation of violence from non-physical, verbal or emotional abuse to physical abuse, which ranged from shoving and pushing through to inflicting physical blows. Gallagher (2004a) in his work with over 60 families where children have been violent toward their parents cautions that if verbal abuse is ignored it can lead to pushing or threats which gradually escalate to physical violence.

Gender dynamics

There are two sets of gender dynamics to be considered: those related to victimisation; and those related to the perpetration of abuse. There is a body of evidence (Cornell & Gelles 1982; Agnew & Huguley 1989) that mothers are more often the target of adolescent to parent abuse than fathers. Gallagher (2004a) agrees that mothers are far more often the victims of abuse by their children. Of the 75 children in his clinical sample, 74 were abusing their mothers. Twelve were also abusing their fathers and only one was abusing their father only. Cottrell and Monk's (2004) research found that male youth learn through a variety of social messages that it is acceptable to control and dominate women. Conversely female youths appear motivated to abuse mothers in an attempt to distance themselves from the "feminine ideals" that is being attributed to them (Cottrell & Monk 2004).

..... while some teenage boys may be ashamed to report assaulting their mother, they may consider an assault on their father an act of toughness and evidence of their masculinity.

An American study of 1545 male high school students taken from the Youth in Transition data elicited responses from participants which indicated that most abuse was perpetrated against fathers (Peek et al 1985). The results for this study were collected each year for three years from male adolescents' self-reports. Gallagher (2004a) in supporting his research that males are more likely to abuse than females, describes this evidence as "suspect" and raises the possibility that these surveys may include much "trivial violence", stating that "actual abusers" tend to either greatly under-report or fail to respond. Additionally while some teenage boys may be ashamed to report assaulting their mother, they may consider an assault on their father an act of toughness and evidence of their masculinity.

Some large scale studies involving representative samples suggest there is little to no difference in the gender of abusers (Agnew & Huguley 1989; Pagani et al 2004). However, as with studies on intimate partner violence, these quantitative prevalence studies focus on measuring the number of abusive acts, ignoring the contexts in which these acts are perpetrated and the effects of these acts on the victims. Therefore, gender-based differences in the perpetration of adolescent to parent abuse are largely obscured. Using the 1972 National Survey of Youth, which distinguishes between trivial and non-trivial incidents of "assault" on parents, Agnew and Huguley (1989) find "approximately 21% of all incidents of parent assault were trivial...with females being almost twice as likely to commit trivial hits as males" (p.706). No statistically significant gender difference was found in the non-trivial assaults, leaving Agnew and Huguley to conclude that "gender differences in assault are slight or non-existent" (p.707). Further, Eckstein (2004) draws on data from in-depth face-to-face interviews with 20 parents whose adolescents had verbally, physically and emotionally abused them. Her qualitative/interpretive method found that girls and boys abuse at the same rate until 11 years old, and then parental abuse by sons increases incrementally between 10 and 17 years. Female abuse of parents escalates between the ages of 11-13 years and then diminishes. However clinical data from Gallagher (2004a) and descriptive analysis by Stewart et al (2006) conclude that the majority of perpetrators are male. Of the 129 respondents to Stewart et al's survey, 70.3% were male with the most aggressive behaviour experienced or displayed between 13-15 years of age.

Understanding adolescent to parent abuse

Adolescent abuse of mothers

Adolescent-to-mother abuse occurs within the context of an "intense intimate and long-standing emotional, familial and caring bonds" (Jackson 2003, p.327). Whilst women can take steps to remove themselves from abusive relationships, severing your abusive child from your relationship is often not a viable option. A common thread in the research indicates that mothers are less likely to report episodes of violence because of the stigma and guilt associated with disclosure. They blame themselves for their children's behavior and the violence is diffused by the victim status their sons adopt (Daly & Nancarrow, 2007).

Power and control are at the heart of all forms of violence. In adolescent to parent abuse, violence is used as a means to control parents. In cases where mothers have been former victims of abuse they tend to respond to adolescent violence as victims, surrendering their adult role (Downey 1997, p.73). Gallagher (2004a) cites sole mothers being victimized by their children after having experienced violence from their previous partners as being one of the two common patterns in adolescent to mother abuse. Mothers are often targeted by abusive sons and daughters because they are perceived as weak and submissive. Harbin and Madden's (1979) research indicates that abused parents act like other victims of abuse (child and spouse) in denying its seriousness.

Livingstone (1980) proposes that the high rate of adolescent violence toward single mothers can be explained by the inhibiting force that fathers may have in two parent families; the presumption that adolescents in two parent families may not witness or experience abuse at the same rate as single parent families; and the possibility that two parent families may not have the same financial stresses.

Additional reasons for child to mother abuse may be attributed to the fact that in most families, mothers engage in more limit-setting and supervision, making them the obvious targets for frustration (Pagani et al 2004). Mothers are usually physically weaker than fathers; may be less likely to retaliate in a violent situation; and have a heightened sense of responsibility and guilt for the bad behavior of their children (Gallagher 2004a).

Children's exposure to abuse

Cottrell and Monk's Canadian study uses data from semi structured focus groups and individual interviews to demonstrate that youth who abuse their parents have often been physically abused themselves as children and commence abuse when they have the strength to do so (Cottrell & Monk 2004). There are a number of authors who make a strong connection between child abuse and later adolescent violence (Downey 1997). Dodge et al (1990 cited in Downey 1997, p.74.) assert "…a child's experience of being physically harmed is a predictor of later aggressive behavior".

Stewart et al (2006) report that 25.3 percent of the children in their sample of 129 mothers had witnessed violence in the home. It must be acknowledged that in the context of children's experiences of domestic violence, the term "witness" is problematic, as it ascribes a "passive onlooker" status to the child and minimises the strong and pervasive effects that exposure to domestic violence creates. Numerous qualitative studies identify that children "witnessing" domestic violence "are actively involved in seeking to make meaning of their experiences and in dealing with the difficult and terrifying situations which confront them" (Laing 2000, p.1).

Researchers studying adolescent to parent violence note that if violence has been witnessed in families and has become intergenerational, it may be considered normalised behavior (Cottrell & Finlayson 1996; Cottrell 2001). Straus et al's (1980) findings that children begin threatening their mothers after seeing their fathers become violent is supported by Gallagher's (2004a) theory that some parents who have been victims of spouse abuse lose respect in the eyes of their children. However, when theorising on the cause of adolescent to parent abuse, there are many other factors to consider, as discussed below. In addition, the literature shows that between 30-60 percent of children exposed to spousal domestic violence are also directly abused themselves (Edelson 2001).

Table 2, below, represents the number of adolescents between the ages of 12-18 years living in a household during a violent family relationship, as reported to services participating in CDFVR's Domestic and Family Violence Database. As indicated, almost one in five (19.52%) of the domestic violence incidents reported during this 18 month period involved at least one child aged between 12-18 years being in the household during the violent relationship. Whilst this data does not identify whether adolescents were present during the violent incidents, it is likely that, as they were members of the household during the relationship they would have been exposed to some element of the abuse.

Parental use of corporal punishment

Pagani et al's longitudinal study asked parents of 15 and 16-year-olds about their use of corporal punishment, defined as "the use of physical force with the intention of causing pain, but not injury, for the purposes of management….."(2004, p.535). Straus & Donnelly (1993) suggest that parents who use such authoritarian measures to control their adolescents risk creating resentment by using parenting strategies more commonly used on younger children. Peek et al (1985) consider corporal punishment as a predictor of adolescent to parent violence, possibly in self-defense. Pagani et al (2004) support this assertion, particularly in situations where adolescents have experienced a violent childhood and have not developed appropriate self-regulatory processes. They suggest that parents who inflict severe corporal punishment, upon experiencing defensive violence, may also be more inclined to escalate their level of corporal punishment, creating a heightened level of aggression and retaliation.

Parenting styles and over-entitled children

There is a relationship throughout the literature between entitlement and adolescent to parent violence. Physical attacks and threats by adolescents toward their parents are seen by some researchers as an attempt to replace ineffective parenting. As the parent abdicates their power, the adolescent begins to manifest their sense of self and entitlement (Harbin & Madden 1979).

Contemporary parenting styles have moved away from a unilateral style of parenting towards a more equal relationship which, while supporting that the adolescent has rights, can lead to a severe crisis in leadership within families (Bobic 2002). An overly permissive style of parenting could lead to parent-child power reversal where youth see the rewards of their inappropriate or negative behaviour to outweigh the consequences (Cottrell & Monk 2004). Pagani et al's 2004 research indicates that additional risk factors such as weak parent-child attachment through poor communication and life sharing opportunities make it difficult for parents to enforce a level of family limit setting. Gallagher (2004b) contends that well meaning parents who try too hard to be perfect may produce adolescents who treat their parents like servants.

Table 2 Presence of adolescents in households where there is domestic and family violence

Age of children	Number of incidents of violence where adolescents were living in household	% of total (children living in households)
12-14 years	5291	11.4
15-18 years	3768	8.12
Total	9059	19.52%

Source: Domestic and Family Violence Database Queensland Centre for Domestic and Family Violence Research, CQUniversity

He asserts these adolescents generally come from middle class backgrounds and have over-responsible parents who produce over-entitled children; and some come from sole parent families who are trying to compensate for the past.

Additional factors

Alcohol and drug abuse are included in the literature as risk factors in adolescent to parent abuse, although there is not a consistent pattern of agreement. Pagani et al's 2004 longitudinal study illustrated that substance abuse increased the risk of verbal aggression by over 60%, while problematic substance abuse by parents increased adolescent physical aggression by more than 70%. Their explanation for this increase in aggression include: lack of consistent communication of home rules and discipline which may evoke confrontation by the adolescent; or the possibility of parents responding to their adolescent's substance abuse with a higher level of corporal punishment which may evoke retaliation.

Cottrell & Monk (2004), while agreeing that alcohol and drugs are linked to abusive behavior, believe that abuse arises in response to parents' concern at their adolescent's substance misuse. This position is supported by Pelletier & Coutu (1992) who attempt to dispel the myth that adolescent violence is caused by intoxication, explaining that drug and alcohol consumption is often peer group related, and consequently would occur away from the family home. They contend that parents' concern and stress may indirectly trigger a disagreement, which leads to a violent confrontation.

It may be possible that, in a less inhibited state of mind, aggressive adolescents are more likely to seek confrontational situations. However alcohol and drugs are simply the catalyst for this behavior, not the cause.

What can we do?

Education and support

Adolescent to parent violence is a taboo subject. Affected parents feel responsible for their own victimisation or fear the stigma of others' blame (Stewart et al 2006). Bobic (2002) concludes that the central issue is one of awareness raising and assisting parents and caregivers to overcome the guilt and shame and to seek help. She calls for greater support for families who are experiencing adolescent to parent violence. Cottrell & Monk (2004) identify more education for service professionals about the wide range of factors that contribute to this abuse and urge a more family treatment-focused approach.

In Queensland our approach to this issue should include raising the profile of adolescent-to-parent violence by developing resources, training and professional development that provides clear and consistent response guidelines. Our society's understanding of parental abuse and its causes and effects is important in promoting primary prevention. There is a need to create a culture and environment which encourages and enables women to disclose their abuse without feeling shame and failure and provide an understanding of the complex array of circumstances which contribute to this abuse.

There is a need to create a culture and environment which encourages and enables women to disclose their abuse without feeling shame and failure and provide an understanding of the complex array of circumstances which contribute to this abuse.

It is also worth considering research on the role that "attachment" has between parents and adolescents. Adolescents living in their family homes experience a range of positive as well as abusive interactions. Some of these communicative interactions have at some time set the stage for adolescent to parent abuse (Eckstein 2004). Gallagher conceptualises the importance of responsibility within family relationships with a set of scales. His clinical experience has led him to believe that abuse is enabled in an environment where entitlement outweighs responsibility and respect is cultivated where responsibility outweighs entitlement (2004b).

Justice responses

Whilst mothers are hesitant to seek assistance that may lead to criminal charges against their abusive adolescent, there is often a need to take some action to self protect and stem the escalation of abuse. If the young person is prepared to admit their offence to police, the matter can then be referred to Youth Justice Conferencing instead of sending the matter to court. Conferencing can involve a police officer, a Youth Justice convener, the adolescent who committed the offence, the adolescent's support person and the victim. Youth Justice Conferencing is a restorative justice measure that aims to hold the perpetrator accountable for their actions and give them the opportunity to take ownership for what they have done.

Conversely, it aims to give victims a voice, validate their account of what happened, acknowledge that they are not to blame for the violence and enable them to contribute to case decision making. Whilst this measure supports the adolescent to take steps to prevent further abusive behavior, its contribution to the support for the parent subjected to the abuse it limited. Stewart et al (2004/05) assert that there is some evidence that criminal justice and medical modeling have been used to veil the role that gender, power and violence play and enabled a superficial understanding of this complex family issue (Stewart et al 2004/05). Stubbs (1995; 1997; 2002a; 2002b); Coker (1999; 2001); and Busch (2002) also draw attention to the limitations of restorative justice for cases of domestic violence, because of the inherent power and control issues in such cases. While they were concerned specifically with men's violence against their female intimate partners, Daly and Nancarrow (forthcoming) analysed three cases of adolescent sons' violence towards their mothers that were dealt with by a youth justice conference, finding evidence to validate concerns about the limitations of current models of conferencing in addressing gender-based violence.

Kratcoski (1984) suggests that intervention models to control family violence should involve techniques to "unlearn" behavior within the context of where it was originally learned. Youth Justice programs which address the dimensions of power and control will provide a more effective response to adolescent-to-parent violence.

Conclusion

Despite 30 years of research into adolescent-to-parent abuse, there is no incidence data for Australia although there is anecdotal evidence to suggest that it is increasing. The paucity of data in Australia has led to a reliance on American statistics to support clinical research and practice. To address adolescent-to-parent abuse our first steps should be to promote awareness that this type of abuse exists; provide environments and opportunities for parents to disclose and seek assistance; and work toward reducing the shame, self-blame and isolation experienced within families. Justice responses should support not only the perpetrator but acknowledge the severity of the victim's abuse and provide them with appropriate support whilst working with both parties to end the use of power and control within their relationship.

It is normal for adolescents to demonstrate healthy anger and conflict within their family unit in their transition from childhood to adulthood. However anger is an emotion and violence is about power and control (Inner South Community Health Service 2008). By breaking the cycle of adolescent development that accepts violent behaviour and instilling values that enable relationships based on respect for self and others to develop, we will make some progress in addressing this problem.

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Feedback on 2008 Indigenous Family Violence Prevention Forum

Participants at this year's Indigenous Family Violence Prevention Forum – Addressing Problems – Sharing Solutions, contributed valuable feedback which will see next year's Forum expand to three days to include skills development workshops.

The Forum evaluation asked the 95 practitioners who attended the Forum whether they would like to see skills development workshops on domestic and family violence included in the 2009 program. An overwhelming 84% (80) said "yes". Fifty-four of the 111 forum participants included their workshop preferences. These included workshops on: perpetrator programs; working with children; elder abuse; drugs and alcohol problems; homelessness issues; skill development (including what programs are working and what aren't) and program development (mentoring, grief and loss, outreach skills early intervention and prevention).

When participants were asked if they would be prepared to present a skills development workshop ten people indicated that they would and 20 indicated they "may be interested". We are now asking people to look at the six categories (above) and confirm whether they have the skills and knowledge to deliver a workshop which relates to these most requested areas of skill development.

Dates for CDFVR's 2009 Forum are May 11, 12 & 13. If you would like to discuss your interest in delivering a skills development workshop or clarify the breadth of each category please contact Annie Webster on (07) 49407838 or email a.webster@cqu.edu.au. The 2008 report and evaluation is available on http://www.noviolence.com.au/public/forum2008/evaluationreport.pdf

Database highlights

Domestic and Family Violence Database Summary: Disability

By Heather Nancarrow, Director, CDFVR

Background

Since October 2003, CDFVR has maintained a Domestic and Family Violence Database comprised of client information provided by 29 domestic and family violence support services across Queensland. Information is collected for all new client matters presenting at these 29 participating services. The initial purpose of the Domestic and Family Violence Database was to contribute information for the Queensland Department of Communities' evaluation of the impact of changes to the *Domestic and Family Violence Protection Act 1989*, which commenced in March 2003, broadening the coverage of the Act to include a range of 'non-spousal' relationships. The participating services received funding in 2003 to respond to this broader range of relationships, in addition to their work on 'spousal' domestic violence. There are other domestic and family violence support services across the State, including all of the women's refuges and safe houses that do not participate in the data collection. Therefore, the database constitutes a large state-wide sample collected over several years from specific domestic and family violence services. The data do not represent the incidence of domestic and family violence in Queensland, but they do provide some insights into the complex needs of people accessing domestic and family violence support services across Queensland.

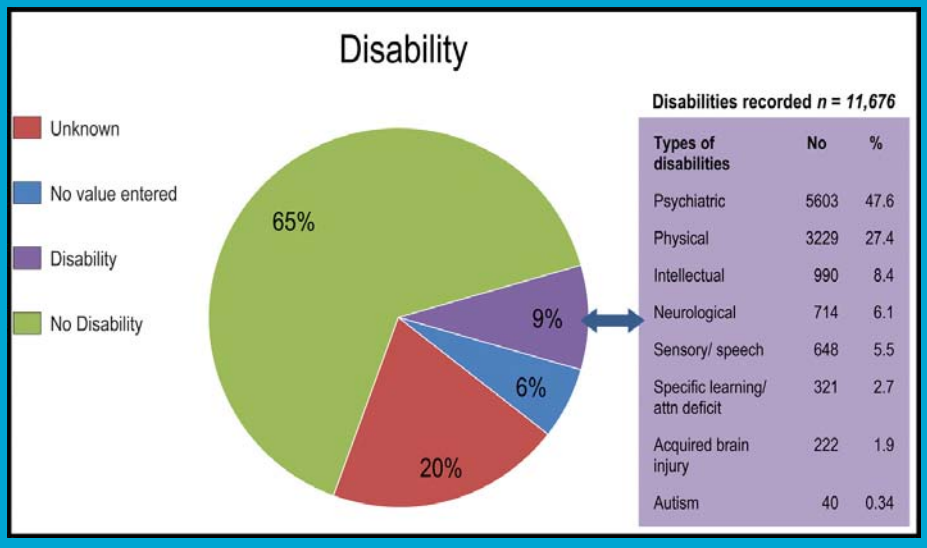
Disability

CDFVR's Domestic and Family Violence Database includes information on disability. The question and response options on disability are from the Australian Institute of Health and Welfare's (AIHW) Australia's health, community services and housing metadata registry. The definitions of each type of disability can be found at: http://meteor.aihw.gov.au/content/index.phtml/itemId/347342.

The following brief summary from the Domestic and Family Violence Database relates to the period from 3 October 2003 to 30 June 2008. During this period of time a total of 126,519 new client matters were recorded in the Domestic and Family Violence Database. As seen in Graph 1 below, for more than half (64.8%) of these new client matters no disability was present. However, in just over 20 percent of cases the service did not know whether the client had any kind of disability. This high proportion of new clients for whom the presence of disability is unknown is most likely a consequence of two factors. First, many of the services contributing to the Domestic and Family Violence Database are providing crisis intervention or court support where there is very little time available for data collection not immediately relevant to the provision of that service. Second, some service providers have expressed a degree of discomfort with asking new clients about disabilities, where the need for the information may not seem obvious to them or their client. Further, for 5.8 percent of the total 126,519 new client matters there was no information about disability recorded at all, meaning that the presence of a disability is not known for more than a quarter of all cases in the Domestic and Family Violence Database for this period of time.

Of the total 11,767 (9.4%) of new clients who were known to have a disability, a psychiatric disability was the most commonly identified, followed by physical disability. The table in Graph 1 below indicates a breakdown of the disabilities reported for this group of new client matters.

Graph 1 Recorded disabilities (3 October 2003 – 30 June 2008)



Types of disabilities	No	%
Psychiatric	5603	47.6
Physical	3229	27.4
Intellectual	990	8.4
Neurological	714	6.1
Sensory/ speech	648	5.5
Specific learning/ attn deficit	321	2.7
Acquired brain injury	222	1.9
Autism	40	0.34

Of the total 126,519 new client matters recorded, 90.7 percent (114,697) were non-Indigenous Australians, 7.8 percent (9846) were Indigenous Australians, and for 1.6 percent (1976) of new client matters, cultural identity was not known. Where known, 65.7 percent (75,409) of the non-Indigenous new clients reported no disability, compared to 60.4 percent (5953) of Indigenous clients reporting no disability. Table 2 below summarises the range of disabilities recorded for new client matters and the percentages of non-Indigenous and Indigenous new clients for whom each type of disability was recorded. Overall there appears to be very little, if any difference in the rate of disability, of any type, between non-Indigenous and Indigenous clients whose details are recorded in the Domestic and Family Violence Database.

Table 2 Indigenous status by type of disability

	Non-Indigenous		Indigenous	
Disability type	**Frequency**	**%**	**Frequency**	**%**
Physical	2951	2.5	251	2.5
Specific learning/attention deficit	300	.2	16	.0
Intellectual	898	.8	79	.8
Autism	39	.0	1	.0
Acquired Brain injury	196	.2	22	.2
Psychiatric	5197	4.5	374	.4
Neurological	666	.5	42	.4
Sensory/speech	586	.5	52	.5

Queensland's *Domestic and Family Violence Protection Act 1989* provides for court-ordered Domestic Violence Protection Orders for 'spousal' relationships (including current and former married and de facto partners of the same or opposite sex; and biological parents of a child); other family relationships (including parents, step-parents, grandparents, siblings and others); intimate personal relationships (including 'enmeshed dating relationships and couples who are engaged to be married, or betrothed or 'promised' under cultural practices); and 'informal' care relationships (as opposed to care arranged through formal, agency channels). Table 3 below shows, as expected, that the rate of disability present for new clients in the informal care categories is higher than for other relationship categories. More than one-third of new clients being cared for in an informal care relationship had a physical disability; compared to the next highest rate of just over 5 percent of new clients in 'other family' relationships reporting a physical disability. A similar pattern is evident in relation to intellectual, psychiatric, neurological and sensory/speech disabilities. In this context, it should be noted that informal care is often provided by spouses and other family members and these categories of relationships may be identified instead of the informal care relationship category when these clients present at a domestic and family violence support service.

Table 3 Disability by type of relationship

	Spousal (n=95305)		Other family[1] (n=10,780)		Intimate personal (n=10536)		Informal care (provider) (n=147)		Informal care (receiver) (n=159)	
Disability type	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
No disability	64203	67.4	6658	61.7	6774	64.3	76	51.7	31	19.5
Physical	2065	2.2	548	5.1	296	2.8	25	17.0	58	36.5
Specific learning/attention deficit	184	.2	82	.8	35	.3	1	.7	0	0
Intellectual	566	.6	168	1.5	139	1.3	8	5.4	13	8.2
Autism	17	.0	10	.1	7	.1	0	0	1	.6
Acquired Brain injury	149	.1	23	.2	32	.3	3	2.1	3	1.9
Psychiatric	3835	4.0	711	6.6	714	6.8	9	6.1	18	11.3
Neurological	409	.4	163	1.5	64	.6	3	2.0	29	18.2
Sensory/speech	416	.4	130	1.2	36	.3	2	1.4	13	8.2
Unknown	19641	20.6	1947	18.1	1997	19.0	22	15.0	15	9.4

[1]*Family members other than parents, step-parents, grandparents and siblings have not been included in this count, due to the very wide range of variables, so the totals for relationship type do not add to the total of 126,519 new client matters.*

Policy Initiative

Queensland's Indigenous welfare reform agenda: Family Responsibilities Commission

By Michelle Bradford, Education Officer, CDFVR

Queensland's Family Responsibilities Commission formally commenced business on 1st July 2008. Underpinned by the state's *Family Responsibilities Commission Act 2008*, the Commission represents a partnership between four Aboriginal Cape York communities, the Federal Government, the State Government and the Cape York Institute for Policy and Leadership.

Aurukun, Coen, Mossman Gorge and Hope Vale communities have all agreed to participate in the trial of the Commission, which runs until 1st January, 2012. The Commission is led by David Glasgow, a former Queensland Magistrate and a total 24 Local Commissioners (reflecting six people drawn from each of the four participating communities) have been appointed to lead the Commission's activities on the ground.

Map of the Cape York region of Queensland, which indicates the Aboriginal communities in the region and highlights the four communities participating in the FRC trial. Source: "From Hand Out to Hand Up: Design Recommendations" May 2007, Appendix B, p.127

The Family Responsibilities Commission (FRC) initiative is part of a broader federal and state government Indigenous welfare reform agenda conceived out of long standing concerns, and the more recent and highly publicised public outrage, regarding levels of child abuse and neglect, substance abuse and violence in Indigenous communities. To this end, the Council of Australian Governments has identified targets relating to Indigenous health, education, housing and employment, and the Queensland Government announced increased commitment to a raft of programs and initiatives such as tighter restrictions on alcohol supplies to communities, and detoxification and rehabilitation programs. In addition to these, the children from the four trial communities are also receiving comprehensive health checks.

Noel Pearson, Director of the Cape York Institute for Policy and Leadership and co-author of the Institute's first design report of the Cape York Welfare reform project titled, "From Hand Out to Hand Up: Design Recommendations" is widely credited with being the architect of the Family Responsibilities Commission initiative. This report specifically recommended the creation of a Family Responsibilities Commission, and together with the subsequent "From Hand Out to Hand Up: Volume 2" report, the Institute outlined a blueprint for reform in the key areas of housing, education, supports and evaluation for Aboriginal remote communities.

A speech delivered by Queensland's Premier, Anna Bligh in October 2007 described the aims of the welfare reform strategy, of which the FRC is a key element, as "finding a way to restore social norms in [remote Indigenous] communities, to change dysfunctional behaviours, to ensure the safety and well being of families, to ensure that children are going to school and to build local capacity to make sure that there are real opportunities for employment and economic development" (Qld Parliament Hansard).

So, how does the FRC work? Aboriginal and non-Aboriginal people who have lived for at least three months in one of the four trial communities, and are recipients of welfare payments or Community Development Employment Projects (CDEP) program funding are subject to the *Family Responsibilities Commission Act 2008* and can be brought before the Commission as a result of any one of the following reasons.

- The person's child is not enrolled in school without lawful excuse, or has three absences in a school term without reasonable excuse.
- The person is the subject of a notification with the state's statutory child protection authority, the Department of Child Safety.
- The person is convicted of an offence in a magistrates' court.
- The person breaches the housing tenancy agreement of their state or council-owned housing (includes malicious damage, rent arrears, illegal purpose, nuisance, or condition report).

The *Family Responsibilities Commission Act 2008* has provisions that require state and private school Principals, Department of Housing Officers, Child Safety Officers, and magistrates' courts to report people meeting any of the above criteria to the FRC. The Commission, which sits locally and is led by Local Commissioners, summons those people who have been referred, and conducts an interview to review their behaviour and assess their situation. Based on a review of the relevant information, the Commission then hands down a decision that can range from a warning, to an agreement that forces the person to receive a community support service, to an order that requires the person's income to be fully managed for up to 1 year.

By 29 June, 2008, the concurrent child health checks initiative had screened 385 children aged 5 to 12 years from the four trial communities. The health screenings were provided by a dedicated nurse or general practitioner, and uncovered 66 dental cases; 19 serious hearing problems which required referral to an ears, nose and throat specialist; 15 children with significant nutrition issues, 21 children requiring referral to a paediatrician; and 101 children needing follow up screening in a further 3 months. Of the children receiving the health screens, it is not clear how many were already known to the Department of Child Safety; however none were assessed as suspected child abuse or neglect and requiring referral for a statutory child protection response (Courier Mail, 14.08.08).

.....the health issues exposed by these checks are more indicative of the types of health service shortfalls that Indigenous leaders have been complaining of for many years (The Courier Mail, 14.08.08 p.30).

Senior reporter with the Courier Mail, Margaret Wenham comments that this finding is important, particularly in the context of Aboriginal communities frequently being portrayed as "seething nests of abusers", and suggests the health issues exposed by these checks are more indicative of the types of health service shortfalls that Indigenous leaders have been complaining of for many years (14.08.08 p.30). This perspective prompts a re-think about the role of welfare reform in improving Aboriginal children's health and raises questions about the accuracy of claiming a direct relationship between this improvement and the activities of the FRC.

What has been the progress of the FRC initiative? The Commission commenced its conferences in the four trial communities in August this year and reports that, at the time of going to print, a total of 204 referrals have been brought to the Commission for consideration. The two leading triggers for these notifications are school non-attendance and magistrates' court notices.

While much attention has focused on the Commission's power to remove an individual's freedom to manage their own income, and have it managed by the state for up to 1 year, David Glasgow emphasises this action is a last resort, and the goals of the Commission's activities are to assist individuals and families to take greater responsibility for their children's welfare through a process that identifies and responds to their support needs. The Commission reports that to date, no orders requiring income management have been made.

Noel Pearson, argues the FRC has an essential role to play in restoring Indigenous authority and law and rebuilding social norms.

The following example of the process used to review a case and arrive at a ruling by the Aurukun-based Commission, was reported by the Courier Mail on 15.08.08 (p.10). "At the hearing yesterday, a 14-year-old Aurukun mother of a one-month old baby was advised to seek contraceptive advice and ordered to attend parenting classes. The girl agreed to attend art classes two days a week, but refused to return to school. Commission chief, Magistrate David Glasgow, described the conference which was conducted almost entirely in the Wik language with the girl, her parents and grandmother, as very productive".

In Premier Bligh's words, the Family Responsibilities Commission initiative is "a bold experiment", and staunch advocate, Noel Pearson, argues the FRC has an essential role to play in restoring Indigenous authority and law and rebuilding social norms. Detractors express concern about the punitive methods available to the Commission and the parallels to the historically disempowering and oppressive government policies and practices. Undoubtedly, the trial will be watched closely and its independent evaluation, which will be undertaken at its conclusion, will be eagerly awaited by many.

The Indigenous Government Co-ordination Office (IGCO) of the Department of Premier and Cabinet produces a fortnightly electronic newsletter to promote the range of activities connected with the roll out of Cape York's broader welfare reform agenda. Anyone wishing to receive these newsletters can register with Aileen Wallace via email at: Aileen.Wallace@premiers.qld.gov.au.

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Evidence based practice

Engaging traumatic stories of violence and abuse: **Vicarious trauma in helping professions**

By Michelle Bradford, Education Officer, CDFVR

It's widely acknowledged that direct exposure to events perceived as threatening to one's safety and overwhelming of one's ability to cope, is traumatic. The stress associated with experiencing such trauma, referred to as post traumatic stress, produces a range of physical, psychological and emotional symptoms that are at best uncomfortable and, at worst, catastrophic for the traumatised person's daily functioning. More recently, the field of traumatology has recognised that counsellors, who repeatedly engage with the traumatic stories of their clients, are indirectly exposed to the same trauma and are also at risk of developing post traumatic stress. Earlier literature characterised these occupationally induced trauma reactions with terms such as burnout, counter-transference, compassion fatigue or secondary traumatic stress. More recently however, the term "vicarious trauma" has emerged to provide a more complex and sophisticated explanation of counsellors' reactions to clients' trauma (Trippany, Kress and Wilcox 2004, p.31; Figley 1995; VanBergeijk and Sarmiento 2006; Blair and Ramones 1996). This article will explore vicarious trauma as a type of occupationally induced stress and examine risk factors and prevention and treatment strategies in personal, professional and organisational contexts.

McCann and Pearlman introduced the concept of vicarious traumatisation in 1990 to refer to *"a transformation in the therapist's (or other trauma worker's) inner experience resulting from empathic engagement with clients' trauma material. These effects are cumulative and permanent, and evident in both a therapist's professional and personal life"* (Pearlman and Saakvitne 1995, p.150).

Whilst vicarious trauma has been used interchangeably with secondary traumatic stress, burnout, compassion fatigue and counter-transference, each condition can be differentiated by their theoretical propositions and the populations to which they refer. Equally, it is recognised that key features of some or all of these conditions can overlap and present in a person's experience. The central distinguishing characteristics of each of these occupation-related stress conditions are listed below.

Secondary traumatic stress (STS)

- Approaches traumatisation from the perspective of observable symptoms that parallel Post Traumatic Stress Disorder (PTSD), and is less concerned with the context and aetiology of the traumatic reaction (Pearlman & Saakvitne 1995).
- This stress may occur over time or after a single exposure.
- Has been identified in numerous populations such as police officers, emergency workers, therapists, child protection workers, clergy, crisis workers and bank officers (VanBergeijk & Sarmiento 2006, p.85).
- Is not recognised in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

Burnout

- Essentially refers to the physical, emotional and mental exhaustion that arises from working at high stress with limited rewards, or in situations where basic goals and conditions needed to produce work satisfaction are not achievable (Pearlman & Saakvitne 1995; VanBergeijk & Sarmiento 2006).
- Distinguishable from vicarious trauma in terms of the contribution of the workplace environment (culture, workload, resources) rather than the interaction of the traumatic story with the individual therapist.

Compassion fatigue

- Has been used synonymously with burnout; was first used to describe burnout among nurses.
- Is "fatigue that can result from working in a profession that requires therapists to maintain careful empathic attunement, selflessness, and the capacity to form connections with, and respectfully hold projections, affect, and transference from, a range of clients" (Pearlman & Saakvitne 1995, p.153).
- Shares a core concept with vicarious trauma, that is, the impact of empathy and caring in the context of a counselling relationship (Australian Childhood Foundation, 2008) however, it is not considered to produce basic changes to the helper's world view (VanBergeijk & Sarmiento 2006).

Counter-transference

- The counsellor's process of seeing her/himself in the client, of over-identifying with the client or meeting needs through the client (Figley 1995, p.9).
- Counsellor's emotional reaction to a client as a result of the counsellor's personal life experiences (Australian Childhood Foundation 2008).
- Is specific to the counsellors' experiences during or around counselling sessions, whereas vicarious trauma effects transcend the session, and affect all aspects of counsellors' lives (Trippany, Kress & Wilcox 2004, p.32).

The occupational stress conditions of burnout, compassion fatigue and countertransference are related to, and can co-exist with, vicarious trauma; however, vicarious trauma is distinguishable from these conditions in the following ways. Firstly, vicarious trauma uniquely refers to the trauma reactions experienced by therapists or counsellors as a result of their empathic engagement with their clients' traumatic material. Secondly, the aetiology of vicarious trauma lies in the counsellor's relationship and open engagement of empathy with the traumatised client. Thirdly, the impacts of vicarious trauma induce permanent changes to the counsellor's fundamental beliefs about the self, others and the world and significantly disrupt one's identity, sense of meaning and connection, psychological needs, interpersonal relationships, ability to tolerate emotion, and sensory memory (Pearlman & Saakvitne 1995, p.155; Trippany, Kress & Wilcox 2004).

.....vicarious trauma uniquely refers to the trauma reactions experienced by therapists or counsellors as a result of their empathic engagement with their clients' traumatic material.

So, how do we understand the progression of vicarious trauma, identify factors that increase the likelihood of developing it and make sense of ways to prevent and treat it? McCann & Pearlman (1990) and Pearlman & Saakvitne (1995) conceptualise vicarious trauma from the perspective of Constructivist Self Development Theory (CSDT). This perspective essentially asserts that individuals progressively develop their sense of self and the world in response to life experiences. In this way, people actively construct their own realities through developing perceptions or a set of "cognitive schemas" that enable their understanding and interpretation of life experiences. It follows that repeated interaction with clients' stories of traumatic life experiences will challenge and perhaps alter counsellors' cognitive schemas and perceived realities (Pearlman & Saakvitne 1995, p.160; Trippany, Kress & Wilcox 2004, p.32).

The self and vicarious trauma

Vicarious trauma equates to an attack on the "self-hood" of the counsellor. The Constructivist Self Development theoretical perspective identifies five components of the self and refers to the way in which the self and the individual's perception of reality are developed. These five components are: 1) frame of reference; 2) self-capacities; 3) ego resources; 4) psychological needs; and 5) cognitive schemas, memory and perception. The following section briefly overviews each component of self and outlines typical symptoms of disruption and distortion of each component as a result of vicarious trauma (Trippany, Kress & Wilcox 2004; Pearlman & Saakvitne 1995).

1) Frame of reference refers to a person's identity, worldview and belief system that provide a foundation for perceiving and interpreting the self and the world. "It also involves cognitive processing of causality and attribution", moral principles and life philosophy. (Trippany, Kress & Wilcox 2004, p.33; Pearlman & Saakvitne 1995). Disruptions to a counsellor's frame of reference risks a disconnection from identity leading them to doubt and question themselves as individuals, and in their various roles, also leading to loss of self awareness and a psychological paralysis that questions self esteem and memories of childhood histories, and manifests a negativity and cynicism about people's motivations and events occurring in the world (Pearlman & Saakvitne 1995). "The most malignant aspect of vicarious traumatisation is the loss of a sense of meaning for one's life, a loss of hope and idealism, a loss of connection with others, and a devaluing of awareness of one's experience" (Pearlman & Saakvitne 1995. p.161).

"The most malignant aspect of vicarious traumatisation is the loss of a sense of meaning for one's life, a loss of hope and idealism, a loss of connection with others, and a devaluing of awareness of one's experience"
(Pearlman & Saakvitne 1995. p.161).

2) Self capacities are inner-capabilities that enable an individual to manage emotions, maintain positive feelings about themselves, and sustain interpersonal relationships. Disruption to self-capacities through vicarious trauma is likely to manifest as a loss of identity, difficulties relating to others, inability to control negative emotion, feeling incapable of meeting the needs of significant others and actively avoiding contact with images and information that conveys the suffering of others (Trippany, Kress & Wilcox 2004).

3) Ego resources enable an individual to "meet their psychological needs and relate to others interpersonally" (Trippany, Kress & Wilcox 2004, p.33). These resources include the ability to conceive consequences, set boundaries, and protect the self. Perfectionism, over extension at work and an inability to experience and express empathy toward clients, are typical manifestations of a vicariously traumatic disruption to the self's ego resources (Trippany, Kress & Wilcox 2004).

4) Psychological needs refer to fundamental human needs for safety, trust, esteem, intimacy and control; each of which will be briefly examined below.

Safety needs fundamentally require a sense of security, and disruption in attaining these needs can produce high levels of fearfulness, perceived vulnerability and over-caution for the safety of significant others and the immediate environment. *Trust needs* are reflected in the individual's ability to trust their own perceptions and beliefs, and the ability to form healthy attachments to others. The foundations of trust upon which the counsellor's world view rests, is shaken and destabilised through exposure to repeated stories of client trauma. The disrupted trust needs of a counsellor experiencing vicarious trauma often manifests as self-doubt, inhibited self-trust and questioning one's ability to effectively judge and intervene with clients (Trippany, Kress & Wilcox 2004, p.33).

Esteem needs refer to valuing self and others. Vicarious trauma can trigger feelings of inadequacy and prompt counsellors to doubt their abilities to help someone. Counsellors' esteem for others can also be confronted and challenged as they're faced with the reality of other people's cruelty and injustices in the world. *Intimacy needs* are characterised by the need to feel connection with oneself and with others. Disruption to intimacy needs through vicarious trauma often manifest as feelings of emptiness when alone and intense difficulty enjoying solitude. Counsellors experiencing vicarious trauma may push away or increase their dependence on the significant people in their life (Trippany, Kress & Wilcox 2004, p.33).

The final basic psychological need of all humans, *Control needs*, reflects self-management and ability of the individual to express their feelings and direct their actions and future. Disruption to one's control needs can result in helplessness or over-control in other areas. The vicariously traumatised counsellor becomes distressed and questions their ability to take charge of their lives and influence their future (Trippany, Kress & Wilcox 2004).

5) Cognitive schemas, memory and perception, relates to how individuals process information about these fundamental psychological needs and develop their core beliefs about themselves and the world (Trippany, Kress & Wilcox, 2004). Pearlman & Saakvitne (1995b, cited in Trippany, Kress & Wilcox 2004, p.34) identify five aspects to an individual's *memory system*: verbal memory (cognitive narrative); imagery (images stored in the mind); affect (emotions experienced); bodily memory (physical sensations); and interpersonal memory (dynamics in current relationships). Traumatic memories become fragmented as they are stored across some or all of these five aspects and, without therapeutic integration of these fragments, interfere with self awareness and perception. Through empathic engagement in the therapeutic relationship, these traumatic memories can become temporarily or permanently incorporated into the counsellor's memory system, causing the counsellor to experience post trauma symptoms themselves, such as disturbing and intrusive traumatic images and thoughts, dreams, nightmares and dissociative episodes, and producing negative impacts for their safety, trust and control needs and for their interpersonal and intimate relationships (Blair & Ramones 1996).

Traumatic memories become fragmented as they are stored across some or all of these five aspects and, without therapeutic integration of these fragments, interfere with self awareness and perception

In summary, the consequences of vicarious trauma for the counsellor's personal and professional functioning can be profound. Symptoms associated with vicarious trauma generally mimic post traumatic stress symptomatology and manifest in the individual's physical, sensory, emotional, cognitive and reflective areas of daily functioning.

Understanding the risk

Vicarious trauma occurs within the context of an empathic relationship and connection with a traumatised client and her/his traumatic stories. A counsellor's ability to empathise is what makes them both most effective in their work with traumatised clients *and* most vulnerable to experiencing vicarious trauma (Figley 1995). A range of personal, professional and organisational factors are also associated with increased risk of developing vicarious trauma (Trippany, Kress & Wilcox 2004; Pearlman & Saakvitne 1995).

Personal factors include a personal history of childhood trauma; limited self awareness in relation to levels of anxiety, stress and physical fatigue; blurred boundaries between work and home; maintaining a work - life *imbalance*; and forgetting to participate in relaxing and pleasurable activities (Australian Childhood Foundation 2008; Trippany, Kress & Wilcox 2004).

Professional factors include inexperience and insufficient training in working with people affected by trauma; working solely or primarily with trauma survivors; number of hours spent each week working with traumatised people; long term exposure to traumatic stories; working with clients where tangible evidence of success is very limited; not accessing supervision or utilising its benefits; and over-empathising with clients' experiences and not maintaining strong boundaries (Bober and Regehr 2006; Australian Childhood Foundation 2008).

Organisational factors associated with increased risk for counsellors developing vicarious trauma include, limited awareness and understanding of the effects of vicarious trauma, compassion fatigue and burnout; cultures that blame and stigmatise; high caseloads with a large percentage of traumatised and complex clients; low commitment to professional development; and absence of a clear and reflective supervision model and process (Australian Childhood Foundation 2008; Trippany, Kress & Wilcox 2004; Bober & Regeher 2006).

Prevention and treatment

Just as vicarious trauma can develop in personal, professional and organisational contexts, strategies for treatment and prevention must also target these contexts. Pearlman & Saakvitne, (1995) and Trippany, Kress & Wilcox (2004) argue that counsellors working with trauma should monitor their own cognitive schemas and actively acknowledge and seek to resolve any disruptions experienced as a result of their work. Other recommended personal strategies reflect a range of self care activities typically prescribed for other forms of stress. These include, maintaining a personal life and a balance of work, play and rest; regular physical activity; social contact with friends; relaxation; finding creative outlets for energy; attending to spiritual needs; and participating in non-trauma volunteering or political activism.

Prevention and management strategies within the professional realm include, regular supervision with an experienced trauma-therapy supervisor; peer supervision as a means of minimising isolation, normalising vicarious trauma experiences, reflecting on practice and receiving support; professional development and training; build professional connections and networks; maintain connection with one's goals for working in the trauma field; and very importantly, advocating for a caseload balance that avoids overload of traumatised clients (Bober & Ramones 2006; Trippany, Kress & Wilcox 2004).

Organisational strategies for preventing and decreasing the effects of vicarious trauma on its workers include, providing a safe, private and comfortable workspace; creating an atmosphere of respect; developing adjunctive services and resources to support the trauma work; ensuring additional professional development resources and supports such as opportunities for supervision, consultation, professional development and adequate staffing; employee benefits, including pay rises; limiting the number of traumatised clients on the counsellor's caseload; and providing for caseload diversity and casework respite (Pearlman & Saakvitne 1995; Trippany, Kress & Wilcox 2004).

.....counsellors working with trauma should monitor their own cognitive schemas and actively acknowledge and seek to resolve any disruptions experienced as a result of their work.

Bober & Regeher (2006, p.8) argue that the organisation plays a critical role in preventing and adequately responding to vicarious trauma in its workers, and further, vicarious trauma intervention efforts should shift from education strategies (that aim to augment individual coping responses) to "advocacy for improved and safer working conditions". Research undertaken by these authors identified a positive association between the number of hours per week spent counselling traumatised individuals and the levels of traumatic stress and intrusion symptoms reported by counsellors. Further, the study found that "years of experience" was associated with higher levels of the longer term effects of disruption to belief systems around self-intimacy and other-intimacy. "This suggests that degree of exposure has an impact on intrusion and avoidance symptoms but that altered beliefs do not appear to occur in the short run" (p.7).

In terms of reducing counsellors' immediate traumatic symptomatology, the study concluded that personal self care strategies and professional support strategies were not effective, and that "the primary predictor of trauma scores is hours per week spend working with traumatised people…"(p.8). Bober & Regeher therefore argue that the solution to preventing and managing vicarious trauma lies in the organisation "distributing workload in order to limit the traumatic exposure of any one worker. This may not only serve to reduce the impact of immediate symptoms but may also address the potential longitudinal effects of disrupted beliefs regarding intimacy (p.8)"

Vicarious trauma develops in personal, professional and organisational contexts and therefore prevention and treatment strategies must also address these contexts.

Conclusion

Vicarious trauma is a serious, pervasive occupational stress condition that produces long term or permanent implications for the affected person's core beliefs about self, others and the world. By definition, vicarious trauma is unique to trauma work in a therapeutic setting and stems from counsellors' empathic connection with clients' traumatic material. Other stress conditions of burnout, compassion fatigue and countertransference can co-occur in a person's experience of vicarious trauma, however it is also considered to be distinct and distinguishable from these conditions. Vicarious trauma develops in personal, professional and organisational contexts and therefore prevention and treatment strategies must also address these contexts.

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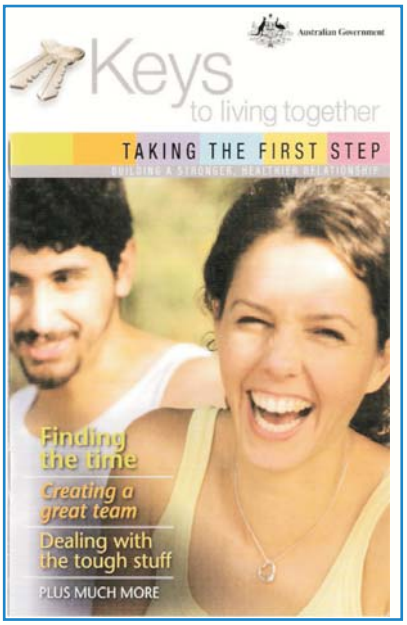
Resource Review

Keys to living together: Building a stronger, healthier relationship

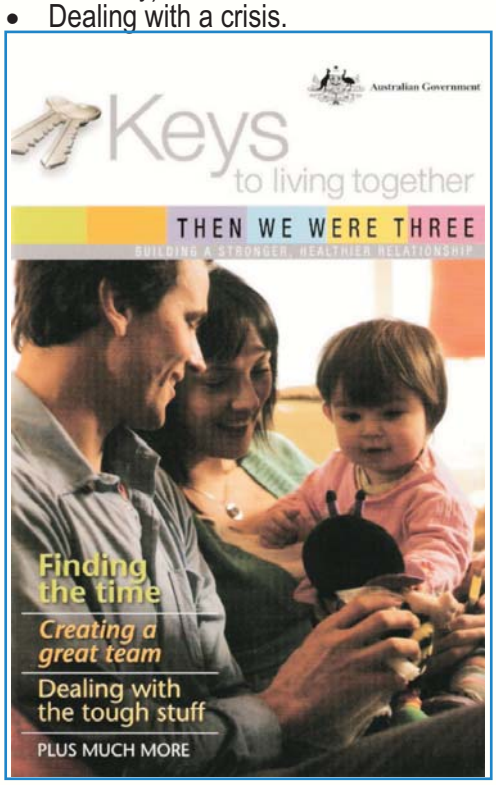
By Michelle Bradford, Education Officer, CDFVR



The Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) recently produced a series of three resource kits called, "Keys to living together". Each kit comprises a DVD and a mini magazine and offers tips, advice and suggestions aimed at building stronger and healthier relationships. The kits focus on couple relationships, parenting relationships and stepfamily relationships and each topic area is approached from a positive and protective perspective that values relationships and explores ways to strengthen and enjoy them. The kits are titled: "Taking the First Step"; "Then There Were Three"; and "Instant Families".

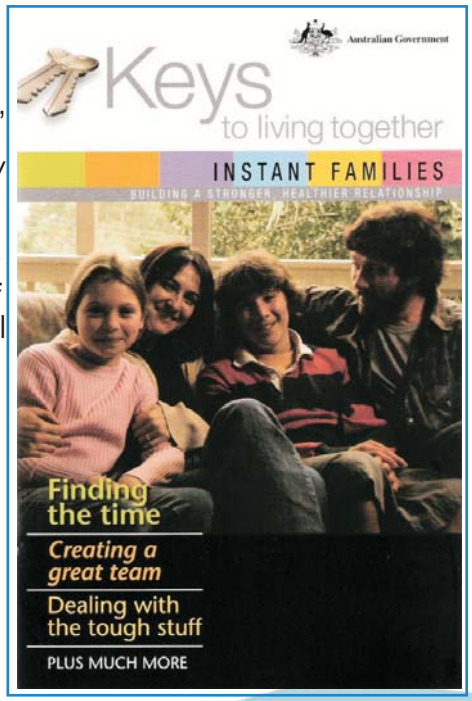
Taking the First Step explores the importance of a solid foundation for a healthy intimate relationship and presents a range of articles and activities about essential relationship tools for couples to consider. The topics covered include:

- Time for relationships (including setting expectations and priorities);
- Working together (including sorting out who does what, dealing with conflict);
- Parenthood (deciding whether or not to have children, expectations of parenting);
- Talking about the difficult stuff (including finances, moving in together, marriage, infidelity); and
- Dealing with a crisis.



Then There Were Three acknowledges and normalises the stress and tension that often accompanies a couple's transition into family-hood. The activities and articles contained in this kit aim to assist couples with preparing for the changes that childbirth and parenting creates for couple relationships, as well as providing suggestions for nurturing and strengthening their relationship. In addition to the topics explored in *Taking the First Step*, this kit also promotes ways for both parents to actively connect with their children, and steps to developing an agreed parenting approach.

Using the lens of blended or step-families, the **Instant Families** kit acknowledges the complexities and challenges inherent in moulding new families and draws on many of the same topic areas covered in the other two kits to explore strategies for nurturing and strengthening relationships. In addition to topics such as setting expectations and priorities; working together and dealing with conflict; managing finances; and dealing with crises, *Instant Families* examines the unique challenges of creating stability and predictability in the new environment; integrating individual personalities, wants and needs into the family's daily operations; and incorporating "strangers" into the new extended family unit, *"...research figures suggest that it can take from 18 months to five years for a stepfamily to 'shake down' into a new unit"* (p.18).



The "Keys to living together" kits are comprehensive and well considered and useful for supporting couples and families to value and nurture their relationships. The strength of each kit lies in its focus on concrete strategies for creating and maintaining safe, respectful and satisfying relationships.

Copies of the kits are available free of charge from FaHCSIA, phone 1800 050 009 or email: keys@fahcsia.gov.au; and electronic copies can also be downloaded from the Department's website: http://www.fahcsia.gov.au/internet/facsinternet.nsf/family/keys_info.htm. FaHCSIA also advises that it is currently preparing further resources kits for more family types and families with other needs.

Workshops, conferences and date claimers

02-04 Oct 2008
Discovering balance: prison reform, restorative justice and human rights Conference
Perth, WA
http://irjpr.net.au/conference/
Email: conference@irjpr.net.au

07-08 October 2008
Using Narrative Practice in Work with Groups and Communities
Brisbane, Qld
www.lighthouseresources.com.au
Email: info@lighthouseresoures.com.au

14-15 October 2008
Implementing Strengths Based Practice Within Organisations
Brisbane, Qld
www.lighthouseresources.com.au
Email: info@lighthouseresoures.com.au

20-23 October 2008
17th International Safe Communities Conference: Working Together to Make a Difference
Christchurch, New Zealand
http://www.conference.co.nz/index.cfm/Iscc08/Welcome/

21, 22 & 23 October 2008
Introduction to a Strengths Approach
Brisbane, Qld
www.lighthouseresources.com.au
Email: info@lighthouseresoures.com.au

31st October 2008
Distinguished Visitor Program - Randal Ross
Red Dust Healing Program
CQUniversity, Boundary Road, Planlands, Qld
Phone: 49407834
Email enquiries@noviolence.com.au

05-06 November 2008
Working with Children Living with Domestic Violence Using a Strengths Approach
Brisbane, Qld
www.lighthouseresources.com.au
Email: info@lighthouseresoures.com.au

05-07 November 2008
Family Relationship Services National Conference 2008 - Collective Wisdom: Together We are Better
Cairns, Qld
http://www.frsa.org.au/site

05-08 November 2008
The Australian Association for Infant Mental Health (AAIMH) - Angels in the Nursery
Supporting Parent-Child Relationships
Supporting benevolent parental influences
Adelaide, SA
http://sapmea.asn.au/conventions/aaimh08/index.html

10-14 November
Innovative Responses to Family Violence: Working with Offenders, Victims and Children
Sydney, NSW
http://www.signsofsafety.net/files/0811_10-4_inovative_responses_to_family%20violence_workshop_flyer.pdf

11-12 November 2008
Constructive Approaches to Difficult Conversations
Brisbane, Qld
www.lighthouseresources.com.au
Email: info@lighthouseresoures.com.au

18-19 November 2008
Constructive Ways of Working with Conflict
Brisbane, Qld
www.lighthouseresources.com.au
Email: info@lighthouseresoures.com.au

20-21 November 2008
QEC 5th Biennial International Conference - Reaching Out to Vulnerable Families: Achieving Better Outcomes for Children
Melbourne, Vic
http://www.qec.org.au/biennial-conference.php?id=61

25, 26 & 27 November 2008
Introduction to a Strengths Approach
Brisbane, Qld
www.lighthouseresources.com.au
Email: info@lighthouseresoures.com.au

26-28 November 2008
Criminology : linking theory, policy and practice - 21st Annual conference of the Australian and New Zealand Society of Criminology
Canberra, ACT
http://www.anzsoc.org/conferences/2008/

26-28 November
9th International Narrative Therapy and Community Work Conference
Adelaide, SA
http://www.dulwichcentre.com.au/conference.htm
Email: dulwich@senet.com.au

3-5 December 2008
International conference on homicide: domestic related homicide
Surfers Paradise, QLD
http://www.aic.gov.au/conferences/2008-homicide/index.html
Email: homicide@con-sol.com

22-23 Jan 2009
11th NZ Early Childhood Research Conference
Wellington, NZ
http://www.childforum.com/symposium.asp

18-20 May 2009
2009 Anaheim International Conference on Sexual Assault, Domestic Violence & Stalking
Anaheim, CA, USA
http://www.evawintl.org/conferencedetail.aspx?confid=7

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