Male counsellors and feminist practice in New South Wales sexual assault services: Perspectives of female counsellors and service users

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Statement of originality

I hereby certify that the work embodied in the thesis is my own work, conducted under normal supervision. The thesis contains no material which has been accepted, or is being examined, for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968 and any approved embargo.

Signature: ……...

Julie Hopkins

June 2020

Dedication

I dedicate this thesis to all survivors of sexual harm. I hope it makes a positive difference to their therapeutic journey and brings subsequent benefits to their lives. I dedicate this also to the professionals and managers within the health sector. I hope this thesis gives adequate pause for hearing women's voices and reflections and allows for considered thought to the best service responses we can provide. I hope they have the courage to listen to the real experts and to be fully trauma informed with actions and not just words. In the end, our goals are the same – to respect the dignity of each other and work together to make our services, and our world, a better place for us all to live in.

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Thank you, too, to my children for their patience and tolerance of me, while I hid away in my study or was distracted from their conversations with my mind immersed in thesis mode. I hope, though, I have shown you a love of ongoing learning, and what hard work and persistence can achieve. I look forward to being with you wholeheartedly and with my fullest attention from now on.

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To the service users, I thank you so much for your courage and your trust in me. It is a privilege to communicate the wisdom you own, and I hope that I have honoured this to your satisfaction.

Preface

I am proud to call myself a feminist. I carry this into my professional role as a social worker and my personal roles as a wife, friend, sister, daughter and, most importantly, mother. My feminist identity emerged through my undergraduate years at university that invited me to see the world differently. It opened my eyes to the position and powerlessness of women in society, the challenges we have had to overcome as a group, the fights that were ongoing, and the inequality and injustices experienced solely because of gender, not to mention the disadvantages experienced because of race, religion, age, and ability. Feminist writers and social activists, such as Gloria Steinem, Anne Summers, Eva Cox, Marilyn French, Germaine Greer, Helen Garner, Naomi Wolf, Leah Purcell, Susan Faludi, and Susan Mitchell, as well as academic feminists, like Lena Dominelli, Sandra Butler, and Claire Wintram greatly influenced my thinking. When I began to explore ideas for PhD research, feminist examinations of issues relating to women naturally drew my attention. Feminist thinking, values, ideas, and beliefs were congruent with my experience as a practising feminist social worker working in a sexual assault service. Hence, my feminist identity led to the standpoint I took in this research on women's experiences of sexual assault and sexual assault counselling.

In my clinical practice, I endeavour to be transparent, respectful, and aware of power dynamics, and personal and political issues. I try to raise awareness of the links between the personal and lived experience of my clients and the wider sociopolitical context. I strive to be reflexively aware of the influence of my values and judgements on my interactions with clients and colleagues alike. I value women's experiences and stories and believe they need to be heard, as they are valid and real and, indeed, essential to transforming social structures, policies, and service systems. They highlight the need to challenge stereotypical, gendered assumptions. To make the places in which we live and work more egalitarian and respectful, it

is imperative that we hear all the voices of those who live in this world. This includes the often-unheard voices of women to enable us to see their experiences from their point of view, understand the impacts of their experiences and situations, and hear their hopes, aspirations, interests, and expectations. To this end, this study enabled me to hear the voices of women who had consulted male counsellors on issues relating to sexual assault or abuse. These were the voices I had not heard in conversations surrounding whether male counsellors should be included and employed (or not) in government sexual assault services. I wanted to hear and understand the experiences of these women to learn from them and hear their views on ways in which service-delivery structures could change and grow. My aim, ultimately, was to ascertain how government sexual assault services could best meet their needs.

Abstract

Historically, sexual assault services (SASs) (in New South Wales Health, unless otherwise specified) have adopted a feminist perspective and routinely employed female counsellors working with survivors of sexual assault. The rationale for this stemmed from a gendered understanding of sexual assault, as most victims were women and most perpetrators were male. With no previous studies specifically on male counsellors working with adult female service users in SASs, there was little to guide their entry into this female-dominated domain. To maintain efficient and effective service delivery for female service users within SASs, the study explored two broad areas: the inclusion of and therapy with a male counsellor and ongoing relevance of feminist practice. It sought to provide an opportunity for female service users to add their voices to the conversation about the inclusion of male counsellors in SASs by exploring their unique experiences of, and perspectives on, therapy with male counsellors. In addition, the study enabled female counsellors to share their views on the possible impact of the routine inclusion of male counsellors on, and the currency of feminist practice within, government SASs.

The researcher used a qualitative, narrative-based, phenomenological feminist research approach to hear the women's narratives and gain an understanding of their experience, from their perspective. She conducted in-depth interviews with service users (n=10) and sole counsellors in a service (n=5) and focus groups (n=3) with counselling teams (n=12 focus group participants in three focus groups, n=7, 2, and 3 respectively) using an interview guide. In all, 17 counsellors participated in interviews and focus groups. All the participants came from rural and regional areas.

The findings showed that counsellors were more concerned about male counsellors in this therapeutic space than service users, who did not share their safety concerns. The

counsellors reiterated the importance of a feminist-informed approach. Most saw choice as core to overcoming power imbalances and enabling survivors to exercise control in counselling. The counsellors noted the restricted options for gender choice in rural and regional SASs and the cultural inappropriateness of male counsellors working with First Nations female sexual assault survivors. Further, counsellors and service users thought male counsellors should not work with female survivors in the acute phase. Some service users felt more comfortable talking to female counsellors about intimacy and sexual issues though not all felt comfortable with their approach. Overall, the counsellor-client relational connection and quality of the therapeutic relationship was more important than the counsellor's gender or feminism.

The study concluded that feminism continued to inform SAS practice, despite the shift to trauma-informed care. The counsellors experienced a lack of managerial support and thought managers should be knowledgeable about trauma and complex trauma and support them in responding effectively with up-to-date interventions. The study also showed the continued relevance of an inclusive structurally informed Health response that extended analysis of sexual assault beyond gender to class, race, and culture. The provision of inclusive services would position Health at the forefront in challenging the systemic issues perpetuating violence against women.

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Abbreviations

ABS	Australian Bureau of Statistics
ADVO	Apprehended Domestic Violence Order
AHRC	Australian Human Rights Commission
AIHW	Australian Institute of Health and Welfare
AIC	Australian Institute of Criminology
AIFS	Australian Institute of Family Studies
ALRC	Australian Law Reform Commission
ANROWS	Australian National Research Organisation for Women's Safety
APA	American Psychiatric Association
AVO	Apprehended Violence Order
CASAs	Centres Against Sexual Assault
CEDAW	Convention to Eliminate Discrimination Against Women
CSFV	Centre for Sexual and Family Violence
CJOST	Criminal Justice Sexual Offence Taskforce
COAG	Council of Australian Governments
DAGJ	Department of Attorney General and Justice
DaPP	Dad and Partner Pay
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECAV	Education Centre Against Violence
FACS	Department of Family and Community Services
FLC	Family Law Council
GBSV	Gender-based Sexual Violence
HILDA	Household, Income and Labour Dynamics in Australia report

HNE	Hunter New England
HREC	Human Research Ethics Committee
HREOC	Human Rights and Equal Opportunity Commission
ICD	International Classification of Diseases
ICD-11	International Classification of Diseases - 11th Revision
IPV	Intimate Partner Violence
ISTSS	International Society for Traumatic Stress Studies
LCARC	Legal and Constitutional Affairs References Committee
LHD	Local Health District
MASA	Men Against Sexual Assault
NCAS	National Community Attitudes towards Violence against Women Survey
NICSA	National Initiative to Combat Sexual Assault
NSW	New South Wales
NASASV	National Association of Services Against Sexual Violence
NSVAW	National Strategy on Violence Against Women
NSWLC	NSW Legislative Council
NWHP	National Women's Health Policy
NWJP	National Women's Justice Program
OSW	Office of the Status of Women
PADV	Partnerships Against Domestic Violence
PPL	Paid Parental Leave
PTSD	Post-Traumatic Stress Disorder
RGO	Research Governance Officer
SAAP	Supported Accommodation Assistance Program
SACCs	Sexual Assault Care Centres

SAS	Sexual Assault Service
SASs	Sexual Assault Services
SAMHSA	US Department of Health and Human Services' Substance Abuse and Mental Health Services Administration
SANES	Sexual Assault Nurse Examiners
SARCs	Sexual Assault Referral Centres
SATUs	Sexual Assault Treatment Units
SSA	Single Site Access
SORCs	Sexual Offences Referral Centres
SRCC	Sydney Rape Crisis Centre
UN	United Nations
VAW	Violence Against Women (NSW Strategy for)
WAB	Women's Affairs Branch
WAC	Women's Advisory Council
WCU	Women's Coordination Unit
WEL	Women's Electoral Lobby
WESP	Women's Emergency Services Program
WGEA	Workplace Gender Equality Agency
WHO	World Health Organisation
WRC	White Ribbon Campaign

CHAPTER 1

Introduction to the study

Why does it just have to be women [who support women]? (Victoria)

I think some people are going to say … if you give them a choice, they'll vote for the female every time, but I don't think we can ever know that (C3)

The ethic of choice has long been a catchcry of the feminist movement based on a woman's right to choose for herself within a male-dominated society. In Australia, 1970s feminist activists called on the state to institute programs and services for women to overcome the violence perpetrated against them. Not long afterwards, the language of choice re-entered the scene under the guise of economic rationalism and new public management signalling service-user choice within a privatised service marketplace. Some argued the government's service-user choice mantra was a deliberate attempt to undermine the women's movement and the meagre gains it had made. Sawer (2007) ominously portended the 'fall of the femocrat', referring to feminist bureaucrats who had made some inroads into male-dominated decision-making structures, advising government and serving on policy-making bodies relating to women's issues, while men's interest groups claimed men too had rights and pressured government for inclusive services. Thus, choice (or lack thereof) relating to the counsellor's gender within sexual assault services (hereafter SASs) happened within a choice-saturated service environment, where two interpretations of choice – as a feminist ethic and economic principle – muddied the waters. This qualitative study took place in this context. This chapter

describes the background to, and rationale for, the study, the problem it sought to address, its aims and research questions, and key concepts used in this thesis. It begins with a brief discussion of issues relating to research on sexual assault against women.

Issues for the sexual assault researcher

Feminist researchers have long drawn attention to the highly sensitive nature of qualitative research on sexual violence, which, by its very nature, involved 'repeated exposure to painful experiences of sexual violence, humiliation, and abuse' (Coles et al., 2014, p. 97). They have highlighted the dangers of retraumatisation in talking to women about sexual assault and, in turn, the traumatisation of researchers engaged in such research (Campbell, 2002; Campbell & Wasco, 2005). Coles et al. (2014) observed that 'sexual violence researchers, who have extended contact with trauma victims are, perhaps, especially likely to be at increased risk of experiencing vicarious traumatization' (p. 96). Norris (2011), too, highlighted several issues for the sexual assault researcher. One concerned how the researcher promoted women's sense of agency in any given situation, including research interviewing. Here Norris (2011) noted a positive trend from terms like 'rape prevention' to 'sexual assault risk reduction', as it acknowledged that risk reduction did not ensure risk elimination and, thus, removed the burden of preventing rape from the woman, while emphasising steps she could take to reduce risk. It also emphasised that women did not have complete control over whether men raped them. Secondly, as a sexual assault researcher, who had also studied alcohol consumption and knew that alcohol decreased a woman's ability to recognise possible risk cues, Norris (2011) faced the dilemma of how to research the role of alcohol in sexual assault. There were many sensitive issues like this where researchers risked crossing the line into myths relating to women's behaviour in provoking sexual assault. To study women's responses to sexual assault without

appearing to blame the victim, feminist researchers validated women's experience and promoted agency and assertive resistance.

The researcher was aware of the sensitivity of her research and the judgement and blame that survivors faced and so was careful in the words she used and the way she formulated the interview questions. She also considered the pacing of the interview and spent time on developing rapport before proceeding. Due to the sensitivity of sexual assault and abuse, the researcher explained at the outset that the participant did not need to recount the details of the violence that had happened to them. She established the parameters of the interview and made the expectations clear by restating that the purpose of the interview was to hear about their counselling experiences. All she needed to know was whether the abuse had occurred in childhood or adulthood and whether it was familial or non-familial. This enabled the researcher to enter the conversational interview with an understanding of the boundaries in place and thereby lessen the risk of traumatisation from hearing stories of personal violence. As an experienced sexual assault counsellor and social worker, the researcher was well used to hearing such stories and adept at establishing clear boundaries and agreements in the beginning stage of the relationship. The researcher was also well versed in the need for debriefing and supervision, as required. As Visser (2017) noted, 'debriefing is something that could potentially benefit researchers in offloading after an interview' (p. 11). The researcher dealt with possible concerns about confidentiality and privacy by only discussing the interview content with her research supervisors. She adopted a reflexive stance and felt well prepared to embark on the interview process, with a sound knowledge of the topic and common issues inherent in the experience of sexual assault research and sexual assault counselling, aware of self, power, and positionality (Fenge et al., 2019). Fenge et al. (2019) noted that 'developing a reflexive stance may support researchers to develop "self-care" when working with disturbing data' (p. 3). The

researcher further outlines the way in which she dealt with these and related issues arising in this research in Chapter 7.

Researcher's positionality

As Kralik and van Loon (2008) observed, it is important, at the outset, that the researcher explain her positionality and its effect on the values underpinning, and her assumptions going into, the research process. The researcher is a white, middle-class woman with 11 years' experience in sexual assault counselling. She is also a qualified social worker with values firmly rooted in a feminist standpoint of transparency, respectful engagement, and awareness of power and gender dynamics and the links between personal experience and the wider sociopolitical context. She strives to be reflexively aware of the influence of her values and judgements on her interactions with clients and colleagues alike and values women's experiences and hearing their stories as valid, real, and essential to transforming social structures, policies, and service systems. Informed by her feminist standpoint and values, and practice experience, the researcher's assumptions on initiating the study were as follows:

1. Female counsellors believed that male counsellors could fill a service gap, particularly in working with men and male adolescents, as well as women; they could provide a male 'role model' and challenge women's fear of men.
2. Male clinicians had filled a few positions in government SASs in New South Wales (hereafter NSW), though were not working mainly with women.
3. Internationally, male counsellors worked with males and females in SASs.
4. Government SASs still routinely advertised for female-only counsellors.
5. SASs still operated from a feminist perspective.
6. There were male counsellors working with women about their experiences of sexual assault, especially in private services.

7. Service users could tell her whether they felt their work with a male counsellor had been helpful to them.
8. From their stories, the researcher could gather evidence to show whether service-users' experiences related to forms of practice consistent with feminist thought.
9. A safe space for counselling was essential for healing.
10. There would be some discomfort from female counsellors and service users in government SASs about male counsellors entering the healing space.
11. Female counsellors could share their views about the inclusion of male counsellors in government SASs.

These assumptions flowed from the researcher's practice as a feminist sexual assault counsellor. Her feminist approach also informed her choice to study the experiences of counsellors and service users. However, there were many differences between her clinical and research role, though both shared the aim of hearing women's stories and improving women's lives. The researcher explains this further in the background to, and rationale for, the study.

Background to the study

Historically, female-dominated SASs have adopted a feminist perspective and mainly employed female counsellors working with women who have been sexually assaulted (Astbury, 2006; Carmody, 1990, 1997). The rationale for this stemmed from NSW Health's understanding of the gendered nature of sexual assault and abuse, given most victims were women and most perpetrators were male (Evans, 2003; NSW Health, 2003, 2004, 2013, 2020). To date, routine recruitment requirements specified that government SASs reserved counselling positions for females, although NSW SASs had employed male counsellors on limited case-by-case occasions, due to service mergers and policy change to bring them into the sexual assault and violence prevention landscape. Nevertheless, this was a long-established

women's domain that interpreted sexual assault through the lens of gendered power relations, specifically male dominance and privilege within patriarchal social structures (Brenner, 2014; Evans, 2003; DeKeseredy & Schwartz, 2010; Morgan, 2011). Given the long-held assumption that female counsellors in SASs practised from a feminist perspective, the researcher wished to explore female counsellors' views on the changes to the SAS landscape that might accompany the routine inclusion of male counsellors. The researcher was curious to know whether this change in policy and service delivery challenged the well-established feminist stance on sexual assault and feminist-informed practice within the sector and wondered what impact it would have if relevant policy changes cemented this stance. Thus, the central question arose: What were the views and, where appropriate, experiences of female counsellors on the inclusion of male counsellors in SASs?

Secondly, the researcher wanted to hear the voices of female service users on the issue of male counsellors. Among other things, she wanted to know whether their views were consistent with those of professionals and academics in the field: What were the experiences of adult female survivors of sexual assault or sexual abuse, who had consulted male counsellors on this presenting issue, in government or nongovernment services?

More broadly, the researcher wanted to explore the impact of greater inclusivity generally. She believed that examining changes surrounding the employment of male counsellors in NSW SASs might raise similar issues as any move towards greater inclusivity: Were female-only services reinforcing the very rigid gender roles and stereotypes of masculine and feminine identity, traits, roles, and responsibilities they sought to change? Were they, indeed, maintaining the *status quo*? The inclusion of male counsellors challenged the rigid gender stereotypes of female-only SASs arising from the perceived direct relationship between gender inequality and violence against women. It also opened the possibility that male

counsellors could influence the attitudes and behaviours of men who perpetrated violence or condoned, minimised, or dismissed such behaviours (NSW Health, 2020).

Relatedly, the researcher wished to explore the impacts of these changes on organisations: What adaptations in organisational culture and employment practices might the service need to accommodate these changes? In addition, she wanted to know whether, and how, the employment of male counsellors in NSW SASs might, or had already, changed the dominant feminist ethos in policy and clinical practice. The researcher was curious to know whether male counsellors, like female counsellors, could develop relationships that facilitated and promoted the healing of adult female survivors of sexual assault or sexual abuse, and whether an adherence to a feminist stance made this possible. From a feminist perspective, given its ethic of choice, the researcher wondered whether providing service users the option of having a male or female counsellor might be a feminist way of practising or was this change another instance of patriarchy flexing its muscles in a backlash against feminism, given its historic marginalisation of men, including male counsellors, in SASs with women-only workforce These questions arose in a cultural context of growing information on, and awareness of, men's health and rights and a deepening understanding of male victims of sexual abuse stemming from the Australian Government Royal Commission into Institutional Responses to Child Sexual Abuse 2013-2017 (hereafter Royal Commission) (Commonwealth of Australia, 2017).

Rationale for the study

The researcher's initial thoughts on the role of male counsellors in SASs began when the government health service, where she worked as a sexual assault counsellor, introduced a male psychiatric registrar. This groundbreaking change raised concerns within the sexual assault counselling team about a male working in the longstanding female-dominated workplace

environment of SASs. These concerns centred on the possible impact of this change on female service-users' sense of safety within the service. In response, the supervising psychiatric specialist informed the team that international SASs accepted male clinicians and the addition of a male to the service would be beneficial to all client groups. She did not present evidence to support this assertion and so, for the researcher, critical questions emerged. Could it be that the gender of the therapist was less of an issue than previous analyses had led us to believe, or did the importance lie more in the practice framework being feminist informed, with the gender of therapist being an added, or secondary, factor? Was gender more important than other factors when the presenting issue was sexual assault? Would service users agree? With no conclusive evidence to date, was the gender of the therapist an essential element in a safe and effective therapeutic relationship for sexual assault counselling? As feminist understandings highlighted the need to consider and address power inequalities in society that resulted in violence against women, so too was there a need to consider power issues within the therapy room. Did providing a choice of gender of counsellor go some way to promoting power balances between therapist and service user and did this link to the challenge of power imbalances between men and women in society in general?

While the male registrar did work with adult women, he also worked with children and adolescents of both genders at the SAS. In time, the team became familiar with, and began to value, his framework and practice because he held a clear feminist stance and demonstrated a strong commitment to social justice. However, the questions remained as to female service-users' experiences of male clinicians in this therapeutic field, particularly in relation to counselling beyond psychiatric assessment and intervention. Such questions remained despite anecdotal claims that male counsellors could provide a positive role model for men and women, boys and girls, and develop and promote safe, trusting relationships with female service users. These claims contradicted what the team had heard, as part of their work, about male

counsellors in the private sphere on occasion not believing the stories of female service users. Hence, the researcher was interested in the experiences and views of women service users and wanted to hear their voices in these conversations. Often, these women had experienced complex trauma and multiple instances of violence, betrayal, and hurt through their childhood and adult years. They were best qualified to speak about their experiences with male counsellors.

Statement of the problem

Previous studies on male counsellors working with adult female service users in SASs appeared limited, if not absent. Anecdotal information suggested that male counsellors working with adult female service users could benefit this client group but there was no known evidence from women service users to support this claim. If such information were available, there lay the potential to support policy and service change leading to the routine inclusion of male counsellors in government SASs rather than a limited case-by-case basis. Further, there had been little research examining the currency of feminism in government SASs (Egan, 2019). An Australian researcher, Egan (2016, 2019), undertook a comprehensive study of SASs in NSW:

> In-depth interviews were conducted during 2008 and 2009 with practitioners recruited from ten NSW sexual assault services selected to represent the diversity of the sector (urban and rural, non-government and government). Two-thirds of the participants were sexual assault workers and one-third service managers, the majority of whom continued to be involved in direct client work (Egan, 2016, p. 99).

Egan (2019) noted that some feminist scholars had expressed concern about the depoliticisation of the issue of sexual violence against women within these services, with an observed shift towards individualised service responses rather than a broader structural focus on political activism and social change.

Aims of the study

This research sought to assist in the informed implementation of appropriate, responsive, effective, and efficient service delivery for adult female service users within NSW SASs. In keeping with its feminist research objectives, it aimed to develop 'knowledge explicitly dedicated to bringing about change and improvement in our situation as women' (Wadsworth, 2001, p. 2). In keeping with this ethos, the study aimed to provide an opportunity for women service users to add their voices to the conversation about the inclusion of male counsellors in the traditionally female-oriented workplace of NSW-government SASs by exploring their unique experiences of, and perspectives on, sexual assault counselling with male counsellors. The study did not include women service users who had not sought therapy from a male counsellor, as the focus of the research was on female service-users' reflections on their experiences of therapy with male counsellors, where the main issue was sexual abuse or sexual assault.

Secondly, the study aimed to enable female counsellors to share their views on the currency of feminist practice within government SASs, and the possible impact of the inclusion of male counsellors on this sector, whether and how the culture of service delivery had changed over time, and what further changes might be needed to accommodate their inclusion. It thus explored the experiences and perspectives of:

- Female counsellors employed in NSW-government SASs.
- Adult female service users who had engaged in counselling with a male counsellor, as adults (18 years old and over), at a government, nongovernment, or private service about sexual assault or sexual abuse, whether the violence occurred in childhood or adulthood.

The researcher wanted to hear what adult female service users had to say about their experiences: 'I wanted a conversation led by the women who'd been left out' (Gates, 2019, pp. 62-63). A prior study of NSW SASs had not interviewed service users (Egan, 2015). This study, therefore, was unique in adding a service-user perspective. As Ullman (2010) observed, it was essential to study survivors' experiences from their own perspectives to:

> Contribute vital knowledge about their experiences in narrative forms and tell us how they feel informal and formal support providers can be helpful. The lack of survivor-informed scholarship is a problem … in the field of sexual assault … Qualitative research can be just as theoretically driven and rigorous as quantitative data, but it yields a richer and more complex set of data that go beyond quantitative research that limits women to the few response options that researchers think of to offer respondents (p. 140).

Draucker (1999) highlighted the importance and relevance of hearing service-users' views and experiences: 'Understanding survivor's perceptions of their therapy experiences and their beliefs about their therapeutic needs could help clinicians understand how formal mental health services may better meet the needs of women who have been sexually assaulted' (p. 19). Similarly, Ullman and Townsend (2008) noted:

> Reports from victims are an important source of information about what type of support they need and feel is helpful. However, it is also important to seek the perspectives of advocates whose role it is to provide direct support and help victims to access resources from other systems (p. 300).

The *National Standards for the Primary Prevention of Sexual Assault through Education* issued by the peak body in Australia, the National Association of Services Against Sexual Violence (NASASV), in 2009 noted service users were the best source of information on the

effectiveness of service delivery and counselling practice. Their authors, Carmody et al. (2009), reiterated that NASASV gave priority to 'client-based review and feedback, research literature, reflective practice and outcome evaluations methods that are client focussed' (p. 23). Therefore, service-user's assessments were essential to the continued enhancement and effectiveness of clinical practice and service delivery, as well as the development of best practice models. Thus, for this study, not only was it essential to hear service-users' voices to have a full and inclusive conversation but also it was imperative for best practice and optimal service delivery to meet the counselling needs of women survivors of sexual assault. The outcomes of the study could then be available for consideration to inform service development and policy implementation. This was particularly relevant at the time of the study with the restructuring and redesign occurring in NSW Health services generally and in sexual assault and violence prevention services specifically.

Initially, the researcher had planned to include male counsellors in the study to obtain their views and experiences of providing specialist therapy to adult female survivors. However, the Hunter New England (HNE) Health ethics committee, an authorising body for research approval and access to Health services, from which the researcher needed authorisation to conduct this study, did not approve this approach. The reason provided by the ethics committee surrounded the concern that the perceived low number of male counsellors in this field would compromise the privacy and confidentiality of the male counsellor participants. Furthermore, while undertaking the research, the researcher became aware of the limited information on effective service models within specialist SASs or generic services (NSW Health, 2020; Wall et al., 2016). To summarise, the study aimed to:

- Provide an opportunity for women service users to add their voice to the discussion about male counsellors in the traditionally female-oriented workplace of sexual assault counselling.

- Explore women service-users' subjective experiences of, and unique perspectives on, consulting male counsellors.
- Add service-users' wisdom for consideration in service development and policy implementation, particularly at a time when restructuring and redesign was occurring in NSW Health services generally and in sexual assault and violence prevention services particularly.
- Enable female counsellors to share their views on the relevance and currency of feminist practice within government SASs, the impact of the inclusion of male counsellors on the workplace environment, and actual or needed changes to the culture of service delivery to accommodate their inclusion.
- Gain insight into the policies and cultures of SASs in this changing environment related to effective interventions and recruitment and employment practices.

Research questions

Essentially the study explored two broad areas: inclusion of and therapy with a male counsellor and ongoing relevance of feminist practice in NSW SASs. Thus, there were two broad research questions for counsellors, as follows:

1. What were their views on the inclusion of male counsellors and its impacts on SASs?
2. What were their perceptions relating to the ongoing relevance of a feminist philosophy and practice?

And two broad research questions for service users as follows:

3. What were their perceptions of their experiences of therapy with a male counsellor and its (positive and negative) impacts?
4. What, if any, elements of feminist practice did they experience?

Structure of thesis

This thesis comprises 10 chapters. Following this chapter introducing the study, Chapters 2 and 3 review the literature on sexual assault and the feminist perspective, and sexual assault counselling and therapeutic approaches, respectively. Chapters 4 and 5 respectively describe national and NSW state policy, while Chapter 6 discusses the service context and Chapter 7 outlines the research methodology. Chapters 8 and 9 present the study's findings from counsellors and service users respectively. The final chapter contains a discussion of the findings, outlines the study's conclusion and implications for policy and practice, ending with suggestions for future research.

Key concepts used in the study

The following definitions lend clarity to key concepts informing, used in, and most relevant to, this study.

Complex trauma

Complex or developmental trauma arises from a person's exposure to multiple, severe, and pervasive traumatic events, such as prolonged abuse or profound neglect. These traumatic events are often invasive and interpersonal in nature and have wide-ranging, long-term effects (Briere & Scott, 2015). The International Society for Traumatic Stress Studies (ISTSS) (2019a) defined complex trauma as including three core elements of Post-Traumatic Stress Disorder (PTSD), as well as three additional elements associated with the impact of trauma on systems of self-organisation, specifically emotion-regulation difficulties, negative self-concept, and interpersonal relationships problems (Berliner et al., n.d.; Oprel et al., 2018). Salter (2019) reported that the women he interviewed described complex trauma as a relational experience in that it affected their relationships, though they felt its physical impacts (psychosomatic pain

and bodily fatigue and tension) most keenly. Professionals, however, tended to address psychological rather than physical symptoms and their relational impacts (Salter, 2019).

There was some variation, however, in official diagnostic recognition of Complex PTSD (C-PTSD), also referred to as complex trauma. This had an impact on research as most researchers selected subjects based on officially recognised diagnoses. Specifically, the most recent fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association (APA), 2013) does not include this diagnostic category (Kezelman & Stavropolous, 2019; Shapiro, 2018). However, the 11th revision of the World Health Organisation's (WHO, 2018) International Classification of Diseases (ICD-11) will include C-PTSD from January 2022 (Kezelman & Stavropolous, 2019).

The ISTSS (2019b) Expert Consensus Guidelines for Complex PTSD recommended a phased approach for complex trauma treatment. Kezelman and Stavropoulos (2019) described the 'gold-standard' phased-treatment model: Phase I involved safety and stabilisation, Phase II processing, and Phase III integration. They added that Phase I was vital to trauma recovery; it was impossible to overstate 'the importance of this step' (p. 42). The ISTSS (2019b) provided the latest guidelines on PTSD in adults.

Domestic abuse

The term domestic abuse aimed to convey the message that domestic violence was about more than the commonly understood element of physical violence (as explained below). It emphasised that coercive control was an intrinsic element of violent interpersonal relationships (Hill, 2019).

Domestic violence

In her review of domestic violence in Australia, Mitchell (2011) noted:

> Domestic violence refers to acts of violence that occur between people who have, or have had, an intimate relationship in domestic settings. These acts include physical, sexual, emotional and psychological abuse. Defining forms of violence, its perpetrators and their victims, is complicated by the many different kinds of intimate and family relationships and living arrangements present in Australian communities. Domestic violence is most commonly perpetrated by males against their female partners, but it also includes violence against men by their female partners and violence within same-sex relationships (pp. 1-2).

As discussed below, writers used the term domestic violence interchangeably with family violence.

Family violence

The Australian Law Reform Commission (ALRC) and NSWLRC (2010) noted there was no distinct or consistent definition of family or domestic violence. Family violence encompassed varying degrees of severity and took many forms, including:

> Physical abuse, sexual abuse, damage to property, emotional abuse, social abuse, economic abuse, psychological abuse, and spiritual abuse. Whatever form family violence takes, a central feature is that it involves a person exercising control and power over the victim by inducing fear, for example by using threatening behaviour (p. 189).

Family violence was a culturally inclusive term: 'For many indigenous people the term family violence is preferred as it encompasses all forms of violence in intimate, family and other relationships of mutual obligation and support' (ALRC & NSWLRC, 2010, p. 189). Some indigenous communities also preferred the term 'community violence' for this reason.

Feminism

Feminism is an ideology based on a gendered analysis of power relations in which women were insubordinate to men. It fought for social attitudes and practices that undermined male dominance and promoted gender equality and women's emancipation (Gamble, 2001). Historian Linda Gordon (1979) defined it as an 'analysis of women's subordination for the purpose of figuring out how to change it' (p. 107). Eisenstein (1984) noted it was not just one way of thinking but contained multiple views, always with the interests of women at its centre and aims to benefit and advance women's position in society. Andrew (2014) advised that the common typology distinguishing between liberal, radical, and socialist feminism might not necessarily apply to Australia as it did not fit the distinctions feminists made at the time, as 'individuals could have been more than one of those things at various times, or even [simultaneously]' (Magarey, 2005, p. 10). For ease of reading, the researcher uses the terms feminist perspective, feminism, and feminist inclusively to reflect diverse feminist thought and activities and, where she discusses a specific form of feminism, she uses that particular term accordingly.

Liberal feminism

Calling for change within male-dominated sociopolitical structures, liberal feminists fought for 'equality of opportunity for women within the public sphere' (Gamble, 2001, p. 36), including their right to participate in public life, to be involved in politics and hold political positions, vote, and own property (Eisenstein, 1984).

Radical feminism

Radical feminism called for a revolution to dismantle male-dominated sociopolitical, legal, and cultural structures that upheld unequal power relations. Its goal was to eradicate patriarchy as the primary source of oppression against women (Gamble, 2001). Eisenstein (1984) observed

that radical feminism held that oppression against women, due to their sex, was the oldest form of domination and was the basis of all other forms of discrimination and disadvantage.

First-wave feminism

First-wave feminism spanned the 1790s to the mid-1900s (Gamble, 2001). Known as suffragists, women actively involved in this movement in Australia believed in peaceful, constitutional campaign methods (Maguire, 2019). They focused on equality between men and women and challenged the dominant patriarchal ideology in the public-private sphere. Their main achievement was suffrage for women (Gamble, 2001; Maguire, 2019). Eisenstein (1984) observed that first-wave feminism embraced liberal-feminist and socialist perspectives. The first wave of political protest and awareness raising also focused on women's economic and social justice rights (Maguire, 2019).

Second-wave feminism

Second-wave feminism spanned the 1960s to the 2000s. Its primary aim was to challenge dominant ideological representations of females and femininity through its focus on gender-identity-based hierarchies (Gamble, 2001) and 'to build a society that was less hostile to women and girls' (Maguire, 2019, p. 2). Eisenstein (1984) noted that it examined 'sexuality and sexual behaviour in its social and political context' (p. xv). Carol Hanisch coined the catchphrase the 'personal is political' during this time (Eisenstein, 1984). Consciousness-raising groups were a central feature of this wave of the women's movement (Brown, 2008).

Third-wave feminism

Referring to feminism in the 1990s to early 2000s (Maguire, 2019), third-wave feminism embraced continuity and change, and accepted pluralism as a given, on the 'understanding that no account of oppression is true for all women in all situations all of the time' (Gamble, 2001, p. 43). Eisenstein (1984) noted that:

> There has been something of a retreat from universalism, and an acknowledgement of the diversity of women's experience and situation with respect to race, class, nationality, religion, and other specificities. This is a healthy development. The future evolution of feminist thought must take account of the complexity of women's experience (p. xvi).

Among the diversity of political action and thought during this period, two were foremost with a third following:

- The Girl Power, Riot Grrrl, and DIY Feminism strand, while committed to the goal of equality between the sexes, also promoted fashion and fun, and encouraged expression and displays of anger and aggression in telling the truth about women's lives.
- 'Power feminism' or New Feminism rejected the notion of women as victims (a function of the second wave). Rather, they viewed the fight for equality as largely won; all that remained was for women to take and own the power that was theirs.
- 'Influence[d] by intersectionality theory' (Maguire, 2019, p. 5), a third group of 'third wavers' connected to the history of the women's liberation movement and saw their struggle as an advancement of this. They aimed to further the structural analysis of sex and gender by showing the influence of intersecting categories of race, sexuality, class, gender, ethnicity, religion, and other social categories on women's position and treatment in society (Maguire, 2019).

Postfeminism

Though there was no agreed-upon definition of postfeminism, from the 1980s onwards, the 'backlash' to second-wave feminism's focus on victimisation, autonomy, and responsibility critiqued its implicitly heterosexist and anti-male orientation. It sought an agenda that found a

place for men. Critics of postfeminism saw this as a contemporary manoeuvre to discredit feminism and as regressive for women (Gamble, 2001).

Fourth-wave feminism

Maguire (2019) explained that this contemporary movement had developed intersectionality into 'a crucial, central idea of mainstream feminist thinking' (p. 9). Consequently, it had become 'uncontroversial, obvious even, to say that feminist discourse and action must be grounded in the understanding that racism, homophobia, transphobia, class, economic inequity, age and disability discrimination intersect with sexism and misogyny' (Maguire, 2019, p. 9). An additional development of this movement has been the 'collapsing and morphing of gender and sex binaries … [and] a more nuanced and complicated understanding of sex, gender and the relationship between the two' (Maguire, 2019, pp. 9-10). It brought terms like 'cisgender', 'queer', and other gender-neutral pronouns into mainstream consciousness (Maguire, 2019).

Feminist

Feminist refers to a view of social phenomena focused on gendered power relations leading to the subordination of women. Eisenstein (1984) provided this explanation:

> In my understanding of the term 'feminist', then, I see an element of visionary, futuristic thought. This encompasses a concept of social transformation that, as part of the eventual liberation of women, will change all human relationships for the better. Although centrally about women, their experience, condition … feminism is therefore also fundamentally about men, and about social change (p. xiv).

Maguire (2019) defined a feminist as 'someone who works to correct the injustices and inequalities that stem from sexism and misogyny' (p. 13).

Feminist practice or therapy

Feminist practice based on feminist ideology surrounding women's oppression included an analysis of power dynamics (Brown, 2008). Feminist therapy emerged from female therapists' challenge to the male-dominated field of psychotherapy that held the male perspective as absolute and contained many sexist attitudes and ideas. Brown (2008) wrote that 'feminist therapy sprang into existence at the end of the 1960's as a form of protest against sexism in the mental health professions' (p. 277).

Gender

Brown (2008) defined gender as 'a set of socially constructed roles and ways of relating … conveyed to infants based on the sex to which they are assigned' (p. 285). As Eisenstein (1984) explained, 'the sense of one's gender … was arrived at in response to the environment of the family, to the interaction between parents and child' (p. 6). As such, 'gender was the culturally and socially shaped cluster of expectations, attributes, and behaviors assigned to that category of human being by the society into which the child was born' (p. 7). Further, the term 'gender' has been defined as a social term or construct (Brown, 2008; Eisenstein, 1984) that focuses on two sexes (particularly in the Western world) (Brown, 2008) and also to distinguish the diversity of sexual orientations not captured within the binary notion of sex, where the individual was male or female based on physical characteristics. As Brown (2008) noted, 'in patriarchy … those characteristics constructed into masculinity are valued, and those associated with femininity devalued, even when the person exhibiting feminine characteristics is of the male sex' (p. 285). Non-binary notions of gender have led to acknowledgement of lesbian, gay, bisexual, transgender, and intersex people commonly referred to as LGBTI. Gender studies and identity politics have drawn attention to these variations broadening the initial focus of women's studies arising in the 1970s (Eisenstein, 1984).

Gender-Based Sexual Violence (GBSV)

GBSV was an umbrella term incorporating, and used interchangeably with, domestic violence, intimate partner violence, rape, sexual abuse, sexual assault, sexual violence, and violence against women. More specifically, the United Nations High Commissioner for Refugees (n.d.) defined sexual and gender-based violence (SGBV) as any act perpetrated against a person's will, 'based on gender norms and unequal power relationships. It encompasses threats of violence and coercion. It can be physical, emotional, psychological, or sexual in nature, and can take the form of a denial of resources or access to services. It inflicts harm on women, girls, men and boys' (n.p.).

Intimate Partner Violence (IPV)

IPV was another form of GBSV that involved 'violence largely between family members and intimate partners, usually, though not exclusively, taking place in the home' (Krug et al., 2002, p. 6). It included 'behaviour within an intimate relationship that causes physical, sexual or psychological harm to those in the relationship, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours' (WHO, 2014, p. 82).

Patriarchy

The term 'patriarchy' derives from the Greek word meaning 'the rule of the father' (Eisenstein, 1984, p. 5). This term formed an important part of the feminist critique of power relations to explain why society subordinated women's interests to those of men. Feminists regarded patriarchy as 'a system of institutionalised oppression maintained by ideological means' (Gamble, 2001, p. 37). It was the primary form of female oppression; without its elimination, other forms of oppression would continue. Eisenstein (1984) cited feminist Kate Millett's view of the way in which patriarchy continued in society:

> Instead of being openly coerced into accepting their secondary status, women were conditioned into embracing it by the process of sex-role stereotyping. From early childhood, women were trained to accept a system which divided society into male and female spheres, with appropriate roles for each, and which allocated public power exclusively to the male sphere (p. 6).

Further, prevailing social attitudes embedded patriarchy into the social structure, intrinsically shaping people's sense of self and others (Eisenstein, 1984). More evolved understandings of patriarchy also considered its impact on men: 'Patriarchy is an invisible mainframe that regulates how we live. It sets parameters around "acceptable" behaviour for both genders: men should be "strong, independent, unemotional, logical and confident", and women should be "expressive, nurturant, weak and dependent"' (Hill, 2019, p. 135).

Post-Traumatic Stress Disorder (PTSD)

PTSD was a diagnosis given to trauma survivors exhibiting chronic reactions (that continued more than one month after the traumatic event). Symptoms warranting this diagnosis included 'persistent hyperarousal, avoidance of reminders of the traumatic event, involuntary recall of the incident (e.g. via intrusive images or flashbacks) and compromised quality of life' (Kezelman & Stavropolous, 2019, p. 258). The third edition of the DSM (APA, 1980) included this diagnosis in response to the trauma symptoms exhibited by men returning from the Vietnam War, following the work of feminist therapists and mental health workers working with Vietnam veterans (Brown, 2008).

Rape

Sasson and Paul (2014) defined rape as 'completed or attempted unwanted vaginal, oral, or anal penetration through the use of force or threat of physical harm, or when the victim is unable to consent because he or she is drunk, high or unconscious' (p**.** 35). Many have

challenged definitions connecting rape with 'force' and the term rape remained ambiguous and inconsistent (Bagwell-Gray et al., 2015). As Cossins (2019) noted, rape was not a consistent legal term across Australia's states and territories, though scholars and the broader community used this term when referring to sexual intercourse without consent.

Rape culture

Eisenstein (1984) wrote 'rape culture' referred to 'the pervasive male ideology of rape' (p. 32) that denoted 'a cultural atmosphere in which the raping of women was taken to be normal, even expected, and in which male attitudes towards women, and those of women toward themselves and other women, were colored by this assumption' (p. 32). Rape culture implied the pervasiveness of rape myths, discussed below.

Rape myths

Kashmider et al. (2015) defined rape myths as 'beliefs held by many individuals within society that surround rape and sexual assault. Rape myths are untrue, can minimize the experience of rape, and are distinguished from rare situations in which the victim has fabricated details' (p. 8).

Sex

The biological makeup of a person (Eisenstein, 1984).

Sexual abuse

Generally, the term 'sexual abuse' referred to acts of sexual violence against children that, because of their age and level of development and understanding, were nonconsensual (Tarczon & Quadara, 2012). The NSW Health (2020) policy and procedures defined sexual abuse as 'sexual activity or behaviour that is imposed, or is likely to be imposed, on a child or young person by another person' (p. 10).

Sexual assault

NSW legislation defined 'sexual assault' as a penetrative sexual offence, i.e., one involving penetration of the genitalia by part of the body, including the penis or mouth or finger, or an object (ALRC & NSWLRC, 2010). The NSW Sexual Assault Strategy (2018-2021) noted 'sexual assault' was a broad term describing all sexual offences against women, men, and children, ranging from sexual harassment to aggravated sexual assault that occurred when a person was 'forced, coerced or deceived into sexual acts against their will or without their consent' (NSW Government, 2018a, p. 7).

Sexual Assault Services (SASs)

In NSW, SASs were government-provided services for female and male survivors of sexual assault and sexual abuse with a history of employing female-only counsellors. In other parts of Australia, different titles were used for such services, e.g., in Victoria they were Centres Against Sexual Assault (CASAs). Internationally, different models operated in response to sexual assault. For example, in the USA, there were numerous centres and coalitions providing sexual assault services (Ullman, 2005, 2010, 2014), including a program where Sexual Assault Nurse Examiners (SANES) provided the initial supportive and medical response to victims (Campbell & Wasco, 2005) and advocates in Rape Crisis Centres rendered (mainly short-term) support and counselling services (Ullman & Townsend, 2007). In England, Sexual Assault Referral Centres (SARCs) offered victims forensic examination and referral pathways to other services, e.g., Independent Sexual Violence Advocacy for counselling (Brooker & Tocque, 2016). In the Netherlands, sexual assault services, such as the Centre for Sexual and Family Violence (CSFV), had been established to provide optimal multidisciplinary (medical, legal, acute, and short-term psychosocial) responses to victims of sexual assault and family violence (Bicanic et al., 2014). Ziljstra et al. (2017) noted these were 'a new phenomenon' (p. 205), where victims could use 'the same services and knowledge of gender-based violence' (p. 199).

There were similar Sexual Assault Care Centres (SACCs) in Belgium (Hendriks et al., 2018). In Ireland, Sexual Assault Treatment Units' (SATUs) core function was acute medical and psychosocial care to victims and external referral for ongoing counselling (Eogan et al., 2013; Kelleher & McGilloway, 2009). The SATU in the Republic of Ireland was the first in Europe; it opened in 1985 (Eogan et al., 2013).

Sexual violence

Another form of GBSV, sexual violence involved 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work' (WHO, 2002, p. 149).

Survivor

This was a strengths-based term for victims of sexual assault and sexual abuse to emphasise their *survival* of the ordeal perpetrated against them.

Therapy

Therapy or clinical treatment for survivors focused on the multiple impacts of sexual assault and sexual abuse. Whereas most therapeutic systems arose within mental health (psychiatry and psychology), in sexual assault there was increasing recognition that the traumatic event precipitated mental distress, not a mental health problem *per se* (Salter, 2019).

Trans

Trans (without the asterisk) applies to trans men and trans women, while trans*, as used by Love et al. (2017), denotes an effort to include all non-cisgender gender identities. However, according to Killerman (2017), this is in fact a misunderstanding of what the word *trans* means, that is, 'all non-cisgender' people.

Trauma

Trauma resulted from psychological injury following a traumatic event or experience, though Covington (2008) described it as 'both an event and a particular response to an event' (p. 379). The ISTSS (2009, 2012, 2019a, 2019b) defined traumatic events as shocking and emotionally overwhelming situations that might involve actual or threatened death, serious injury, or threats to physical integrity. Kezelman and Stavropolous (2019) noted that traumatic events generally triggered an instinctive fight-or-flight reaction and a biological survival-or-freeze response when the person could not escape the danger. In such situations, 'the normal impulse for action is arrested' (p. 266). The ISTSS (2019a, 2019b) noted that people's reactions to traumatic events varied considerably and ranged from relatively mild (creating minor disruptions) to severe and debilitating (affecting social functioning and personal wellbeing). Acute Stress Disorder and PTSD were mental health diagnoses associated with traumatic stress reactions. Other difficulties co-occurring with mental health symptoms included physical health problems and changes in beliefs about safety.

Trauma-Focused Practice (TFP)

TFP concentrated on the psychological injury experienced following a traumatic event.

Trauma-Informed Practice (TIP)

Also referred to as Trauma-Informed Care, TIP worked from the understanding that trauma (psychological injury) was the result of *something done to someone* and not something that was wrong with that person (Salter, 2019). In responding to the impact of trauma, TIP used a strengths-based framework that emphasised the importance of survivors' physical, psychological, and emotional safety given their 'history of violence/victimisation' (Australian Institute of Family Studies (AIFS), n.d., p. 13). Its 'reconceptualization of symptoms as the outgrowth of *initially* [emphasis in original] protective strategies to defend against overwhelm

underlines that all clients are resourceful' (Kezelman & Stavropolous, 2019, p. 38). Thus, TIP created opportunities for survivors to rebuild their sense of control and empowerment (Hopper et al., 2009).

Trauma-Informed Service (TIS)

TISs used:

> A framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives and their service needs … services have an awareness and sensitivity to the way in which clients' presentation and service needs can be understood in the context of their trauma history (Wall et al., 2016, p. 9).

Generally, unlike trauma-specific services, described below, TISs did not necessarily treat trauma or the range of symptoms with which its different manifestations were associated directly. Instead, the *possibility* of trauma in clients' lives was a central organising principle of trauma-informed care, practice, and service provision (Kezelman & Stavropolous, 2019). The US Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) noted that:

> A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization (p. 8).

Trauma-Specific Service

NSW Health (2020) described a trauma-specific service as one that provided 'therapeutic approaches with the aim of helping a person manage and reduce trauma-related symptoms and

integrate their experiences of trauma so these no longer intrude on the present' (p. 12). Trauma-specific services used treatment approaches and interventions that were 'directly addressed to the treating of trauma in its various forms' (Kezelman & Stavropolous, 2019, p. 267). Wall et al. (2016) explained that trauma-specific interventions referred to 'clinical services or programs designed to treat and ameliorate the actual symptoms and presentations of trauma' (p. 4).

Victim

The term victim served to emphasise the criminal nature of sexual assault and to distinguish between victims and offenders or perpetrators. It provided a political frame of reference. The term 'survivor' has gradually replaced 'victim' to acknowledge the strength and resilience of those who have overcome traumatic events and experiences.

Violence

The WHO (2014) defined violence as 'the intentional use of physical force or power, threatened or actual, against oneself, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation' (p. 4).

Violence against women

Another form of GBSV, violence against women was an all-encompassing term that encapsulated myriad forms of violence and abuse perpetrated by some men against some women. As defined by the United Nations Declaration on the Elimination of Violence Against Women (UN, 1993), the term 'violence against women', which included domestic violence, intimate partner violence, and sexual assault, referred to:

> Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life (p. 2).

The WHO (2014) noted it included 'any act of gender based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether in public or in private life' (p. 84). White Ribbon Australia (n.d.a) highlighted that 'violence against women affects women's well-being and prevents them from fully participating in society. It impacts on families, the community and the nation' (n.p.).

Violence prevention

Violence prevention emphasised public education to stem the tide of violence against women in society. Violence prevention campaigns focused 'on changing not just individual attitudes but also perceptions within a larger community that violent behavior is socially unacceptable or that prosocial behavior, such as actively intervening to prevent SV [sexual violence] or SV-supportive behaviors, is expected and encouraged' (DeGue et al., 2012, pp. 3-4).

Conclusion

This chapter introduced the study. It described the background to, and rationale for, the study, the problem it sought to address and its aims and research questions surrounding the inclusion of male counsellors to government NSW SASs and the currency of feminist practice. Though conceived within a feminist framework, the researcher uses the third rather than the first person suggested by some feminist writers (Mitchell, 2017). She made a conscious decision to write from this perspective to ensure that the voices of the women participants remained central and that that of the author did not intrude. However, the researcher's feminist stance and voice were

implicit in her style of writing and the content she included placing the research topic, framework, and process in context. The researcher took great care not to let her values and perspectives influence the participants, or the research findings and outcomes. To ensure accuracy in reporting, the researcher provided a detailed description of the research process and ethical issues involved in conducting this study in Chapter 7. Given the intersubjective nature of qualitative feminist research, however, of necessity, this thesis represents the voices of the researcher and the researched. As Mitchell (2017) explained, 'to separate a woman from her experiences and context … is to deny that woman a voice' (p. 3). The following chapter reviews the literature on sexual assault, feminism and its connection to sexual assault and therapy, and frames the feminist perspective taken in this study. In addition, it introduces the therapeutic context in this field of practice with its focus on feminist-informed practice and considerations relating to the gender of the counsellor.

CHAPTER 2

Sexual assault and the feminist perspective

It should be the decision of the person seeking help and there should be options (Helen)

Feminist practice … provides some choice and that's a good thing because sexual abuse is all around someone else's power and control, so you really need to make sure you get that (C6)

This chapter examines sexual assault and the feminist perspective. In the first section, it discusses changing definitions of sexual assault, its prevalence, and barriers to disclosure and reporting to police, including prevailing myths about sexual violence, before moving to discuss the feminist perspective. The second section begins with a discussion of various waves of feminism as it sought to respond to historical and cultural changes in the treatment of women in society. Since sexual assault is a gendered crime, feminist understandings of gender are central to its perspective on sexual violence and its personal impacts. The discussion then moves to feminist-informed practice, which is person-centred, politically informed, and values the therapeutic relationship. The chapter ends with a review of issues relating to client choice on the gender of the counsellor, the focus of this study.

Sexual assault

Changing definitions of sexual assault

In Australia, over the last 50 years, there have been changing definitions and major reforms to the legal conceptualisation of sexual assault from being a crime against women to a gender-neutral offence, where 'gender neutral legal terminology is … used to describe the victims (complainant) and perpetrators (defendant) of sexual assault' (Fileborn, 2011, p. 1). Until the 1980s, when the *Crimes (Sexual Assault) Amendment Act 1981* (NSW) made marital rape a punishable offence (Easteal, 2011), rape in marriage was legal. Even up to the early 2000s, there were judges who cautioned juries about 'accepting the testimony of women and children about rape unless they had corroborating evidence' (Gilmore, 2019, p. 78; see also Easteal, 2011). Elsewhere, England and Wales did not change their criminal legislation to include rape within marriage until 1991 (Faludi, 1991; Mason & Lodrick, 2013) and it was not until 1993 that all 50 US states made these reforms. To date, inconsistencies in the definition of, and laws pertaining to, rape in marriage remained (Zaick, 2019) with no common definitions of sexual assault in Australia or internationally (Thompson & Armato, 2012). Instead, people used the term sexual assault interchangeably with other terms, such as sexual violence, sexual harm, and sexual abuse (AIFS, n.d.; Fernandez, 2011; Fileborn, 2011; Khan, 2015; NSW Health, 2020; Tarczon & Quadara, 2012). Generally, however, the term 'sexual abuse' referred to acts of sexual violence *against children* that, because of their age and level of development and understanding, were nonconsensual (Tarczon & Quadara, 2012). Put simply, children (aged under 16 years) were not able to give consent to any sexual activity, and any such activity, therefore, was illegal. The NSW Health (2020) policy and procedures defined sexual abuse as 'sexual activity or behaviour that is imposed, or is likely to be imposed, on a child or young person by another person' (p. 10).

The term ‘sexual assault’ meant nonconsensual acts of sexual violence *against an adult*. The NSW Rape Crisis Centre (n.d.) defined sexual assault as a crime involving ‘any unwanted sexual behaviour by one [person] or a group of people, against another without their consent’ (n.p.). NSW Health (2020) described ‘sexual assault’ as a broad term used to describe a crime in which ‘a person is forced, coerced or tricked into sexual acts against their will or without their consent, or if a child or young person is exposed to sexual activities’ (p. 10). The NSW Sexual Assault Strategy (2018-2021) noted ‘sexual assault’ was a broad term describing all sexual offences against women, men, and children, ranging from sexual harassment to aggravated sexual assault that occurred when a person was ‘forced, coerced or deceived into sexual acts against their will or without their consent’ (NSW Government, 2018a, p. 7).

Criminal legislation on sexual violence in different states also used varying terminology (Gilmore, 2019). For example, legislation in NSW defined ‘sexual assault’ as a penetrative sexual offence, i.e., one involving penetration of the genitalia by part of the body, including the penis, mouth, finger, or an object. Legislation in Victoria, Queensland, South Australia, and Tasmania described this offence as ‘rape’, in Western Australia as ‘sexual penetration without consent’, and in the Australian Capital Territory (ACT) and Northern Territory as ‘sexual intercourse without consent’ (ALRC & NSWLRC, 2010). The legal definition of ‘sexual assault’ notwithstanding, the literature and broader community often used the term ‘rape’ when referring to sexual intercourse without consent (Cossins, 2019).

The issue of consent was central in contemporary law. As Easteal (2011) explained ‘consent is what distinguishes between consensual sex and sexual assault’ (p. 18), i.e., a person must consent freely to sexual contact; coercion or force to engage in sexual acts constituted a crime (Cossins, 2019; Dyer, 2019; Mason & Monaghan, 2019; NSW Rape Crisis Centre, n.d.). The *Crimes Act 1900, Part 3, Division 10, 61I* (NSW) defined sexual assault as a crime involving ‘sexual intercourse with another person without the consent of the other person

[where the perpetrator] … knows that the other person does not consent to the sexual intercourse' (n.p.; see also Mason & Monaghan, 2019).

Mason and Monaghan (2019) noted that, in 2007, NSW introduced 'a positive definition of consent as free and voluntary agreement … into the physical element of sexual assault … and an objective component … into the mental element' (p. 36). They described this as:

> A new way of satisfying the mental element for sexual assault … In addition to actual knowledge that the complainant was not consenting and recklessness as to whether she was consenting, a defendant is now also taken to know that the complainant was not consenting if he has 'no reasonable grounds for believing' that she is consenting to sexual intercourse (s 61HA(3)(c)) (p. 28).

They noted that the 'introduction of this objective component to the inquiry into the accused's subjective mental state was intended to offer better protection to victims, especially in situations where the defendant has "genuine but distorted views about appropriate sexual conduct" (Hatzistergos, 2007, p. 3585)' (Mason & Monaghan, 2019, p. 28). Easteal (2011) referred to this as an 'objective fault test' (p. 20) explaining that if the prosecution were to 'prove there was no consent (physical element) … it has to prove under s 61HA(3)(c) of the 1900 Crimes Act … that the defendant had no reasonable grounds for a belief in consent' (p. 20). NSW was the only state in Australia that still conducted a subjective test to establish whether the *accused* reasonably believed there was consent or knew that the complainant had not given consent as opposed to having 'to prove that *a reasonable person* [emphasis added] would know under the circumstances that there was no consent' (Gilmore, 2019, p. 181). This was the case in Victoria, and most recently, Queensland with their legislation now in line with the rest of the country. Given the difficulties surrounding consent, Mason and Monaghan (2019) believed it might 'be time to revisit its centrality to the formulation of rape law' (p. 37).

In May 2018, the Attorney-General of NSW requested the NSW Law Reform Commission (LRC) undertake a review of consent in sexual assault matters (NSWLRC, 2018). Since this research focused on SASs in NSW, it took the term sexual assault to mean instances where a person was 'forced, coerced or tricked into sexual acts against their will or *without their consent* [emphasis added], or [where] … a child or young person [was] … exposed to sexual activities' (NSW Health, 2020, p. 24).

Prevalence of sexual assault

While statistics were useful in understanding and describing issues in contemporary society, their reliability depended on myriad factors, including levels of reporting and disclosure, especially on sensitive matters like sexual violence. Reliable sexual assault statistics were difficult to capture, due to, among other things, 'barriers to disclosure, the low rate of reporting to police, [and] varying definitions of sexual assault and abuse' (Tarczon & Quadara, 2012, p. 1). These factors affected the reporting of sexual assault and the way in which the criminal justice system gathered, recorded, and analysed information on this crime (Astbury, 2006). As Tarczon and Quadara (2012) observed, 'the complexity of recording and counting such information make this a particularly hidden type of violence' (p. 1). Thus, statistics on the prevalence of sexual assault might not accurately reflect what was happening in the community. Indeed, it was 'generally accepted in sexual assault research that undercounting is much greater than over-counting … Therefore, any statistical data available are likely to be an underestimation' (Tarczon & Quadara, 2012, p. 14). Despite this, most accepted that 'sexual violence is a global problem' (Mason & Lodrick, 2013, p. 28).

Closer to home, the NSW Bureau of Crime Statistics and Research (BOCSAR) (2019) reported that, from January to December 2019, the number of reported sexual assault incidents was 6,269. The reported offences of indecent assault, acts of indecency, and other sexual offences was 8,268. The data collected over the five-year period from January 2015 to

December 2019 showed an upward trend in the number of reports to police, with a 5.9% increase for sexual assault and 4.7% rise for indecent assault and other sexual offences.

Research consistently showed that large numbers of people experienced sexual assault, though most victims were women and girls (Australian Bureau of Statistics (ABS), 2017a; AIFS, n.d.; Astbury, 2006; Costello & Backhouse, 2019; Crome, 2006; Fernandez, 2011; NSW Health, 2020; Tarczon & Quadara, 2012; Ullman, 2010; Wall, 2014). For example, the Personal Safety Survey 2016 (ABS 2017a) data showed that one in nine Australians (11.7% or 2.2 million) had disclosed an experience of sexual violence since the age of 15 years; one in five women (18% or 1.7 million) and one in 20 men (4.7% or 428,000). The data demonstrated that sexual violence against women in the preceding 12 months, disclosed through the survey, had remained steady over the years 2005 (1.6%) to 2016 (1.8%), though had increased from 2012 (1.2%) to 2016 (1.8%) (NSW Health, 2020). This contrasted with disclosures of physical violence that had declined for men and women over the past decade (ABS, 2017a).

The prior Personal Safety Survey (PSS) (ABS, 2012) showed similar results: 17% of adult women disclosed sexual abuse from the age of 15 years compared to 4% of men (Zilkens et al., 2017). Further, the 2016 PSS (ABS, 2017a) noted that, in the most recent incident of sexual assault, 87% of women (553,700) were harmed by a male they knew; and the incident was most likely to have occurred in the home of the person who was harmed (40% or 252,400), or in the perpetrator's home (17% or 109,400). Thompson and Armato (2012) likewise found that sexual assault occurred mostly in private homes. The 2016 PSS showed that women were nearly three times more likely to have experienced partner violence than men, with approximately one in six women (17% or 1.6 million) and one in 16 men (6.1% or 547,600) having an experience of partner violence since the age of 15 years. The data showed that women were eight times more likely to experience sexual violence by a partner (current or former) than men, since the age of 15 years: one in 20 women (5.1% or 480,000) and one in

167 men (0.6% or 53,000). In relation to sexual harassment, the PSS 2016 found that 53% of women (5 million) and 25% of men (2.2 million) recalled an experience of sexual harassment through their lifetime; women were twice more likely to experience this type of crime than men (ABS, 2017a; Costello & Backhouse, 2019). The Australian Human Rights Commission (AHRC) (2018a) report showed that, over the preceding five years, 39% of women (almost two in five) and 26% of men (one in four) had experienced sexual harassment in the workplace. The perpetrators were mainly men with 79% of victims experiencing harassment from a male offender. It further reported that, of those harassed, fewer than one in five had made an official complaint (17%) (AHRC, 2018; Trioli, 1996, 2019). Further, the AHRC (2017), in its findings of sexual assault and sexual harassment on university campuses, found that one in five students had experienced sexual harassment in 2016 and 1.6% of students had experienced sexual assault on campus during 2015 or 2016. The survey also examined bystander activity and found 'only 21 per cent of people who saw another student being sexually harassed in 2016 took any action in response to the incident. Only 37 per cent of people who saw another student being sexually assaulted in 2016 took action in response to the incident' (AHRC, 2017, p. 9).

Based on ABS (2017a) data, Costello and Backhouse (2019) reported that one in six people in Australia had experienced violence (physical or sexual violence since the age of 15 years) from an intimate partner (16% or 2.9 million); one in four women (23% or 2.2 million) and one in 13 men (7.8% or 703,000). This demonstrated that women were three times more likely to experience violence from an intimate partner than men were. In addition, they noted that women were approximately four times more likely than men to have experienced sexual assault since the age of 15 years, that is, one in six women (16.9% or 1.6 million) compared with one in 23 men (4.3% or 384,800).

In its report *Family, Domestic and Sexual Violence in Australia*, the Australian Institute of Health and Welfare (AIHW) (2018) noted that, nationally, in 2016, one in three (36%, or

8,200) recorded sexual assaults occurred in the context of domestic and family violence and there had been an increase in reports of sexual assault over the last five years. Police statistics from 2016 showed that, nationally, they responded to more than 23,000 sexual assault complaints. Of these, most were reports of sexual assault against females (18,900), or 52 sexual assaults daily, and the remainder were reports of sexual assault against males (4,100), 11 a day. The report noted that:

> The victimisation rate of sexual assault related to family and domestic violence increased slightly from the previous year to 34 victims per 100,000 people. The majority of victims were female—6,900 female victims compared with 1,200 male victims. The increase in recorded sexual assault *related to family and domestic violence* [emphasis added] can be attributed to either an increase in the number of sexual assaults, or an increase in reporting rates, or a combination of both (AIHW, 2016, p. 51).

Regarding child sexual assault, women were twice more likely than men to have experienced child sexual abuse by an adult before the age of 15 years, i.e., one in nine females (10.7% or 1 million) compared to one in 22 males (4.6% or 411,800). Most women and men, 91% (907,300) and 83% (343,700) respectively, knew the perpetrators of these crimes (Costello & Backhouse, 2019).

Gilmore (2019) noted that, for every 100 rapes in Australia, the victim knew the perpetrator in 88 cases, with 45 being the victim's intimate partner. Salter (2019) reported findings from his Australian study that showed two-thirds of child sexual assault victims were girls and that, for sexual assault victims aged over 18 years, 90% were women. His research demonstrated that women experienced higher rates of interpersonal trauma than men; women's experiences of trauma were more likely to be repeated, occur multiple times, involve physical violation and a sense of betrayal, invade physical and psychological boundaries, and be

frightening. Similarly, NSW Health (2020) highlighted that women's experience of violence perpetrated by men often involved feelings of anxiety or fear for their personal safety (ABS, 2017a; Leser, 2019).

NSW Health (2020) reported that three times as many Indigenous women experienced sexual violence than non-Indigenous women. The NSW Sexual Assault Strategy (2018-2021) reported that, in 2016, Indigenous people experienced sexual assault at a rate of 2.4 times that of non-Indigenous people (NSW Government, 2018a).

Gilmore (2019) referred to data from *Our Watch*, which revealed that First Nations women were around 35 times 'more likely to be hospitalised due to family violence (which frequently includes rape) than other women' (p. 98). Research also showed that people from lesbian, gay, and trans communities were at greater risk of sexual violence (Gilmore, 2019; Love et al., 2017; NSW Government, 2018a; NSW Health, 2020). This also applied to women with a disability: 'International research indicates that up to 70% of women with disabilities have been victim-survivors of sexual violence; and that up to 90% of women with an intellectual disability have experienced sexual abuse' (NSW Health, 2020, p. 217). These statistics identifying at-risk groups remained consistent with reports of sexual harassment. For example, the AHRC (2018a) report showed that people who identified as other than heterosexual or straight experienced sexual harassment at higher rates (52% compared to 31%). This was true also for First Nations people (53% compared to 32%) and people with a disability (44% compared to 32%).

There was widespread agreement that sexual violence was a gendered crime and most perpetrators of sexual assault were male (AIFS, n.d.; Fernandez, 2011; Morgan, 2011; NSW Health, 2020; Sable et al., 2006; Thompson & Armato, 2012; Ullman, 2010; Wall, 2014). The NSW Literature Review report (AIFS, n.d.) highlighted that 30 years' research supported observations of the gendered nature of the crime of sexual violence and males perpetrated 85-

95% of sexual offences. NSW data on sentencing for 2009 and 2010 showed that only eight of a total 638 (1.3%) convicted offenders were female (Ringland, 2011).

Costello and Backhouse (2019) reported from the ABS (2017a) data that a male perpetrator sexually assaulted female victims in 98% (1.7 million) of cases; a female perpetrator committed sexual assault in only 4.2% (72,200) of the reported cases. The data for male victims showed similar numbers for sexual assault by a male or female perpetrator, 51% (291,000) and 55% (237,000) respectively.

Earlier studies showed the same pattern of sexual violence against women. For example, '85% of victims who reported sexual assaults to police in 2011 were female' (Tarczon & Quadara, 2012 p. 7); in most cases, the victim of sexual assault knew the perpetrator (AIFS, n.d.; Thompson & Armato, 2012). The Australian Institute of Criminology (AIC) (2013) found that, in 2012, 45% of all victims knew the perpetrator and, in 27% of cases, a family member perpetrated the assault; strangers accounted for only 19% of recorded sexual assaults. Referring to Campbell et al.'s (2003) study on femicide in abusive relationships, NSW Health (2020) highlighted that:

> International research shows that physically abused women who also experienced forced sexual activity or rape, were 7-times more likely than other abused women to be killed by their partner; and that sexual assault by a partner was the strongest indicator of escalating frequency and severity of violence, more so than stalking, strangulation and abuse during pregnancy (p. 217).

Zilkens et al.'s (2017) Australian study supported these claims. They found that 'the prevalence of a body injury was highest in women sexually assaulted by an intimate partner when compared to any other assailant type, as was the prevalence of non-fatal strangulation, biting, use of other blunt force and weapons' (p. 117). Similarly, in relation to physical assault, an ABS (2020) media release stated that 'physical injuries were also more common when the

perpetrator was a male partner (58 per cent), compared with another known male (45 per cent) and a male stranger (29 per cent)' (n.p.). A 2016 study analysed the economic costs to the community of violence against women. It found that the cost for the nation in 2015-16 was AUD22bn per year (AIHW, 2018).

Internationally, the WHO (2017) estimated that about one in three (35%) women worldwide had experienced physical and or sexual intimate partner violence or non-partner sexual violence in their lifetime. Statistics established by UN Women showed that 70% of women worldwide had experienced physical and or sexual violence at some point in their lifetime; 60% of sexual assaults were committed against girls under 16 years of age and 25% of women had experienced physical and sexual violence during pregnancy (Khan, 2015).

While data demonstrated consistently that women experienced sexual violence in greater numbers than men did, research also showed that sexual assault against males was a growing issue (AIFS, n.d.; Crome, 2006; Fernandez, 2011). As the WHO (2014) noted, 'boys and men also suffer sexual violence, although this remains poorly documented' (p. 76), while Ullman (2010) highlighted that 'much less is known about this even more hidden portion of the sexually victimized population' (p. 49). Love et al. (2017) wrote that, globally, an estimated 25% of women and 10% of men had experienced sexual violence in their lifetime. NSW Health (2000) SAS statistics showed that 10% of survivors presenting at SASs for a recent assault were male.

The Royal Commission's (Commonwealth of Australia, 2017) findings showed that two in three survivors presenting to the Commission were male and the number of male victims was higher than previously thought. Others had portended that:

- There might be more acts of sexual violence on males in contemporary society than captured in official statistics.

- The low number of male victims reflected the invisibility of these crimes and common assumptions that females were not perpetrators and men were not victims prevented male victims from coming forward (Brenner, 2014; Gilmore, 2019; NSW Health, 2020; Sable et al., 2006).

Gilmore (2019) noted the data from the ABS PSS (2017a) strongly supported wider research showing the existence of male victims of female violence though they were 'rare and far less likely to suffer serious injuries or experience sexual violence' (p. 143). Salter (2019) claimed that, generally, men's experience of trauma occurred later in life and was more likely to occur on the street or in public places, be a single incident, and be physical in nature. It was considerably less likely to take the form of sexual violence committed by a loved one on whom they were dependent.

Sexual assault also occurred in same-sex relationships, where there was a female perpetrator and female victim, and a male perpetrator and male victim (Carlson, 2005; Crome, 2006; NSW Health, 2020; WHO, 2014). However, there was a lack of understanding and acknowledgement of this type of crime (Love et al., 2017; Thompson & Armato, 2012).

Barriers to disclosure and reporting to police

Barriers to reporting were well-documented in the literature, with little change over time (Astbury, 2006; Carrington & Phillips, 2003; Gilmore, 2019; Love et al., 2017; NSW Health, 2020; Sable et al., 2006; Sanderson, 2013; Tarczon & Quadara, 2012; Thompson & Armato, 2012; Ting & Palmer, 2020; Ullman, 2010). They included victims' feelings of shame for themselves or their family and their fear that people would not believe them, due to community stereotypes and myths relating to sexual assault. Another factor was the victim's own misunderstandings of sexual assault and her consequent feelings of guilt, embarrassment, self-blame, and confusion about the offender, due to their relationship. Many had received threats

and bribes and feared conflict from, or retaliation by, the offender. Most distrusted the police and criminal justice systems, due to their inaction and the low number of convictions and prosecutions, and had experienced discrimination and stereotyping from other services.

Ting et al. (2020) found that, in the 10 years to 2017, there were more than 140,000 sexual assaults reported to the police in Australia. However, studies demonstrated consistently this did not reflect the scale of the problem, because 'sexual assault is under-reported to police' (Zilkens et al., 2017, p. 119); 87% of women had not contacted the police (ABS, 2017a); and approximately 85% of sexual assault offences went unreported (Fileborn, 2011). Similarly, US data estimated that victims had not reported the sexual assault to the police in between 66% and 96% of cases (Thompson & Armato, 2012). Likewise, Ullman (2010) noted that rape remained 'a disproportionately underreported crime … [with] a similar pattern of underreporting … also the case for child sexual abuse' (p. 45). Gilmore (2019) referred to the AIC estimate that less than 30% of victims of sexual assault and related offences reported the incident to the police.

Journalists Ting and Palmer's (2020) examination of the ABS data on police responses to reports of sexual assault in Australia from 2010 to 2018 found that less than one in three reports to police resulted in legal action, with 60% remaining unsolved or incomplete. They concluded that sexual assault had 'the lowest rates of reporting, investigation, prosecution, and conviction of any violent crime … And when you think about it, that's amazing, given that it's usually also the second-most serious crime on our criminal law statutes' (n.p.).

Gilmore (2019) observed that rape had 'the lowest rates of reporting, investigation, charges laid, cases at trial, conviction and custodial sentence of any of [the] violent crimes' (p. 78). Data revealed that only 3% of sexual assault cases resulted in guilty verdicts and only 1% in a conviction, and these statistics had not altered much in the past 20 years (Gilmore, 2019).

Importantly, the data confirmed that false complaints of sexual assault were rare: between 2% and 8% (Gilmore, 2019). As Gilmore (2019) explained:

> For every 100 rapes that occur in Australia … five will be reported to police, two will go to court, one rapist will be found guilty and 0.5 rapists will go to prison. For every single false report of rape, 130 rapes are actually committed (p. 101).

Trioli (2019) reported that university experiences of sexual harassment and assault were largely underreported: '94% of those harassed on campus, and … 84% of those who were assaulted, did *not* [original emphasis] make a formal complaint' (p. 175). Bongiorno et al. (2020) concurred that sexual harassment in higher education institutions was common and stated that 'male-to-female sexual harassment is a serious and prevalent issue' (p. 14). They supported the figure that less than 6% of those who experienced sexual harassment reported the incidents. In summary, research showed that violence against women was endemic in Australian culture given that:

> One woman a week is killed by a man who claimed to love her. One in three Australian women have experienced violence from a man they know. Women are almost three times more likely than men to have experienced violence at the hands of a partner since the age of fifteen. Intimate partner violence contributes more to the burden of disease of adult women than any other risk factor (Gilmore, 2019, pp. 103-104).

Perpetrators of sexual assault

Regardless of risk-reduction measures, women were not to blame for sexual assault: 'Sexual assault is the perpetrator's responsibility, and as such, perpetrators need to suffer consequences' (Norris, 2011, p. 372). The challenge, however, was the way in which to promote this public health message to break entrenched violence against women. It was

necessary to work with perpetrators and, as radical feminists had argued, the whole of society to break the cycle of violence against women through public education to alter the societal systems, structures, and underlying attitudes and beliefs contributing to sexual violence. One way was to emphasise the evidence on perpetrators. The patterns of prevalence, discussed above, and contemporary research revealed several facts about perpetrators:

- Most perpetrators of sexual assault were men (AIFS, n.d.; AHRC, 2018a; Fernandez, 2011; Morgan, 2011; NSW Health, 2020; Sable et al., 2006; Thompson & Armato, 2012; Ullman, 2010; Wall, 2014).
- Most victims of sexual assault knew their perpetrators (Costello & Backhouse, 2019; Gilmore, 2019; Mason & Lodrick, 2013).
- Apprehending and prosecuting perpetrators was a costly and lengthy process that was often traumatic for the minority of survivors who had reported the assault to the police, and the relatively few cases that made their way to court (Chen & Ullman, 2010; Henninger et al., 2019).
- Perpetrators commonly denied, normalised, or attempted to justify their behaviour (Wegner et al., 2015).
- Men's negative attitudes toward women and lack of empathy for them, as well as greater empathy for the male perpetrator, were a factor in sexual harassment and violence against women (Bongiorno et al., 2020).
- Perpetrators' tactics affected women's responses to sexual assault (Wegner et al., 2015).
- Working with survivors was a complex process for all professionals (Carlson, 2005; Kezelman & Stavropolous, 2019).

Wegner et al. (2015) listed the characteristics of sexual assault incidents that encouraged their justification of the offence:

- Men's higher expectations of sex than women's; this could be due to men's higher expectations of *entitlement* to sexual activity.
- Men's misperceptions of sexual intentions (strongest indicator) that the legal system often used to support the accused (perpetrator) in court, where the issue of consent was central (Dyer, 2019).
- Victim and perpetrator's alcohol consumption.
- Attempts to get the woman alone, which suggested the interaction was not mutual and was a move towards nonconsensual sexual activity.
- Consensual sexual activity prior to unwanted sex that fit with the myths discussed below.

Their study confirmed that:

> Feelings of sexual entitlement are incredibly common among perpetrators … These men have not learned that their partners' wishes must be respected regardless of how sexually frustrated that might leave them. The pervasiveness of these beliefs suggests that creative and engaging primary prevention programs are needed that address double standards about sexuality from an early age (Wegner et al., 2015, pp. 1030-1031).

Further, they found that:

> Expectations for having sex and consensual sexual activities are more often associated with intimate partner sexual assaults; whereas, misperception of sexual intent, alcohol use by the victim and perpetrator, and isolating tactics are more often associated with casual partner sexual assaults (Wegner et al., 2015, p. 1031).

The NSW Council on Violence Against Women (1999) reported that gender stereotypes could be a significant causal factor in crimes against women, such as domestic violence and sexual

assault. Men and boys could commit a crime involving sexual violence because they did not believe it was a crime and thought it was acceptable, 'natural', or unavoidable to force a woman to have sex or to use physical force against their girlfriends, partners, or wives.

Our Watch reported that, in 2015, research examining attitudes among young people aged between 12 and 24 years found that over 25% believed behaviours such as 'male verbal harassment' and 'pressure for sex towards females' were normal in relationships. Further, it found that one in four of the male respondents believed that controlling or violent behaviours were signs of strength in men (Alexander, 2015). However, the Australian National Research Organisation for Women's Safety (ANROWS) (2017) National Community Attitudes towards Violence against Women Survey (NCAS) showed that there were overall improvements in community understanding of, and attitudes towards, violence against women between 2013 and 2017. Despite this, it also showed that 'men have a lower level of understanding of violence against women, a lower level of support for gender equality, and a higher level of attitudinal support for violence against women' (Webster et al., 2018, p. 5). ANROWS (2017) also found that a third of respondents did not know that sexual assault by a stranger was less likely than sexual assault by someone the victim knew; 40% thought it was an exaggeration that women received unequal treatment; and 40% believed that women lied about sexual assault to get back at men (Webster et al., 2018). Ignorance like this and gender stereotypes, such as the following, could exacerbate gender-based crimes:

- Men were not responsible because women's dress or behaviour provoked them, or they were drunk.
- Women deserved the use of force (e.g., they were 'nagging').
- It was 'natural' that women should submit to men.
- Forced sexual acts by boyfriends, husbands, or partners were not really rape.

- Non-consensual sex constituted rape only if the perpetrator had threatened the woman using a weapon or physical force (Office of the Status of Women (OSW), 2002).

Clearly, perpetrator justifications related strongly to myths about sexual assault. In their study, Bongiorno et al. (2020) showed that:

> Feeling empathy for men who sexually harass women based on taking the male perpetrator's perspective is an important factor in helping to explain why women are likely to be blamed for their own sexual harassment, especially by men, but also by women where the male-perpetrator's perspective and outcomes become a focus (p. 22).

Their findings suggested that interventions and social-change campaigns should focus:

> On reducing empathy for male perpetrators … by challenging myths that women provoke men's sexual harassment or often lie about being sexually harassed … [and] challenging media reports that give undue prominence to their [men's] professional accomplishments or … focus on how the man's life will be negatively affected if there is a finding of sexual violence against him (Bongiorno et al., 2020, p. 22).

They suggested universities and other organisations could use their findings to improve the way in which they handled complaints of sexual harassment. They needed 'to implement training to ensure that decision makers, who are often other men, are made aware of this potential bias and trained to not be unduly influenced by their empathy for that perpetrator' (Bongiorno et al., 2020, pp. 22-23).

Myths about sexual assault

There were many myths that still held sway in the community as were evident in people's attitudes, media reports, court matters, organisational policies, and religious institutions

(Cossins, 2019; Edwards et al., 2011). Lonsway and Fitzgerald (1994) defined rape myths as 'attitudes and generally false beliefs about rape [and sexual assault in general] that are widely and persistently held, and that serve to deny and justify male sexual aggression against women' (p. 133). Despite years of awareness-raising, protests, research, and legislative reform, misinformation still abounded (Ullman, 2010). From a radical feminist perspective, myths performed a central function in the perpetuation of violence against women; they helped to shift responsibility from the perpetrator to the victim, thereby maintaining the *status quo*. If perpetrators were not responsible for their actions, or their actions were minimised or dismissed due to circumstances, or even accepted and condoned, then there would be no reason to change the structural order of men holding most power in society. As Edwards et al. (2011) explained, 'given patriarchy's marginalization of women and their experiences, rape myths serve to legitimize sexual violence against women' (p. 762). Further, Mason and Monaghan (2019) noted that these myths functioned to 'excuse sexual aggression by men and place blame for sexual assault on women' (p. 27). They also influenced personal decision making about disclosure of sexual assault and abuse and increased the likelihood of non-disclosure and non-reporting to police (Egan, 2019; Lievore, n.d.). Campbell et al. (2009) noted that women with high rape-myth acceptance tended to be less likely to acknowledge their experiences as sexual assault, which consequently decreased their support-seeking and hindered healing. Further, the acceptance of rape myths was 'one of the most consistent predictors of victim blame in sexual assault scenarios' (Cossins, 2019, p. 462). Research also showed a shift towards a covert blaming of the victim rather than direct and overt blame (McMahon, 2011). McMahon (2011) highlighted that a focus on individual causal factors only led to a failure to see the larger picture contributing to sexual violence. Discussed below are some common myths.

She asked for it

This involved a judgement that a woman asked for sex, among other things, because of the way she dressed, walked alone at night, went back to his house, or invited him into her home. Mason and Lodrick (2013) observed that people judged victims of rape, and sexual assault generally, as culpable, perceiving their behaviours before the rape as 'risky'. They highlighted that it was unreasonable to assume that a woman consented to sex from the way she dressed, or because of her reputation and prior agreement to intimacy or even sex with the accused on another occasion. Yet, many believed that these behaviours made women responsible for the rape. This was 'clearly at odds with the law as it stands, and can have devastating consequences for recovery as guilt and shame are compounded' (p. 29). Edwards et al. (2011) noted this myth followed from the 'widespread belief that women are responsible for preventing bodily violations' (p. 767). Race and other forms of oppression exacerbated the blame and individual focus on the victim. For example, black women and women of colour, and low-income women and sex workers, were more likely to be seen (even partly) as responsible and the perpetrator less accountable (unless the perpetrator was a black man) (McMahon, 2011).

Men only assault women

There was much evidence refuting this myth: 'While more than 80% of rape victims are women, rape can (and does) also happen to men' (Gilmore, 2019, p. 86). Most agreed that statistics on men as victims of sexual assault were underestimates: 'Most experts believe that official statistics vastly under-represent the number of male rape victims' (Krug et al., 2002, p. 154). Questions and assumptions about sexual orientation also occurred when a male sexually assaulted another male. The erroneous portrayal of male victims as effeminate and homosexual served to shift blame to their appearance or behaviour and therefore detracted from perpetrator responsibility. It privileged and protected a particular type of masculinity when studies have

shown that ‘both victims and offenders of male rape are frequently heterosexual’ (Mason & Lodrick, 2013, p. 29).

He was sick or mentally unwell

This was an explanation offered post-1970 to make sense of this social problem, when social understandings centred on individual behaviour and focused on ‘the psychology of the perpetrators’ (Ullman, 2010, p. 33). McMahon (2011) noted that this view of mental illness rather than rape as a criminal act existed from the middle of the 20th century and saw convicted offenders sent to psychiatric hospitals rather than prison. As Egan (2019) emphasised, ‘sexual assault is not an illness or about deviance, it is a crime and an act of violence’ (p. 173). However, this myth remained current in community attitudes, despite a plurality of research that showed this to be false (McMahon, 2011).

She didn’t say no or fight back

It was an ‘inaccurate assumption that rape always involves violent force’ (Mason & Lodrick, 2013, p. 28). Research reported that ‘rape often occurs without leaving substantial physical injuries’ (Gilmore, 2019, p. 86) and ‘physical force is not necessarily used in rape, and physical injuries are not always a consequence’ (Krug et al., 2002, p. 162). This could apply equally for female and male victims. This myth returned to the issue of consent and the thinking that a ‘real’ rape had occurred when there were injuries showing that she or he had put up a fight or tried to stop it. Research and evidence demonstrated strongly the common neurobiological reaction of a victim to freeze or submit to an ordeal of sexual assault. This instinctive reaction was a primal evolutionary response to a threatening situation, and a way to survive. Further, some women (and equally men) did not have capacity to say ‘no’, due to alcohol or drugs, being asleep or unconscious at the time, thinking the male was someone else, or due to force, manipulation, or threats. As Mason and Lodrick (2013) stated, ‘consent is actively given and

actively reinforced, it is not passively assumed' (p. 29). Cossins (2019) further stated that 'a significant minority or a majority of victims will display tonic immobility [meaning they would freeze] during a sexual assault' (p. 486).

Sexual assault is perpetrated by strangers

Evidence clearly showed that 'most rapes, and other sexual assault, are committed by someone known to the victim' (Mason & Lodrick, 2013, p. 28); 'stranger rape is the least common rape in any western country' (Gilmore, 2019, p. 86); and 'marital rape is much more common than stranger rape' (Edwards et al., 2011, p. 765).

Women lie about rape

Studies have consistently debunked this myth with most researchers suggesting false rape allegations were 'highly infrequent' (Edwards et al., 2011, p. 767). International studies demonstrated that very few allegations (between 2 and 8%) of sexual assault made to the police were false (Edwards et al., 2011). Leser (2019) noted that 'false rape accusations constitute less than 10 per cent of reported rape cases, possibly as low as 2 per cent' (p. 153).

Feminist perspective

Waves of feminism

According to Gamble (2001), feminism encompassed 'a theory (or set of theories), something capable of being studied and debated on an academic level, [and] … simultaneously a movement which retains a commitment to change the real world outside the universities' (p. vii). There were different understandings and explanations of feminism, each with their own ideas of how to understand and address gender inequality (e.g., radical, liberal, Marxist, and socialist feminism). However, there was some agreement that feminism reflected 'the struggle

to increase women's access to equality in a male-dominated culture' (Gamble, 2001, p. viii) and a movement which women joined to support one another in the fight against patriarchy to improve their lives (Gamble, 2001; Thompson & Armato, 2012).

Feminist campaigns against oppression have occurred in waves. Women's voices first emerged to challenge rigid gender roles and attitudes towards women in England in the late 16th century. From this platform emerged first-wave feminism, which was active during the latter part of the 19th century and beginning of the 20th century. The term feminist, which evolved at the end of the 19th century, referred to female activism on issues and difficulties faced by women, through campaigns and protests for the female vote, education and employment for middle-class women, and marriage reform. Women fought against social attitudes that prevented them from working or performing duties outside the marriage or home and gave men foremost consideration in any issue. For instance, concern that women working would oust men from their rightful positions and duties caused much agitation. Feminist activity slowed down following the First World War though regained momentum in the 1970s (Gamble, 2001; Ullman, 2010).

Second-wave feminism emerged with two differing strands (particularly in the USA). One strand focused on achieving change within the social structure. The other more radical strand claimed that ending women's oppression would emerge only from revolutionary changes to society's institutional structures, such as work, education, religion, and the family. This required consciousness-raising to transform personal experience through political analysis. The 'personal is political' (Gamble, 2001, p. 30) catchcry invited people to rethink dominant ideas that personal problems arose from individual deficiencies. Consciousness raising aimed to enhance awareness and understanding that the issues and problems women were facing were not due to inherent weaknesses, but to the subordination and oppression of women as a social group, which society had treated unfairly. Second-wave feminists

challenged ‘traditional ideas of gender difference and women’s subordination’ (Thompson & Armato, 2012, p. 7). They fought for women’s bodily rights and autonomy and protested for abortion rights, contraception, and sexual freedom (Gamble, 2001). Feminists believed society could and ‘should be changed to give equal power and value to all’ (Brown, 2008, p. 278).

Due to the women’s movement and feminist consciousness raising, the wider community became increasingly aware of women’s issues and the number of feminist academics and therapists grew exponentially (Brown, 2008). Second-wave feminists exposed the silence on violence against women as their perspective on, and understanding of, sexual assault began to grow (Carmody, 2009; Egan, 2019; Eisenstein, 1984; Gottschalk, 2009; Pack, 2011; Wall, 2014). Spurred on by Kate Millett’s (1970) *Sexual Politics,* in which she introduced the term ‘patriarchy, literally meaning ‘the rule of the father’ (Eisenstein, 1984, p. 5), they blamed the oppressive system for women’s subordination. Hence, they expanded Millett’s (1970) concept of patriarchy to mean ‘a system of institutionalised oppression maintained by ideological means’ (Thornham, 2006, p. 31). Susan Brownmiller (1975) went even further in her groundbreaking *Against Our Will: Men, Women, and Rape*. She contended that the threat to, and act of, rape was an instrument of domination by men over women. In her words, rape was ‘nothing more or less than a conscious process of intimidation by which *all men* keep *all women* [original emphasis] in a state of fear’ (p. 1). Indeed, the politicisation of men’s violence against women conveyed essentialist ideas of gender: men were aggressive and sexually violent and women vulnerable and in need of protection (Ullman, 2010). In this way, second-wave feminists mobilised the women’s movement to develop direct support services for female victims of sexual assault (Egan, 2019), as feminist therapists, pioneered by Walker (1979) and Herman (1981), developed ‘models for treating battered women and women survivors of sexual assault and childhood sexual abuse’ (Brown, 2008, p. 282).

Divergent views and opinions arose among feminists during the second wave, when issues of class, race, and sexuality came to prominence as additional sites of discrimination and oppression (Gamble, 2001). Many criticised the white middle-class feminist focus on gender equality that ignored the interests of black, poor, and gay women in the landscape of female subordination. Hence, second-wave feminism was an era of much contention surrounding feminist thinking and women's issues (Gamble, 2001; Ullman, 2010).

Coined in the 1980s, the term postfeminism originated in the media. Susan Faludi (1991) saw it as a devastating reaction to, and backlash against, second-wave feminism rather than a movement to continue the fight against women's oppression. However, postfeminists argued that they had accepted the criticisms and limitations of second-wave feminism and heralded inclusive, diverse, and pluralistic third wave thinking and its 'twin imperatives of continuity and change' (Gamble, 2001, p. 52). They acknowledged the struggles and gains of past feminist movements and need for ongoing activism and protest, adding their understanding of the diversity of women's sexuality and experience of oppression. This 'poststructuralist interpretation of gender and sexuality is central to third-wave ideology' (Ullman, 2010, p. 33). It called for a more flexible approach to manage contradictions and diversity and 'actively work against the social injustices which still form part of the everyday experience of many women' (Gamble, 2001, p. 53).

These contradictions inhered in contemporary social issues, structural inequalities, and systems discrimination, such as gender pay equality and equal paid parental leave for mothers and fathers. It was not possible to address sexual assault and violence against women without examining underlying issues arising from gender discrimination and sex role stereotyping. Third-wave feminists understood that campaigning for an end to violence against women meant challenging attitudes towards women and the discriminatory policies and practices maintaining their subordinate social position in society. The ensuing changes would benefit

men and women, as they would lead to changed social attitudes towards men as well. For example, if mothers (or 'primary' caregivers) were no longer the ones responsible for childcare and childrearing, then it might be possible to consider how these roles were distributed free of assumptions and role expectations tied to either gender.

Despite many years of feminist attention to the issue of equal pay for equal work, gender-based income disparities persisted. In 2013, the government instituted the Workplace Gender Equality Agency (WGEA), with powers ascribed under the *Workplace Gender Equality Act 2012* (Cth). The WGEA was responsible for the promotion and improvement of gender equality in Australian workplaces. Australia's Gender Equality Scorecard stated that 'the Agency's vision is for women and men to be equally represented, valued and rewarded in the workplace' (WGEA, 2018, p. 1). In 2018, it reported that Australia's gender pay gap was 21.3% and found that men still took home AUD25717 on average more per annum in full-time earnings than women: 'Gender pay gaps favour men across all levels of the workforce' (WGEA, 2018, p. 5). Further, more than half of the women compared to just over a quarter of men in employment were working on a part-time or casual basis. Around 40% of women were not in the workforce, compared to 25% of men. Caring responsibilities were the primary reason for women working part time or not at all, while, for men, it was their participation in further education (Gilmore, 2019). The Household, Income and Labour Dynamics in Australia (HILDA) report stated that 'the disproportionate involvement of women in unpaid work arguably limits their labour market availability and career options and contributes to a persistent gender pay gap' (in Gilmore, 2019, p. 221).

Australia's paid parental leave (PPL) policies that entitled parents paid leave from work to give birth to, and care for, their babies were far behind many countries in the Western world. Australia was one of the last countries to develop and introduce PPL policies that were less generous than those in comparative economies. Australia offered 18 weeks PPL at minimum

pay for the ‘primary’ carer, while entitling ‘secondary’ carers to two weeks Dad and Partner Pay (DaPP) leave. In comparison, the UK offered 39 weeks full-time PPL, while Canada offered 35 weeks (Dent, 2018).

The AHRC (2014) Fathers and Partners Survey, a case study of fathers and partners that took leave under the DaPP scheme, showed that 85% of fathers and partners had taken less than four weeks leave on the arrival of their newborn and less than 2% of fathers had applied for extended leave. The ABS (2017b) reported that only one in 20 fathers chose to take PPL. Baxter (2019) reported on AIFS’ study on changes to parental work practices that found minimal alterations to fathers’ work patterns. This showed the persistent assumption that childcare was the responsibility of the mother as the primary carer. The terminology – Dad and Partner Pay – highlighted the embedded gendered assumption and stereotype of men as breadwinners and women as carers. Society continued to portray childcare, family violence, sexual violence, the gender pay gap, and reproductive rights as women’s issues relevant only to women, when men had ‘a necessary relationship to feminism - the point after all is that it should change them too’ (Heath, 1987, p. 1). As Gilmore (2019) observed, perspectives strengthening gender-role stereotyping hid the fact that men too could be victims of sexual assault. Further, it was:

> Not just about the women victims, they are equally about the (mostly) men who commit these crimes. Enabling men to ignore their responsibility for addressing rape and domestic violence by framing it as a women’s issue is … victim blaming at a policy level and it has to change if we are going to make any headway in reducing men’s violence against women (Gilmore, 2019, p. 224).

Feminist understanding of gender

As already noted, patriarchy featured largely in second-wave feminist ideology about male dominance and women's subordination and dominant conceptions of masculinity and femininity in society. Second-wave feminists employed a binary notion of gender, based on biological differences, while, since the early 1980s, third-wave postfeminist and gender studies scholars highlighted social constructions of gender roles and stereotypes. Connell (1987) used the notion of 'hegemonic masculinity' to explain men's power over women: 'It serves as an analytical instrument to identify those attitudes and practices among men that perpetuate gender inequality, involving both men's domination over women and the power of some men over other (often minority groups of) men (Jewkes et al., 2015, p. S112). Jewkes and Morrell (2012) defined hegemonic masculinity as:

> A set of values, established by men in power that functions to include and exclude, and to organize society in gender unequal ways. It combines several features: a hierarchy of masculinities, differential access among men to power (over women and other men), and the interplay between men's identity, men's ideals, interactions, power, and patriarchy (p. 40).

It reflected the feminist structural understanding of the sociocultural forces embedding rigid ideas of what it meant to be a man or woman in society. Theorists used the term 'hegemonic femininity' in a similar way (Griffin, 2018; Schippers, 2007). However, not all harmful masculinities were hegemonic (Connell, 2005), such as those whose origins lay 'in adversity, including in violence experiences in childhood that have enduring psychological impact, manifesting in a lack of empathy and remorse, which enable acts of violence while positioning the male actors as themselves victims (Jewkes et al., 2015, p. S114).

Hearn (2012) observed that men's violence against women had not been a major focus in developing the theoretical concept of hegemonic masculinity. Yet the notion was compatible with feminist understanding of the myths and gender inequities supporting and sustaining violence against women, which have drawn attention to social understandings of gender (masculinities and femininities), sexual roles, and power relations. Feminists argued that violence against women occurred partly due to societal formations and definitions of masculinity and male authority, and acceptance of gender inequality. Therefore, it was due largely to predominant perceptions surrounding masculinity and authority. Thompson and Armato (2012) saw men's violence against women as 'the most obvious expression of masculinity' (p. 289). They argued that, for some males, especially young men, there might be confusion about acceptable and respectful behaviour and expectations of males and sexual partners.

Many have attributed unrealistic, misinformed, and incorrect ideas of appropriate sexual behaviour with the tendency for young people to gain much of their understanding and knowledge of sexuality from watching pornography (Brenner, 2014; Edwards et al., 2011). Ullman (2010) noted the 'proliferation of the sex industry, including pornography … sets the larger stage for sexual assault in our society' (p. 14). Brenner (2014) stated:

> Because both men and women are socialized to accept coercive sexuality as the norm in sexual behaviour, men often see extreme forms of the aggressive behaviour as seduction, rather than rape … Similarly, at least in some cases, perpetrator's motivations have little to do with the victim at all but are driven by external pressures such as perceived need to shore up masculinity or gain social acceptance from others (p. 519).

AIFS (n.d.) found that a significant amount of pornography contained graphic images of dominance over, and physical aggression towards, women and messages of assumed consent

and nonreciprocal sexual interactions. Australian data has shown that boys were watching pornography and learning this was what sexual relationships were like from the average age of 13 years (Hill, 2019). The gaming industry's negative portrayal of women as sexual objects created a disconnect when teenage boys encountered women 'so we need to look at what we are producing in content material in our society and what that content is communicating about women … we have to look at all of it to really change our culture' (Leser, 2019, pp. 182-183).

Research has not found a direct link between the viewing of hard-core pornography and sexual violence against women (Hill, 2019). However, it has reported 'alarming results about the way pornography has shaped young people's ideas of pleasure, power and intimacy' (Leser, 2019, p. 223) and SASs, such as the Gold Coast Centre Against Sexual Violence, had observed an increase in violent sexual behaviour (Hill, 2019). This intensified the need for feminist vigilance on sexual assault. Edwards et al. (2011) explained its relevance: 'Pornography itself is not the sole causative factor for aggressive tendencies or rape myth acceptance, but serves to bring these beliefs to the surface and reinforce such already held misogynistic beliefs' (p. 766). Hence, several government inquiries into violence against women, such as the NSW Legislative Council (NSWLC) (2012), had explored the possible link between pornography, masculinities, and sexual violence.

However, third-wave feminists also interrogated the concept of gender in relation to the men's experience and relational capacity. The fact that gender roles and gender stereotypes promoted certain characteristics and not others meant these stereotypical personality traits shaped male and female behaviour. For men, too, the shaping of 'appropriate' behaviour did not allow for optimal development and potential. It was not acceptable for males to portray the 'feminine' qualities of 'tenderness, compassion, vulnerability, friendship, relatedness, creativity, imagination and intuition' (Leser, 2019, p. 136). These qualities were repressed in a

patriarchal society that organised itself along stereotypical gender lines. Third-wave feminists argued, therefore, that patriarchy and gender constructs had been detrimental to men too.

Feminist understanding of sexual assault

Writers used the terms sexual assault, sexual abuse, and violence against women interchangeably in the literature. Generally, they used violence against women as an all-encompassing term, which encapsulated myriad forms of violence and abuse perpetrated by some men against some women. These included physical and sexual violence and psychological, emotional, spiritual, and social abuse. In terms of feminist understandings, particularly second-wave radical and liberal feminism, men used sexual violence to dominate, control, intimidate, subjugate, or have power over women (Brenner, 2014; DeKeseredy & Schwartz, 2010). Viewed through a structural-feminist lens, sexual assault resulted from gendered power relations, specifically male dominance and privilege within a patriarchal society (Brenner, 2014; DeKeseredy & Schwartz, 2010; Morgan, 2011).

Violence against women, in all its forms, was a human rights and social justice issue that, throughout history, resulted from unequal power relations between men and women (Fernandez, 2011). Khan (2015) described violence against women as the 'most pervasive violation of human rights' (p. 213). In a 2012 TEDx talk entitled *Where is Men's Roar,* Jeremy Meltzer, an Australian social entrepreneur, described rape as 'the most systematic and pervasive human rights abuse in the world' (Leser, 2019, p. xiii).

Increased awareness of the extent of violence against women and its significant impacts on individuals, families, and communities led to its recognition as a public health issue (Wall, 2014). The public health perspective, described in the WHO (2002) World Report on Violence and Health, emphasised the importance of the public health approach in responding to and alleviating interpersonal violence (in NSW Health, 2020). The WHO articulated that, as a public health and human rights issue, violence against women resulted in 'long-term personal,

social, health and economic costs to individuals, families and communities' (NSW Health, 2020, p. 18). It drew on an ecological systems framework with its comprehensive, multidimensional focus for understanding sexual assault and violence. It included an analysis of individual factors and the influence and interplay of individual and social factors (the microsystem); formal and informal social services (the mesosystem); and institutional and historical patterns maintaining sexual assault and policies to address it (the macrosystem) (AIFS, n.d.; Astbury, 2006; Campbell & Townsend, 2010; Campbell et al., 2009; DeKeseredy & Schwartz, 2010; NSW Health, 2020; Wall, 2014). Drawing on Bronfenbrenner's (1979) ecological framework, Campbell et al. (2009) highlighted how an ecosystems analysis considered individual bio-psycho-social characteristics, as well as sociodemographic variables, such as race, class, ethnicity, and religion. Psychological factors might include personality traits, cognitions and coping responses, and pre-existing mental health conditions. The individual level would also include assault-related factors, such as severity and degree of physical injury, dangerousness of the perpetrator, and whether known to the victim; and social factors, such as social support from friends and family. An ecosystems analysis examined the multiple systems with which individuals interacted:

- *Microsystem* focused on direct interpersonal interactions between individuals and members of their immediate environment, such as families, friends, and peers.
- *Mesosystem* included interconnections and linkages between individuals and between individuals, groups, and systems (employment, housing, religious, cultural, and informal support).
- *Exosystem* comprised organisations and social systems, including formal assistance systems, such as legal, medical, and mental health services; secondary victimisation when services were inefficient and insensitive; and advocacy services, such as rape crisis centres.

- *Macrosystem* factors comprised societal norms, expectations, and beliefs that formed the broader social environment, including policies, myths, and attitudes condoning male violence and blaming women.
- *Chronosystem* factors encompassed the changes that occurred over time between persons and their multiple environments, including revictimisation, multiple assaults, and negative post-assault experiences.

Understanding the multilevel factors in sexual assault aided assessment and helped identify loci or levels of, and targets for, change (Brenner, 2014; Campbell & Townsend, 2010; Edwards et al., 2011; Pack, 2011; Wall, 2014; WHO, 2002). In this vein, Ballou and West (2000) noted that 'feminist therapists use a bio–psycho–social–cultural–structural model of assessment and diagnosis—a model that provides not only a more complete understanding of personal functioning, but also informs and gives direction to the therapy itself' (p. 278). The ecosystem perspective pointed to various loci of intervention from personal and interpersonal to group, community, and policy levels (Campbell et al., 2009).

Feminists added a structural analysis that considered the interplay of culture, gender, sexuality, class, ability, and power inequities on gender relations. A structural-feminist analysis sought to understand the complex interrelated influences on individuals and families (Love et al., 2017). It acknowledged that everyday interactions and relationships between men and women sustained male privilege and interrogated the norms and beliefs reinforcing male dominance; and highlighted gender inequality as the key determining factor in violence against women (Evans, 2003; Krug et al., 2002; Wall, 2014). The NSW Health (2020) policies and procedures noted that gender inequality reinforced 'gendered power relations regardless of the gender identity of the victim or perpetrator' (p. 25). Krug et al. (2002) explained that 'sexual violence committed by men is to a large extent rooted in ideologies of male sexual entitlement' (p. 162). This sense of entitlement stemmed from unquestioned male privilege that contributed

to acceptance of skewed gender roles and, ultimately, sexual violence (AIFS, n.d.; Brenner, 2014; Edwards et al., 2011; Krug et al., 2002; Wall, 2014). Once interwoven into the fabric of society, this entitlement mentality resulted in men being 'blind to their own power and how normalised the exercise of that power is' (Leser, 2019, p. 182). Similarly, Herman (1992, 1997) observed that such entrenched attitudes and ideas about gender roles affected women's sexual behaviour so they would accede to their partner's desires, even when sex was nonconsensual. In his analysis of the submissions for law reform in sexual assault matters, Dyer (2019) went further, noting it was 'often misogyny … that causes a man not to appreciate the obvious fact that his sexual partner has refused to consent' (p. 26).

An extensive literature identified and emphasised that power and status inequities between men and women were key elements in violence perpetrated against women. Scholars built on Brownmiller's (1975) groundbreaking observation that rape and community attitudes towards it were social productions, not inevitabilities of human culture. For example, Thompson and Armato (2012) cited Jackson's (1995) portrayal of violence against women as 'a manifestation of culturally accepted patterns of male-female sexual relationships' (p. 287) that reflected 'deeply held beliefs and institutional configurations' (p. 270). Krug et al. (2002) referred to 'attitudes and beliefs, as well as behaviour arising from situations and social conditions that provide opportunities and support for abuse' (p. 159) as risk factors for men committing sexual violence (WHO, 2002). However, in drawing attention to the fact that men, too, were victims of sexual violence, Dolan (2017) highlighted:

> The vexing question of why what is received and perceived to be a 'gender analysis' in policy and practice (notably in the area of so-called 'gender mainstreaming') is generally about women, not about men … privileging women's narratives, and exhibiting a normative commitment to addressing male–female gender inequalities writ large (p. 4).

Hill (2019) noted decades of research confirming that men who subscribed to rigid gender stereotypes were more likely to abuse their partners. Gilmore (2019) referred to this wide body of research showing that rape was not about sex but about power and control, and men who committed rape chose to do so. She drew attention to the 2010 Marquette University study finding that men were more likely to commit rape if they believed rape myths to be true or if they associated sex with power. Hence, Gilmore (2019) asserted that 'the underlying driver in violence is not male hormones or 'wiring', but power – and the need to experience that power both in how we see ourselves and how we see our place in the world' (p. 150). She further contended that violence was not only an expression of natural assumptions about male power but also reflected their uncertainty about holding onto it and their fear that they might lose their dominant hold on it, especially with the rising feminist tide. They had to assert their power to prove themselves worthy of having it and to show others they were maintaining their dominant position in society.

Ridgeway (2001) noted that, despite improvements in women's socioeconomic status, social attitudes and beliefs keeping women in a lower social position in society than men remained unchanged. Morgan (2011) believed such observations underscored the essential need for 'an understanding of the unequal power relations between men and women [as this] may be the only effective way of addressing the pervasive problem of violence against women' (p. 9). In addition, issues of power, class, culture, sexuality, and abilities, and their intersection in constructing power relations in society, needed to be considered as part of the larger project of analysing, challenging, and addressing sexual assault at the individual and structural levels (Carlson, 2005; Costello & Backhouse, 2019; NSW Health, 2020; Thompson & Armato, 2012). As Thompson and Armato (2012) highlighted, 'the *domination* [original emphasis] of men and the *subordination* [original emphasis] of women are built into institutional arrangements and practices' (p. 13). Therefore, to reduce violence against women, it was necessary to change

social policies, institutional practices, and service-delivery levels. This can be further linked to accounts of sexual violence that occurred in times of conflict and war. Walby et al. (2015) noted that 'the use of rape as a weapon of war has consequences for the long-term perpetuation of ethnic hatred and political instability' (p. 5). Whether in war or peacetime, sexual violence had long-term consequences, resulted from constructions of gender and issues of power, and included interrelated forms of oppression, such as culture, religion, sexuality, ability, and class.

Regardless of situational circumstances, the NSW Health (2020) sexual assault policy and procedures considered perpetrators of sexual assault 100% responsible for the crime, since, ultimately, they made the decision to perform such acts. The policy encouraged an awareness of the interplay of power and the vulnerabilities of victims, due to *inter alia* age, gender, ability, and mental health issues, in understanding the occurrence of sexual abuse and assault. As Yarrow Place (2009) stated, it was 'important to remember that rape and sexual assault happens when the perpetrator exploits vulnerabilities and this does not make the victim/survivor responsible for the rape or sexual assault' (p. 27). The perpetrator was always responsible for sexual assault, never the victim (NSW Health, 2020; Yarrow Place, 2009).

Feminist-informed practice

Okun (1986) observed that feminist-informed practice had long dominated the sexual assault field. What made feminist practice within SASs feminist in their early days was its focus on valuing women's experiences and achieving improvements in the lives of women, informed by sociocultural and structural understandings of gendered power relations. Indeed, 'the central place of feminism in the development of Australian sexual assault services is well established in existing histories' (Egan, 2019, p. 169). DeKeseredy and Schwartz (2010) stated that most experts would agree with Okun's (1986) assertion that feminism was 'the most important theoretical approach to conjugal violence/woman abuse' (p. 100). Feminists were at the

forefront of the development of government SASs in Australia and a feminist philosophical framework continued to inform practice over subsequent years. Against this backdrop, discussed below are three aspects of feminist-informed practice:

- Person-centred and politically informed
- Centrality of the therapeutic relationship
- Gender of the counsellor

Person-centred and politically informed

Feminist practice developed at the end of the 1960s and evolved in subsequent years of increased feminist understanding and action grounded in a value-based theoretical perspective broadly defined as *person-centred and politically informed*. It sought to have a positive impact on women's lives and society more broadly, and positioned treatment within a sociocultural context of unequal power relations, while, in the case of sexual assault survivors, responding to the personal impacts of the trauma they had experienced (Brown, 2004; Herman, 1992, 1997; Thomas, 1997).

The sociopolitical context of Western society that privileged the voice and contributions of men silenced women (Brown, 2008; Fraser, 2005). The feminist practice assertion that the *personal is political* meant seeing violence against women in a sociocultural and not just an individual context. Thus, it was important to consider issues of power and privilege in the individual stories of women's lives (Astbury, 2006). Brown (2008) described feminist practice as 'a paradigm that developed from the grassroots of practice, and its beginnings occurred in the context of many people's experiences and interactions, all of which have combined to create consensus models of feminist practice' (p. 278). Brown (1994) defined feminist therapy as:

> The practice of therapy informed by feminist political philosophies and analysis, grounded in multicultural feminist scholarship on the psychology of women and

> gender, which leads both therapist and client toward strategies and solutions advancing feminist resistance, transformation and social change in daily personal life, and in relationships with the social, emotional and political environments (pp. 21-22).

Thomas (1997) found three intertwined components in feminist therapy: a feminist value system comprising feminist humanism and feminist consciousness; a therapist-client relationship and therapeutic process based on this value system; and the processes of consciousness-raising emphasising the commonalities all women shared and transferring the therapist's feminist value system to the client. As such, rather than a distinct therapeutic approach, feminist therapy was a philosophical and value orientation committed to personal and social change (Ballou & West, 2000). To this end, its efforts were 'directed toward helping the individual to recognize the sociopolitical and economic forces, the societal structures and gendered expectations that contribute to pain and discomfort while simultaneously discovering personal resources and healthy resistances as means of empowerment' (Brown, 2008, p. 275). Brown (2008) noted that nowadays 'feminist therapy is practiced by people of all genders, with every possible type and configuration of client' (p. 278). A sociocultural analysis not only considered gender but also other forms of oppression, such as race, sexuality, and religion (Love et al., 2017). The critical intersectional framework developed by black feminists and women of colour highlighted the coexistence of multiple oppressions, none of which occurred in isolation (Love et al., 2017). As well as situating the personal problem in the sociocultural and political context, contemporary feminist therapy valued diverse perspectives and experiences and recognised multiple intersecting oppressions (Brown, 2008).

Feminist practice aimed to hear, explore, and understand women's experiences from women's perspectives (Fraser, 2005). Feminist awareness raising, protest, and practice highlighted the connection between personal issues and the political or structural arrangements and foundations of society. This lay 'at the heart of feminist analyses of sexual violence …

[since] power, or the abuse of power inherent in sexual assault, is the linchpin in the production of a specifically feminist counselling practice in this field' (Egan, 2019, p. 175). Thus, among the awareness-raising techniques used was a gender-role and power analysis, involving 'questions about roles and role behaviour that are designed to break down … acceptance of sex-role stereotypes, and they also encourage the women they see similarly to question these sexist assumptions' (Thomas, 1997, p. 452). This was part of reframing the problem (as used in narrative therapy discussed in Chapter 3).

Feminist therapy was anti-oppressive to the extent that it sought to undermine the discriminatory gender stereotypes and biases contributing to oppression, trauma, and related problematic experiences in a safe, non-threatening, accepting environment. As Crowder (2016) explained, 'the collaboration between the therapist and the client is a space not only where personal healing transactions occur, but also a political space, a space that is potentially transformative for the client, the therapist, and society' (p. 28). Put simply, 'a therapy may be feminist so long as it meets the criteria of supporting feminist practice – the creation of feminist consciousness, the development of egalitarian relationship, and the empowerment of the client' (Brown, 2008, p. 291).

Centrality of the therapeutic relationship

The human 'need for sustained warm relationships' (Badenoch, 2018, p. 281) was a central tenet of feminist practice. Much of the feminist literature highlighted the importance of the relationship between the therapist and client (Draucker, 1999; Pack, 2011; Rothschild, 2000; Sanderson, 2013; Ullman & Townsend, 2008; Vilenica et al., 2013). As Brown (2008) noted, the relationship lay at the heart of feminist therapy:

> A relationship founded in the notion that equal value should be accorded all participants in therapy; that each participant is an expert, bringing particular sets of skills and

> knowledge to the collaboration, with no one set more highly valued than another; and that every act of the therapist has one aim – the empowerment of the client (p. 288).

Brown (2008) explained that 'feminist therapy's emphasis on an egalitarian, collaborative, and empowering relationship as the foundation for practice strengthens and deepens empathy and energizes the therapeutic alliance, both factors important to good outcomes' (p. 284). Developing 'an egalitarian and empowering relationship between therapist and client' (p. 287) meant minimising power imbalances by employing a strengths-based approach and avoiding diagnostic labelling.

Given the nature of sexual assault, the therapeutic relationship was where healing occurred (Crowder, 2016; Draucker, 1999; Sanderson, 2013). Herman (1992, 1997) explained that 'recovery can take place only within the context of relationships; it cannot occur in isolation' (p. 133). The essential element for the client was to feel safe and have a sense of control (AIFS, n.d.; Astbury, 2006; Gottschalk, 2009; Herman, 1992, 1997; Pack, 2011; Ullman & Townsend, 2008). The therapist's message to the client was that she believed her and her story. This was integral to the client's recovery and healing (Mason & Lodrick, 2013). Thus, the client should feel heard, believed, supported, valued, validated, and respected: 'In essence, the dehumanisation inherent in complex trauma, in which the individual has been objectified, can only be undone in the presence of a human relationship' (Sanderson, 2013, p. 38).

Feminist practice held to the belief that the woman seeking help was the 'expert' of her situation and, therefore, it was important that she made her own decisions and choices. Through person-centred practice, the client led the process, decided which information she wished to share, and when, and set the pace for recovery (Sanderson, 2013; Ullman & Townsend, 2008). In this context, feminist counselling aimed to provide a space for expression, and for personal and political change, where the 'personal power between the client and therapist' (DeVoe,

1990, p. 33) was as equal as possible. Feminist therapy took the power inherent in the counselling role into account advising feminist counsellors to ensure that they respected and maintained relationship boundaries and helped clients develop awareness, autonomy, self-identity, self-regard, and self-care (Brown, 2008; DeVoe, 1990; Herman, 1992, 1997).

There was strong evidence now for the value of the therapeutic relationship (Hubble et al., 1999) as 'the foundation for success in all psychotherapy' (Kellog & Young, 2008, p. 50). Johnson and Caldwell (2011) highlighted that 'numerous researchers and clinicians across the mental health professions agree that the therapeutic relationship is directly related to change' (p. 307). Heynen et al. (2017) further stated that the 'results of several studies now indicate that the quality of the therapeutic alliance has a significant impact on treatment outcomes … and may even be more predictive of positive therapy results than the type of the intervention' (p. 111). Further, Kezelman and Stavropolous (2019) highlighted that 'the therapeutic relationship itself fosters the client's relational capacity as a step towards building healthy support networks' (p. 39).

Choice of gender of the therapist

Research examining service-users' gender preferences for counsellors has shown a general leaning toward same-sex matching between service user and counsellor, i.e., it found that female service users preferred female counsellors (Landes et al., 2013; Moon et al., 1993). This was most significant when the issues explored in counselling were of a personal, sensitive, or sexual nature, including sexual assault and domestic violence (DeVoe, 1990; Fowler et al., 1992; Furnham & Swami, 2008; Snell et al., 1992).

Gottschalk (2009) explained this premise rested on the finding that 'men have different life experiences and women's perception is that they are not able to empathise in the same way that another woman who has had similar life experiences can' (p. 177). She found that 'clients overwhelmingly preferred a female counsellor' (p. 172). In highlighting the importance of

safety in service provision, a respondent to Gottschalk's (2009) study noted 'the presence of men could cause anxiety for female clients who were recently assaulted and [it was best that services] consciously avoided women and men sitting together in the waiting space' (p. 171). Thus, services had restricted activities of male counsellors, who, for example, could not be the one to answer phone calls (Gottschalk, 2009). In their qualitative study, Hoover and Morrow (2015) found female survivors trusted the researchers because they were women. As one participant said, 'a man couldn't listen and truly understand what I was going through ... but you could understand because you are also a woman' (p. 1481).

Furnham and Swami (2008) noted that 'similarity preference in terms of sex is consistent with the available literature, both in the medical … and counsellor … literatures' (p. 368). Landes et al. (2013) reported that 'some research has shown, for example, that girls who have been sexually abused show an initial preference for female therapists' (p. 331) and Simpson and Fothergill (2004) found that 'many researchers support the idea that female survivors of sexual abuse are best dealt with by female therapists' (p. 590). More recently, research into the gender of counsellor for survivors of sexual assault in the UK revealed that 82% of respondents thought it was 'very or quite important to disclose to a person of the same gender identity' (Love et al., 2017, p. 172).

However, Michel et al. (2013) found that 'data on gender matching and therapeutic outcomes remain unclear because inconsistent findings have prevented researchers from deriving firm conclusions' (p. 480). Research asking participants to consider how they might feel about a future possibility rather than an actual experience of seeing a male or female counsellor focused largely on the anticipated feeling of comfort of working with a male counsellor (e.g., Fowler et al., 1992; Landes et al., 2013; Snell et al., 1992; Stamler et al., 1991). Some of this research focused on the views of children, not adult females, the focus of this study, and thereby examined a different aspect of service provision (Fowler et al., 1992; Moon

et al., 1993). However, Fowler and Wagner (1993) noted that most research focused on adult clients rather than children. Thus, 'reports on the counsellor preferences of sexually abused girls are conspicuously absent from the literature' (p. 65). As Fowler et al. (1992) noted, there was a need for further examination of the role the sex of the counsellor played in the treatment of sexually abused children because sexual crimes differed 'from other situations for which children seek counselling in the degree to which the readily noticeable sex of the counsellor … related to the concern (p. 1). This might affect the child or parent's willingness and ability to trust the counsellor. This was true also for adult service-users' engagement with sexual assault counsellors.

Further, Fowler and Wagner (1993) noted that research on adult service-users' preferences of the gender of the counsellor remained inconsistent. Inconsistencies in findings on gender preference related to the characteristics of the populations under study and the issues (hypothetical or not) service users brought to counselling (Landes et al., 2013; Yilmaz-Gözü, 2013). Further, Fowler and Wagner (1993) reported that male and female service users showed a preference for male counsellors generally, but that female service users preferred female counsellors where issues were 'sensitive', including that of rape. They noted that:

> The traditional practice of assigning female counsellors to female survivors of sexual assault … amid the preponderance of inconsistent preference findings … suggests the existence of abuse-specific dynamics, which may have important treatment implications and which invite further study (p. 65).

Thus, for the most part, the literature leaned towards female counsellors for female survivors of sexual assault with some researchers claiming that only female counsellors were suitable for this work, as feminists had claimed. However, Fowler and Wagner (1993) drew attention to flaws in methodological approaches in much of this research, most of which depended on perceptions rather than actual client experiences. The researcher did not find any studies that

asked participants to reflect on their own experience of therapy with a male counsellor, particularly in relation to the presenting issue of sexual assault or sexual abuse, or violence in general. Nevertheless, the client's gender preference was an important consideration.

Most researchers assumed that trust of one's counsellor was important to the development of a strong therapeutic relationship and most studies have reported that sexually abused girls might develop an impaired ability to trust men. Putting these together resulted in the 'fear that male counselors may abuse their female clients ... [Hence] the recommendation to use same-sex therapeutic dyads has carried such strong face validity that it apparently has not been the object of empirical scrutiny' (p. 66). Thus, most researchers started with the assumption 'that clients will feel more quickly at ease with female counsellors' (p. 66).

Fowler and Wagner (1993) also identified concerning possibilities that could arise with female counsellor and female survivor dyads. These include female counsellors: positioning the service user against men; showing a strong inclination towards, and expression of, anger at men; and assuming women would be uncomfortable discussing the abuse story with men. Fowler and Wagner (1993) asserted that assumptions and ideologies undergirded these concerns rather than research evidence and clinical observations. Their study, although conducted with girls not women, showed that, despite anticipated anxiety about consulting male counsellors, post-treatment results of short-term psychoeducational intervention indicated no such anxiety for further counselling with gender-different dyadic counselling relationships.

Landes et al. (2013) highlighted that counsellor-gender considerations were important for organisations, as the preference of the gender of the therapist might influence the therapeutic relationship and, therefore, therapy effectiveness. Reflecting on their 2013 study on female service-users' preference for female therapists, they stated that their findings were consistent with literature suggesting that 'catering to client's preferences for therapy can lead to better engagement and outcomes' (p. 339). Acknowledging the limited research on the link

between service-user choice and therapy outcomes, Williams et al. (2016) found service users of government-funded psychological treatment centres in England and Wales, who were not offered adequate choices (including gender of therapist), were less likely to feel helped. This lent weight to the feminist principle of choice. As Brown (2008) stated:

> Finding every possible manner in which to invite clients to a more powerful stance is the theme running through what feminist therapists do in practice … the client is invited to begin to know ways that she has choice and, consequently, personal power (pp. 288-289).

Michel et al. (2013) highlighted the widening disparity between male and female counsellors in the female-dominated counselling field noting 'the gender gap in the counseling profession has created a female dominated environment, which contributes to male marginalization and privilege' (p. 480). This was different from the 1970s, when half the counselling profession in the USA was male. The same pertained to Australia prior to the feminist movement. Though Pease (2000) wrote about men working with men in the human services generally, his comments were relevant to the central issue in this thesis of men working with women. He argued:

> A profeminist men's standpoint involves an ability to be critical of men's position in society and how it contributes to the inequality of women and developing an ethical and moral commitment to addressing that inequality and discrimination because of the harm it causes (pp. 59-60).

In her study of what service users wanted from therapy, Draucker (1999) highlighted that 'while clinicians and researchers are busy trying to determine the most effective approaches and techniques, survivors are concerned about support, validation, kindness, and most of all, empowerment' (p. 27). Similarly, in their study of mental health practitioners, Simpson and

Fothergill (2004) found ‘a consistently expressed view was that the therapeutic relationship was also more important than the gender of the therapist’ (p. 593).

Conclusion

This chapter examined sexual assault and the feminist perspective. First, it discussed changing definitions of sexual assault and legal reforms over the years. It examined the prevalence of sexual assault and the barriers to disclosure and reporting to police. It also outlined prevailing myths that maintained discriminatory public attitudes about, and misunderstandings of, sexual assault. It reviewed feminist perspectives that evolved with increasing awareness and analysis of gender, disadvantage, and male privilege. It explored the position of women (and men) in a patriarchal society and the subsequent oppression experienced largely by women. Importantly, it highlighted the structural analysis required to make sense of why sexual assault occurred and the reasons for its pervasiveness throughout society. The sociopolitical lens emphasised the interplay between people’s attitudes and beliefs (whether conscious or not) and the gender roles and stereotypes they sustained. It showed how media representations of women reflected dominant beliefs about gender, and how legislation supported and validated gender stereotypical expectations. The sociopolitical lens construed this as evidence of the power and privilege afforded to (white) men to the disadvantage and exclusion of women. It held that intersecting sociopolitical and cultural factors created the context in which sexual violence against women occurred. The ecosystems framework analysed these dynamics at all levels of society, i.e., in micro, meso, exo, macro, and chrono systems. A combined structural and ecosystems analysis pointed to avenues for intervention and challenge. It supported politically informed, person-centred, feminist practice that valued client choice and self-direction and the centrality of the therapeutic relationship for healing and recovery at the individual level. Feminist therapists informed clients about what to expect from, and did not proceed unless they

had agreed to, the therapeutic process. They focused on safety, respect, equity, and power sharing within the therapeutic relationship. Essentially, feminist therapists saw clients as experts of their own lives and reinforced their experiences, while placing them in the context of intersecting structural disadvantages, such as gender, race, sexuality, class, and disability, through consciousness raising. This structural awareness, combined with an ecosystems focus, made for a comprehensive response that laced the clients' personal problems with broader political understanding of sexual assault. The chapter also examined the question of choice of gender of counsellor within the framework of feminist-informed practice. It noted differing research outcomes pertaining to choice and preference of the counsellor's gender and subsequent therapeutic effectiveness. Overall, research on therapeutic outcomes highlighted the centrality of the therapeutic relationship and the quality of the connection between counsellor and client as more influential than the clinical intervention or modality itself. The following chapter discusses the personal impact of sexual assault and therapeutic approaches used in sexual assault work, including trauma-informed practice.

CHAPTER 3

Sexual assault counselling and therapeutic approaches

It's to do with the click … once that happens [it's] magic (Shirley)

Our feminist perspective … is just giving women who seek our service choice, choice, choice (C2)

This chapter discusses sexual assault counselling and therapeutic approaches, including trauma-informed practice in the belief that clients and therapists, in collaboration, should be able to choose from a range of best practice options suited to their personal needs and issues. It begins with a discussion of the personal impact of sexual assault and examines the influence of variance perspectives on the way in which clinicians approach therapy, before reviewing the range of therapeutic approaches currently in use in sexual assault work. Research on the effects of sexual assault and abuse attested to its complex, multifaceted, serious, and long-lasting impacts on the personal lives of survivors (AIFS, n.d.; Costello & Backhouse, 2019; Campbell & Townsend, 2010; Carlson, 2005; Edwards et al., 2011; Fernandez, 2011; Gilmore, 2019; Herman, 1997; Nielsen et al., 2014; NSW Health, 2020; Regehr et al., 2013; WHO, 2014).

Regehr et al. (2013) noted there was 'evidence that trauma associated with rape may be different than other forms of trauma in part due to the strong element of self-blame, the higher incidence of concurrent depression, and the increased risk of suicide' (p. 258). Similarly, Loxton et al. (2017) showed that women who experienced sexual assault had considerably poorer mental health, with increased rates of anxiety, self-harm, and illicit drug use. Other

effects included post-traumatic stress, social and work adjustment problems, and sexual dysfunction (Regehr et al., 2013). Herman (1992, 1997) noted that rape survivors experienced high, and persistent levels of PTSD symptoms compared to those who suffered from other crimes of sexual violence. Campbell and Wasco (2005) reported that 'within the past 20 years, we have learned that the mental health effects of this crime are devastating as rape survivors are the largest group of persons with post-traumatic stress disorder' (p. 128). The complex, multiple effects of sexual assault included physical (bodily health and medical); emotional, psychological, spiritual, and neurobiological (mental health); legal and educational (social); employment (economic), and government policy and service (political) impacts. Though most of the literature on intervention included case reflections, descriptive analyses, and uncontrolled studies, there were few studies, such as Regehr et al. (2013), which examined controlled effectiveness research.

Influence of perspectives on therapeutic approaches to sexual assault

The way in which clinicians (therapists and counsellors) approached sexual assault determined the way in which they dealt with research evidence (facts) on its multiple impacts. As discussed in Chapter 2, there were multiple perspectives on sexual assault, each of which implied particular therapeutic approaches and social interventions. The discussion also showed the meshing of feminist and trauma-informed practice through the equation of sexual assault with a traumatic experience. Nevertheless, a feminist perspective implied a value-based approach to practice based on an understanding of sexual assault as a gender-based crime, while a trauma perspective led to a focus on its psychological (and neurobiological) impacts and a recovery model emphasising healing, resilience, and resolution.

Feminist-informed

Brown (2008) noted that the US feminist movement, spearheaded by Barbara Wallston in the late 1970s, developed an 'epistemology that analysed issues of gender and power within the lens of feminist theory, rather than a more atheoretical study of women' (p. 283). Wallston's argument had informed the opening of feminist practice to men because the essentialist notion that only women could be feminist therapists, or that feminist therapies were about 'women's issues', began to fade in favour of therapies focused on analyses of power, gender, and, increasingly, other social locations informing identity. Feminist therapists in the early 1990s 'brought to the foreground how sexism and patriarchy were oppressive to men as well, albeit in ways different from how women are affected' (Brown, 2008, p. 283). As community awareness and understandings about men's violence against women grew, so too did feminist theory and feminist therapy. Over the years, feminist theory and practice reflected growing awareness of the importance and value of diversity and inclusivity, as feminist theory grew in the late 1980s 'to attend more specifically to human diversity and complexity' (Brown, 2008, p. 285). This broadened feminist theorising on the impact of 'ethnicity, culture, social class, sexual orientation, disability and ability, and the meanings of indigenous status, histories of colonization, and experiences of emigration and dislocation' (Brown, 2008, p. 294). This progression saw feminist therapy and feminist psychology move, through the 1990s and 2000s, in the direction of inclusion as a known and independent therapeutic approach and one accepted in mainstream psychological practice and care (Brown, 2008).

The perspective that sexual assault was a gendered crime led to a focus on gender-related, social, and legal impacts. As discussed in Chapter 2, it also suggested a person-centred, politically informed response with an intense focus on the therapeutic relationship and personal impacts of the *traumatic sexual assault experience* (Brown, 2004; Herman, 1992, 1997; Thomas, 1997). Thus, feminist practice was also trauma-informed and centred on healing and

recovery. The therapist always focused on client choice, i.e., allowed the client to lead conversations, decide what information she shared, and set the pace for her recovery (Brown, 2008; Herman, 1992, 1997; Sanderson, 2013; Ullman & Townsend, 2008). The sociopolitical lens, mindful of the silencing of women's voices, meant that feminist therapists approached female clients believing and validating their account of the sexual assault, seeing them as experts, who brought 'particular sets of skills and knowledge' (Brown, 2008, p. 288) to the therapeutic encounter. As Herman (1992, 1997) stated, 'the first principle of recovery is the empowerment of the survivor. She must be the author and arbiter of her own recovery' (p. 133). This did not imply an unquestioning stance but meant accept and do not judge while exploring the details of the experience and assessing its impacts. Judging and questioning straight off the bat would merely reinforce the dominant social and legal response of disbelief and fact checking. It would close off disclosure. An accepting and nonjudgmental attitude was also part of creating a therapeutic-relational environment where the client felt safe and comfortable talking to the therapist or counsellor. It also created a trusting environment for feminist consciousness-raising, highlighting 'the commonality shared by all women' (Thomas, 1997, p. 452) to create a sense of not being alone. It was also part of reframing the problem so clients understood they were not to blame for what someone else had done to them; the assault was not due to deficits or weaknesses in them; the perpetrator was wholly to blame and responsible for the assault; and had done this to them to control or dominate them. This reframing was part of helping clients discover 'personal resources and healthy resistances' (Ballou & West, 2000, p. 275), within the feminist empowering, strengths-based approach. This involved a collaborative, egalitarian therapeutic relationship for personal healing and transformative change in which clients developed personal and social awareness, individual autonomy, a strong self-identity, positive self-regard, and protective self-care strategies (Brown, 2008; Crowder, 2016; DeVoe, 1990; Herman, 1992, 1997).

Trauma-informed

The perspective that sexual assault was a traumatic experience led to a focus on its physical, psychological, emotional, and relational impacts. However, there was 'marked variation in the effects of trauma from person to person' (Tseris, 2013, p. 159). Notwithstanding the strength and resilience of survivors in managing the strong and powerful emotions and reminders of the trauma in their daily lives, some commonly felt effects included acute mental health and chronic physical problems. Psychological effects included nightmares, intrusive thoughts, hypervigilance, flashbacks, and increased startle responses. They led *inter alia* to numbness and dissociation, lack of trust in others and the world around them, depression, lack of concentration, substance abuse, self-harm, suicidal ideation, shame and guilt, difficulties with relationships, and lack of self-trust (Astbury, 2006; Campbell & Townsend, 2010; Campbell & Wasco, 2005; Mason & Lodrick, 2013; NSW Health, 2020; Sanderson, 2013; Tseris, 2013; WHO, 2014). Extreme trauma could result in PTSD (Astbury, 2006; Campbell & Townsend, 2010; Campbell & Wasco, 2005; Fernandez, 2011; NSW Health, 2020; Love et al., 2017; Vilenica et al., 2013).

Kezelman and Stavropolous (2019) noted the symptoms of PTSD included 'persistent hyperarousal, avoidance of reminders of the traumatic event, involuntary recall of the incident … and compromised quality of life' (p. 258). Therapists made this diagnosis when patients exhibited chronic reactions to traumatic experiences that impaired their ability to function more than one month after the event (Rothschild, 2000). Chronic reactions usually followed experiences of complex (compounded) or developmental trauma, as seen in patients who had experienced abuse from someone they trusted, e.g., a spouse, partner, family member, or friend (Briere & Scott, 2015; Sanderson, 2013; Tseris, 2013; van der Kolk, 2014). Gallagher and Resick (2012) noted that many individuals with PTSD had 'distorted views of their degree of control over and role during their traumatic experiences and develop a generalized sense of

helplessness as a result' (p.751). In complex PTSD (or complex trauma) individuals experienced 'emotion regulation difficulties, interpersonal problems and a negative self-concept' (Oprel et al., 2018, p. 2). These often resulted in a decline in work or academic performance and attendance and negatively affected social and interpersonal relationships, housing, and personal finances (Thompson & Armato, 2012).

Sexual assault counselling

Mein et al. (2003), writing from a medical-management perspective, noted the importance of counselling for all sexual assault survivors, as psychosocial consequences were 'more common than physical injuries' (p. 266). However, evidence suggested that most victims did not use professional services or report the assault to the police (Bicanic et al., 2014; Campbell & Wasco, 2005; Wolitzky-Taylor et al., 2011), and those who received immediate coordinated assistance within integrated services reported 'improved mental recovery' (Bicanic et al., 2014, p. 2). Integrated services also increased the chances of the offender's apprehension (Bicanic et al., 2014; Campbell et al., 2008, 2012). For those who did approach services, Fernandez (2011) noted that sexual assault counselling involved attending to acute post-sexual assault needs and the enduring effects of sexual assault through psychosocial therapy and support services. In its PTSD guidelines, the UK's National Institute for Clinical Excellence (NICE) (2005), recommended an intermediary phase of 'watchful waiting' following a traumatic event that involved close patient monitoring based on the assumption that most victims improved without active treatment within a few weeks, if the trauma occurred less than one month ago and symptoms were mild. However, they related to PTSD diagnoses in the absence of complex trauma symptoms.

Post-acute care

Post-acute care to survivors of sexual assault involved crisis counselling that focused primarily on their presenting health and safety needs. Most presented with 'post-traumatic stress, depressive symptoms, alcohol or substance misuse or self-harm' (Mein et al., 2003, p. 266). Mein et al. (2003) noted that, when responding to a client's disclosure of sexual assault, it was important to:

- Ensure their privacy, safety, and allow adequate time for them
- Acknowledge their courage in speaking out
- Accept their story in a non-judgemental way leaving the police to investigate its veracity
- Explain that reactions to rape, such as shock, arousal, anxiety and fear were normal, and they were not to blame
- Convey that they were in control and could make choices about reporting, counselling, and medical treatment.

Beyond that, further action following disclosure depended on whether the survivor wanted to make a formal complaint. As this often entailed some time for deliberation, it was important to remember that:

> Most jurisdictions require that the first person who hears an allegation of sexual assault must give evidence if the complaint comes to trial, so [it was necessary to] document the exact words used, even if the victim is referred for forensic management (Mein et al., 2003, p. 227).

Mein et al. (2003) noted that early referral to a sexual assault service assisted forensic testing:

> A forensic assessment involves careful documentation of injuries and testing for the presence of foreign DNA; the findings are compiled in a court medico-legal report. Even if the victim is unsure about wanting to report the assault, if there is any possibility of a complaint being made forensic assessment will preserve evidence in case a formal report is made to police at a later date (p. 227).

At the acute stage, drawing on their medical and legal knowledge, counsellors would provide informed, nonjudgmental, timely responses liaising with relevant medical, and legal personnel as required, to help survivors through forensic medical and legal processes, informing them that DNA evidence was best to be collected within seven days of a sexual assault (Mein et al., 2003; NSW Health, 2020). In conjunction with medical staff, counsellors attended to *inter alia* important medico-legal considerations, such as the collection of forensic data (i.e., DNA swabs), medical examination and screening, and what reporting to the police would involve (WHO, 2003). Mein et al. (2003) noted that, though survivors might not disclose the sexual assault, they might 'present for medical care because of concerns about pregnancy, sexually transmissible infections (STIs), or injury' (p. 226); some wanted general medical care only, while others sought ongoing counselling.

Ongoing counselling and psychotherapeutic work

Ongoing counselling and psychotherapeutic work included:

> Defining and acknowledging SA [sexual assault]; assisting in normalising a client's symptoms and experience through psychoeducation (e.g. dispelling rape myths), which may contribute to self-blame, guilt, shame, depression and anxiety; as well as working

to increasing client confidence, coping skills and trust in others (Fernandez, 2011, p. 600).

SAS counsellors provided a holistic response to survivors and explored all areas of their lives, including their psychological and emotional needs (discussed below), physical health (sleep hygiene, self-care, diet and exercise), and social functioning (connection to, and development of, a supportive network). There were no limits to the number of sessions or length of engagement, though counsellors and service users remained focused on their purposeful work together. With increased caseloads and long waiting lists, management promoted a targeted approach of purposeful engagement. The time spent in therapy depended on the survivor's needs: some would complete therapy in a matter of months, while others would remain engaged for two years or more. Often service users moved in and out of, or withdrew from, therapy, while others persisted with the hard work involved in processing and resolving traumatic memories and symptoms. It was usual for service users to drop in and out of therapy as they progressed along their healing journey. Counsellors understood the:

- Way in which the crime of sexual violence, motivated by power and control, removed the survivor's choice and robbed them of dignity and respect.
- Impact of such betrayal and violation on survivors' sense of safety, and the way in which this compromised their understanding of themselves and the world around them.
- Testing process of disclosure, thus, they believed and supported survivors to aid their healing and recovery.
- Impact of trauma on the lives of sexual assault survivors, including their sense of self, work and study capacities, parenting and other relationships, and spiritual, mental, and physical health.

- Neurobiology of trauma and the relevance and importance of helping survivors understand this.
- Ongoing medical needs and interventions and when they were required, e.g., health needs in the post-acute trauma phase.
- Clinical interventions and support services available.

Counsellors focused on feminist-influenced psychoeducation, exploring the connection between the client's personal problems and political factors, such as the subordinate position of women and social structures maintaining this, the role of power in sexual assault, and social perceptions that women invited sexual violence by the way they dressed and behaved, and the resultant feelings of shame and guilt this engendered. With increased knowledge of neurobiology, psychoeducation also involved discussions of the way in which the brain and body responded to trauma. As Kezelman and Stavropolous (2019) noted, 'psychoeducation about the effects of trauma on the brain and body is a component of effective trauma therapy' (p. 35). This then would help clients to understand *inter alia*:

- Their reactions during sexual assault, such as freezing, to allay anxieties that they could have done something to stop the assault.
- How 'triggers' in the here and now activated stored memories of the trauma that produced physical or psychological responses, such as panic or disassociation.
- How to manage complex emotions and cognitions by learning how they affected everyday life.
- To this end, sexual assault counsellors, in collaboration with survivors, identified their symptoms, and their role in the survivor's life, and developed and encouraged the practice of relevant distress-tolerance, emotional-regulation, and coping strategies. This involved helping survivors:

- Connect to their body by developing an enhanced awareness of the messages (or signs) their body provided.
- Increase their skills in listening to these messages and responding, as required, to facilitate a balanced body and autonomic nervous system.
- Develop an emotional vocabulary and expand their ability to articulate the felt impact of the trauma.
- Expand their sense of their own identity so they did not define themselves only in terms of the sexual assault; they were more than survivors, they were mothers, sisters, friends, and colleagues. Counsellors did this by using a strengths-based approach, exploring and building upon the client's unique knowledge, strengths, resources, and skills.
- Support them to develop skills that they may not have been able to learn earlier in their lives, including assertiveness, social, community engagement, job seeking, dating and relationship, and parenting skills.

Several studies have reported on the work of sexual assault workers in Australia (Egan, 2015, 2016, 2019), the UK (Brooker & Tocque, 2016), the Netherlands (Bicanic et al., 2014), Belgium (Hendriks et al., 2018), Ireland (Eogan et al., 2013; Kelleher & McGilloway, 2009), and the USA (Campbell & Wasco, 2005; Ullman, 2005, 2010, 2014; Ullman, & Townsend, 2007). They provided insights into the work of sexual assault centres in Australian and international contexts.

Therapeutic approaches

The NSW Health (2020) policy and procedures recommended that sexual assault counselling required 'a range of evidence-based responses and interventions that meet the potentially complex safety, psychological, social, legal, medical and forensic, education and information

needs of clients, professionals and communities' (p. 28). The literature review revealed a range of therapeutic approaches used within sexual assault counselling, where a range of trauma-focused and feminist modalities co-existed to provide a holistic, comprehensive, and responsive therapeutic service for the unique needs of the individual survivor. As Brown (2002) highlighted, 'feminist therapists are open to strategies for change whose efficacy and usefulness are clinically demonstrated' (p. 265). Recent research showed that effective trauma therapy focused on three key dimensions: Processing at the cognitive, emotional, *and* sensorimotor (physical, sensory, and body sensation and movement) levels (Kezelman & Stavropolous, 2019).

Most interventions included 'behavioural techniques, such as exposure, systematic desensitization, eye movement desensitization and reprocessing (EMDR); cognitive behavioral therapy [CBT]; cognitive therapy; relaxation; and psychodynamic therapy' (Regehr et al., 2013, p. 259). Taylor and Harvey's (2009) meta-analysis of 15 treatment outcome studies between 1988 and 2005, where therapists used psychotherapeutic approaches for sexual assault victims experiencing PTSD or rape trauma symptoms, revealed beneficial outcomes, primarily assessed in terms of symptom reduction, with these effects maintained a year after treatment. Conversely, other research studies have shown that approaches, such as exposure therapy, CBT, and other psychosocial interventions, had high dropout rates and minimal symptom reduction, particularly at follow up (van der Kolk et al., 2014). Astbury (2006) reported that various psychotherapeutic interventions, particularly cognitive-behavioural and feminist therapies, were effective in the treatment of psychological, psychosexual, and psychosomatic concerns associated with sexual assault. The ISTSS (2019a) noted insufficient evidence to recommend the following PTSD treatments:

> Dialogical Exposure Therapy, Emotional Freedom Techniques, Group Interpersonal Therapy, Group Stabilising Treatment, Group Supportive Counselling, Interpersonal

> Psychotherapy, Observed and Experimental Integration, Psychodynamic Psychotherapy, Psychoeducation, Relaxation Training, REM Desensitisation, or Supportive Counselling for the treatment of adults with PTSD (p. 17).

There were strong recommendations, however, for 'Cognitive Processing Therapy, Cognitive Therapy, EMDR, Individual CBT with a Trauma Focus (undifferentiated), and Prolonged Exposure [PE] for the treatment of adults with PTSD' (ISTSS (2019a, p. 17).

There was strong agreement on the effectiveness of trauma-focused cognitive behavioural therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) as best-practice trauma treatments, particularly for adults with PTSD (ISTSS, 2019b; WHO, 2013). However, the ISTSS (2019a, 2019b) noted the need for further research on the relatively new diagnosis of complex trauma or C-PTSD that the DSM-5 had yet to include (Berliner et al., 2019). TF-CBT had been successful with children, who had 'experienced sexual abuse, exposure to domestic violence or similar traumas' (Wall et al., 2016, p. 4). The ISTSS (2019b), however, noted 'insufficient evidence to recommend Brief CBT-T, CBT-T or Stepped Preventative Care *within the first three months* [emphasis added] of a traumatic event for the treatment of clinically relevant post-traumatic stress symptoms in children and adolescents' (p. 13). However, it had proved effective in the longer term. The ISTSS (2019b) noted that CBT-T included:

> All therapies that aim to help PTSD sufferers by addressing and changing their thoughts, beliefs and/or behaviour. Typically, CBT-T involves homework and includes psycho-education, exposure work, cognitive work and more general relaxation/stress management; the relative contribution of these elements varies between different forms of CBT-T (p. 24).

The NSW Health (2020) policy and procedures provided a word of caution on CBT as research focused primarily on single rather than complex trauma or PTSD (Kezelman & Stavropolous, 2019). Van der Kolk et al. (2014) noted the lack of empirical research citing the US Institute of Medicine's finding that 'available scientific evidence for the treatment for PTSD does not reach the level of certainty that would be desired for such a common and serious condition' (p. 1). They noted that, overwhelmed by trauma memories, survivors had trouble with therapy, and many withdrew, or their symptoms worsened. In the absence of further evidence, the best clinicians could do was to assist survivors to develop affect-regulation and impulse-control skills (van der Kolk et al., 2014).

With multiple perspectives on, and therapies for, the treatment of complex trauma, Shapiro (2018) noted that 'our job as clinicians becomes more comprehensive and textured as we go beyond unilateral models and treat the whole person in the context of an interconnected social system' (p. 6). Kezelman and Stavropoulos (2019), too, noted that, since 2012, when they published their initial document on clinical treatments for complex trauma, 'the already wide range of treatment possibilities has expanded further to include many "new" approaches and practices which may have much to contribute' (p. 27). Generally, therapy for single-incident PTSD often involved helping survivors return to the emotional-regulation skills they had already developed, whereas those who had experienced complex trauma were at the beginning of learning and had yet to develop these skills (Kezelman & Stavropolous, 2019).

A notable issue with effectiveness research related to the diagnostic categories used for PTSD. Many researchers selected research subjects based on a recognised standardised diagnostic manual, such as the DSM-5 (APA, 2013). However, unlike the ICD-11 (WHO, 2018), the DSM did not include a diagnosis of complex trauma (C-PTSD). Further, the ICD diagnosis, added in 2018, would only come into effect on 1 January 2022. Nevertheless, the

ISTSS (2019a) provided evidence-based clinical guidelines to assist clinicians treating patients with PTSD.

The following section provides a brief description of a variety of treatment approaches used by clinicians to meet the multifaceted needs of survivors of sexual abuse and sexual assault, who had experienced trauma and complex trauma, mindful that 'there is no one perfect trauma therapy' (Shapiro, 2010, p. 1).

Art therapy

Art therapy used art as a medium to help survivors develop self-awareness by exploring their emotions and improving their social skills. Its primary aim was to help individuals experiencing emotional and psychological challenges achieve personal wellbeing and improve their level of functioning by addressing unresolved emotional conflicts through creative expression. It helped survivors express any obstructive thoughts and distressing emotions arising from their traumatic experiences and provided an alternative to verbal-only expression (Badenoch, 2018). It invited the unconscious mind to release thoughts and feelings that were disrupting or intruding upon their daily functioning. Used in conjunction with CBT, the unique properties of art therapy combined 'to create an effective model: a dynamic, synergistic pairing that is a powerful and efficient tool in trauma-focused treatment for childhood sexual abuse' (Pifalo, 2017, p. 170).

Body-oriented therapies

Body-oriented therapies, like mindfulness, nature-based therapies, psychomotor therapy, sensorimotor therapy, and yoga used the body as the 'primary access route for treatment' (Mize & Iantaffi, 2013, p. 63).

Mindfulness

As with yoga therapy, mindfulness helped people focus their attention on the present experience in a non-judgemental way and with acceptance and compassion. It did this by helping them to enhance their awareness of their body, mainly through breathing exercises, so they could monitor and manage their sympathetic nervous system and induce a sense of calm (Baer & Huss, 2008; Kabat-Zinn, 2013; van der Kolk, 2014). Further, mindfulness encouraged present awareness rather than automatic and unaware behaviour patterns or actions (Baer et al., 2008). Therapists used mindfulness in various therapeutic modalities, like DBT, TF-CBT, EMDR (Baer & Huss, 2008; Linehan & Wilks, 2015; van der Kolk, 2014), and nature-based therapies (Sundaram, 2014). It had become a shared feature of many modalities (Kezelman & Stavropolous, 2019). Crowder (2016) highlighted congruencies between mindfulness and feminist practice, such as 'communicating deep empathy and meeting people just as they are … Both create a sense of community' (p. 28).

Nature-based therapies

Nature-based therapies focused on 'healing through relationship with nature' (Badenoch, 2018, p. 281). Sundaram (2014) explained that 'nature-based therapy explores the connection between nature and our physical, psychological and spiritual well-being' (p. 52). Crnic and Kondo (2019) stated that 'doctors today see nature as a tool to combat ills associated with the urban environment' (p. 1376). Hawkins et al. (2016) asserted that 'nature-based interventions have long been used as a strengths-based approach to aid in positive human development' (p. 55). This mode of treatment derived from the observed calming effects of human interaction with nature and the natural environment. For example, therapists found that forest bathing had distinct measurable body responses, such as calming of the sympathetic autonomic nervous

system (Badenoch, 2018; Sundaram, 2014). Therefore, such activities could be helpful in lowering stress and anxiety and assist in the healing journey of sexual assault survivors.

Psychomotor therapy

Lucká and Lištiaková1 (2016) described psychomotor therapy as 'therapy through movement' (p. 159). Heynen et al. (2017) noted that it used 'body awareness and physical activity (sporting activities, games, and body experiences) as means to achieve treatment goals' (p. 112). Based on an interactive body-mind model, psychomotor therapy helped survivors create new memories to offset psychological distress and emotional deficiencies arising from past traumatic experiences. This highly structured intervention used body awareness and physical activity to encourage people to access and express their inner reality. The structured program of activity might involve use of three-dimensional objects, such as cushions or lamps (van der Kolk, 2014). In his book, *The Body Keeps the Score*, van der Kolk (2014) provided examples of psychomotor therapy with trauma survivors that positioned people or objects to create a 'tableau' – or three-dimensional structure – to move people or objects or incorporate dialogue. He explained that this allowed 'you to feel what you felt back then, to visualize what you saw, and to say what you could not say when it actually happened' (p. 299).

Sensorimotor therapy

Premised on the idea that 'the body holds a key for trauma recovery and emotional healing' (Leavitt, 2008, p. 221), sensorimotor therapy integrated 'body processing with cognitive and emotional processing' (Mize & Iantaffi, 2013, p. 63). Its founder, Pat Ogden, believed that trauma was stored in the body, sometimes unknowingly, and hidden and unresolved issues led to physical and mental symptoms, such as fear and anxiety (Ogden et al., 2006). Sensorimotor therapy helped survivors to heal by inviting them to become aware of bodily responses through mindful focusing and re-experiencing the mental and physical sensations (for example, through

a body posture or movement or facial expression) associated with the traumatic event or experience in a safe environment (Briere & Scott, 2015; Herman, 1997; Masero, 2017; Ogden et al., 2006; Rothschild, 2000).

Trauma-informed yoga

This relaxation therapy used yoga postures, breathing exercises, meditation, mindfulness, and guided imagery to cultivate an awareness of the body and, thus, improve mental and physical health. Its holistic focus encouraged a mind-body connection. Smoyer (2016) explained that trauma-informed yoga was 'a generic term used to describe a yoga practice that incorporates the research and knowledge about trauma and yoga' (p. 64). Trauma-informed yoga usually involved smaller groups of women who had experienced sexual assault. Aware of their vulnerability, the instructor encouraged them to trust their bodies, proceed at their own pace, and exercise bodily control by making choices to modify, stay in, or let go of a posture (van der Kolk et al., 2014). Used as an adjunct to other therapies, trauma-informed yoga provided a safe space in which the women could re-acquaint themselves with, and feel strength and power in, their own body. It assisted them to listen to their body responses to attune them to their reactions to triggering internal and external stimuli. The relaxing effects of the yoga exercises were valuable to their healing and recovery, as they increased their self-esteem and general sense of wellbeing (Baer & Huss, 2008; van der Kolk, 2014; van der Kolk et al., 2014). As van der Kolk (2014) explained, 'actions that involve noticing and befriending the sensations in our bodies can produce profound changes in both mind and brain that can lead to healing from trauma' (p. 275). Rothschild (2000) noted that, 'while it is well documented that PTSD goes hand in hand with disturbing bodily sensations and avoidance behaviours … attention to sensation and movement as a part of the trauma treatment strategy in psychotherapy has not often been proposed' (p. 101). van der Kolk et al. (2014) observed studies have reported that yoga was:

> An effective adjunctive treatment for a large variety of medical disorders, including asthma, heart disease and hypertension, diabetes, chronic pain, arthritis, and insomnia. Other studies … have demonstrated positive effects of yoga on depression and anxiety and on acute stress reactions (p. 2).

Cognitive therapies (CTs)

Cognitive or cognitive-behavioural therapies (CBTs) were short-term behavioural approaches that used cognitive-processing techniques to help survivors change erroneous thoughts about their traumatic experience and its impact, by examining the relationship between their cognitions (beliefs, perceptions, thoughts, and feelings) and the behaviours that ensued. The ISTSS (2019b) noted that cognitive therapists used various non-trauma focused CBT techniques, including 'stress management, emotional stabilisation, relaxation training, breathing retraining, positive thinking and self-talk, assertiveness training, thought stopping and stress inoculation training' (p. 23). CBT did not involve exposure to, and reprocessing of, trauma memories. It ameliorated symptoms of distress by assisting survivors to acknowledge and challenge distorted and unproductive thought patterns and promote helpful ones. As a specific evidence-based treatment, trauma-focused cognitive therapy (CT-PTSD) focused on:

> The identification and modification of negative appraisals and behaviours that lead the PTSD sufferer to overestimate [the] current threat (fear). It also involves modification of beliefs related to other aspects of the experience and how the individual interprets their behaviour during the trauma (e.g. issues concerning guilt and shame) (ISTSS, 2019b, p. 25).

Also called Cognitive Processing Therapy (CPT) (Gallagher & Resick, 2012; Regehr et al., 2013), their central focus was on survivors' interpretations of traumatic events and ensuing 'states of emotional disturbance … emerging from problematic, maladaptive, and/or unrealistic

… information-processing systems' (Kellog & Young, 2008, p. 43). Among other things, they aimed to address issues of control, self-blame, trust, self-esteem, and intimacy (Gallagher & Resick, 2012). They did this by focusing on maladaptive thought processes, such as 'erroneous interpretations of the event (e.g., self-blame) or distorted views of the self or world (e.g., "nobody can be trusted")' (Gallagher & Resick, 2012, p. 751), informing reactive behaviours in the belief that perception directly influenced survivors' maladaptive responses to their situation. CPTs included 'two written narratives of the traumatic event' (Gallagher & Resick, 2012, p. 751) as part of cognitive reprocessing:

> By repeatedly challenging the maladaptive cognitions through … cognitive restructuring techniques, individuals are able to develop more balanced and healthy appraisals of the traumatic event, themselves, and the world. The restoration of adaptive appraisals promotes recovery from PTSD (Gallagher & Resick, 2012, p. 751).

They also incorporated the process of homework for survivors to practise and strengthen what they had learnt in the CT session. Cognitive therapies included Dialectical Behaviour Therapy (DBT) and Acceptance and Commitment Therapy (ACT) (Astbury, 2006; Fernandez, 2011; Kellog & Young, 2008). Regehr et al.'s (2013) systematic review of effectiveness studies revealed that 'certain types of cognitive and behavioral interventions (CPT, PE [Prolonged Exposure], and EMDR) are indeed effective in reducing symptoms of depression, PTSD, and anxiety in victims of rape and sexual violence' (p. 263). They noted that 'individuals with higher levels of fear and depression have been shown to benefit from CPT and PE in the form of greater reduction in PTSD symptoms' (p. 263). Other studies showing the effectiveness of brief CBT programs in recovery following sexual assault included Foa et al. (2006) and Zoellner et al. (2011).

Acceptance and commitment therapy (ACT)

This CBT approach focused on value-guided, mindful action (Harris, 2007). Baer and Huss (2008) explained that ACT 'departed from cognitive therapy by not attempting to correct unrealistic or irrational thinking through cognitive restructuring. Instead, it proposed that distancing is the primary therapeutic process because it weakens the influence of thoughts on other behaviors' (p. 127), e.g., not only to notice and observe thoughts, such as 'I am hopeless', but also to provide distance by not attaching judgement or analysis or avoiding that thought. In so doing, the effect was to allow and accept the thoughts and emotions to arrive, and then to let them pass. Further, they noted that the name of the therapy emphasised the 'acceptance of thoughts and feelings as they are while choosing potentially effective behavior consistent with goals and values' (p. 128). Mindfulness was one way of facilitating this awareness and change (Baer & Huss, 2008). In sexual assault counselling, this therapeutic approach aimed to assist survivors to acknowledge and accept the emotional and psychological pain they were feeling based on the understanding that it was normal to feel such pain, when they have been harmed (individually and relationally). Accepting this could facilitate change in, and improve the quality of, their lives.

Dialectical behavioural therapy (DBT)

As a comprehensive and structured cognitive behavioural treatment, DBT focused on equipping people diagnosed with borderline personality disorder (BPD), who displayed chronic suicidal ideation and self-harm, such as cutting, with skills to reduce this 'ineffective and maladaptive behaviour' (Linehan & Wilks, 2015, p. 103). It included mindfulness practices, emotion regulation, and distress tolerance as part of its acceptance-based, problem-solving strategies. It has been successful in treating people with BPD who have not benefited

from other psychotherapeutic models (Baer & Huss, 2008; Briere & Scott, 2015; Sanderson, 2013).

Exposure therapy

Also called prolonged exposure therapy (PE) (Gallagher & Resick, 2012; Regehr et al., 2013), Zinbarg and Griffith (2008) defined exposure therapy as 'a widely used form of behavior therapy which involves repeated presentations of feared stimuli to facilitate habituation both within a psychotherapy session and across sessions' (p. 16). Gallagher and Resick (2012) noted it could 'facilitate recovery from PTSD via a habituation process that occurs through repeated imaginal and in vivo exposure exercises' (p. 750). It used cognitive-behavioural techniques to help people manage problematic fears by gradually exposing them to the situation causing their distress, and so helped them 'slowly become les reactive and less prone to disintegrate when they recall the event' (van der Kolk, 2014, p. 256). Many studies found exposure therapy produced 'clinically significant change in PTSD symptoms in multiple randomized controlled trials' (Gallagher & Resick, 2012, p. 750). In relation to sexual violence, for example, it could reduce trauma symptoms through gradually reintroducing survivors to the location, social setting, or activity where they experienced the traumatic event causing them psychological and physical distress provided the therapist created a safe environment to reduce anxiety, decrease avoidance of dreaded situations, and, ultimately, improve their quality of life (Zinbarg & Griffith, 2008). A recent study on exposure therapy with military veterans diagnosed with PTSD and co-morbid substance use disorder (SUD) added to the 'growing literature demonstrating that exposure-based treatments for PTSD do not increase the risk for symptom exacerbation' (Lancaster et al., 2020, p. 50). However, van der Kolk (2014) noted that 'simply exposing someone to the old trauma does not integrate the memory into the overall context of their lives, and it rarely restores them to the level of joyful engagement with people and pursuits they had prior to the trauma' (p. 256). Regehr et al. (2013) noted that 'models of treatment that

involve exposure should be used only when a sound therapeutic alliance has been formed and a thorough assessment has been completed … individuals embarking on this treatment should do so with full and informed consent, and therapists are advised to carefully monitor levels of distress during the treatment' (p. 263).

Narrative therapy

Narrative therapy was a nonpathologising, empowering, collaborative strengths-based approach that viewed personal problems as separate from the person and incorporated an analysis of power and the sociopolitical context (Tarragona, 2008; White & Epston, 1990). It focused on people's skills and competencies rather than their deficits and viewed them as experts of their own lives (Carmody, 1997; Morgan, 2000). Tarragona (2008) explained that 'narrative therapy is based on the idea that we give meaning to our experiences by organizing them as stories or narrations' (p. 186). The ISTSS (2019b) noted that Narrative Exposure Therapy (NET) allowed 'PTSD sufferers to describe and develop a coherent, chronological, autobiographical narrative of their life that includes their traumatic experiences (a testimony). The therapist facilitates emotional processing through … cognitive-behavioural techniques' (p. 25). In this way, narrative therapists helped survivors externalise the problem by exploring the distinction between the self and the issue, and the relationship between the two. They then invited survivors to reshape their story decoupling themselves from the problem. This reframed, strengthened, alternative, more positive, 'unique outcome' counteracted the dominant negative story. This was of prime value as often self-blame and self-hate formed part of survivors' stories of sexual abuse or assault (White & Epston, 1990). Tarragona (2008) explained that, 'generally speaking, the goals of narrative therapy are to accompany clients in a process of rewriting their lives, so that a painful or problematic story does not determine how they define themselves, whereas the development of other stories brings them closer to their preferred identities' (p. 183). As White and Epston (1990), observed, 'those aspects of lived

experience that fall outside of the dominant story provide a rich and fertile source for the generation, or re-generation, of alternative stories' (p. 15).

Neurobiological approaches

Eye-movement desensitisation and reprocessing (EMDR)

EMDR was a strongly recommended trauma therapy, along with TF-CBT (Berliner et al., 2019; ISTSS, 2019b; Shapiro, 2018; WHO, 2013). As an evidence-based, structured, short-term, integrative psychotherapy approach, it had proved effective in the treatment of symptoms of trauma, complex trauma, and post-traumatic stress following sexual assault (Rothbaum, 1997; Rothbaum et al., 2005). Based in neurobiology and informed by the Adaptive Information Processing model, it helped survivors remove painful memories in the brain from the here and now and place them in the past (Carlson, 2005; Shapiro, 2018; Solomon & Shapiro, 2008; van der Kolk, 2014). The ISTSS (2019b) described EMDR as:

> A standardised, eight-phase, trauma-focused therapy, involving the use of bilateral physical stimulation (eye movements, taps or tones). Targeted traumatic memories are considered in terms of an image, the associated cognition, the associated affect and body sensation. These four components are then focused on as bilateral physical stimulation occurs. It is hypothesised that EMDR stimulates the individual's own information processing in order to help integrate the targeted memory as an adaptive contextualised memory. Processing targets involve past events, present triggers and adaptive future functioning. EMDR at times uses restricted questioning related to cognitive processes paired with bilateral stimulation to unblock processing (p. 26).

Brown (2002) noted that, in applying EMDR therapy, feminist therapists treated clients as experts of their own lives and ensured the client's voice was central. They fostered an

egalitarian relationship and acknowledged the power of the client and therapist in their combined work together. To enable change to occur, they facilitated discussion of the targeted issues within a sociopolitical framework and encouraged healing amid consciousness-raising.

Neurofeedback

Advances in neuroscientific research identified the brain as a site for intervention using neurofeedback to train patients 'to achieve control of specific brain signals by means of feedback training' (Wood & Kober, 2018, p. 293). Findings relating to the brain's neuroplasticity pointed to possibilities to change and adapt maladaptive brainwave patterns and neurofeedback paths that transmitted information to parts of the brain (van der Kolk, 2014). Experts using this neuroscientific knowledge taught the patient to regulate brain activity to achieve a desired result. The approach relied on specialised equipment, usually an electroencephalograph (EEG), to map the brain's electrical neurofeedback activity. In this way, experts monitored, measured, and recorded brain activity in real time noting areas of high and low function (Wood & Kober, 2018). These experts then worked with this information to identify and address areas of the brain that might be experiencing dysregulation and helped individuals increase their ability to regulate brain function and promote positive brain activity.

Trauma-informed therapies

The traditional medical biological view of working with people who had experienced trauma symptoms held that something was wrong with the person, that is, he or she had a mental or psychological disease. Most medical approaches included pharmacological treatment. The trauma-informed view, however, held that trauma symptoms resulted from traumatic events and focused on the psychological injury and stress experienced following these events. It emphasised that there was nothing inherently wrong with the person – in sexual assault terms, the problem was what the perpetrator had done to them and the injury it had caused. Rather

than view trauma from a medical individual deficits model, it understood trauma symptoms as protective measures installed initially to shield the person from an intolerable and overwhelming situation or event (trauma-informed model) (Kezelman & Stavropolous, 2019). Salter (2019) described the former as the 'mental illness' model' and the latter as the 'mental injury model'; both understood psychological trauma as a general risk factor for negative life outcomes.

Judith Herman's (1992, 1997) seminal *Trauma and Recovery* gave impetus to trauma-informed feminist practice, which, she said, aimed at 'witnessing' women's experiences. It involved empowering women 'to reclaim the voices that were silenced within a context of trauma, so they may tell their own stories' (Tseris, 2013, p. 161). Many clinicians found Herman's (1997) feminist-informed trauma therapy most effective for survivors of sexual assault (Astbury, 2006; Draucker, 1999; Fernandez, 2011; Pack, 2011). It involved recovery and healing as a three-stage interwoven process: exploring and establishing safety, remembrance and mourning, and, finally, reconnection (Herman, 1997).

Issues of safety, long the focus of feminist therapy, were paramount for those who had experienced single or complex trauma (Astbury, 2006; Kezelman & Stavropolous, 2019; Rothschild, 2000; Sanderson, 2013). Hence, safety/stabilisation was the vital, first step of the gold-standard phased-treatment model (Kezelman & Stavropoulos, 2019). Advances in neuroscientific research had also reinforced feminist trauma-informed therapy. As Badenoch (2018) observed:

> Something is afoot in society right now, attempting to reshape the conversation and practice of recovery from every kind of trauma, and we in our counselling rooms may be able to respond to this emergence as we sense that the essence of trauma isn't events, but aloneness within them. Who we perceive as being with us *before*, *during, and after*

> an event is central to our ability to integrate the trauma throughout our embodied and relational brains (p. 25 emphasis in original).

Badenoch (2018) noted that many treatment modalities had:

> Emerged in recent years, primarily in response to our expanded understanding of the neuroscience of wounding and healing. Each way of working has value [thus] we are able to cultivate a safe space for the fluid emergence of any specific protocol (p. 281).

Additionally, 'the breadth and range of complex posttraumatic symptoms often require more than one interventional modality' (Briere & Scott, 2015, p. 518). Hence, the NSW Health (2020) policy and procedures emphasised that the varying impact of trauma for each client, meant practitioners must choose counselling methods carefully to 'achieve a "best fit" for individual client needs, strengths and hopes for change. This may mean the integration of a number of counselling modalities for many of our clients' (p. 266).

Generally, trauma-informed therapies focused on the psychological injury experienced following sexual assault. They used a strengths framework to help survivors rebuild a sense of control and empowerment, based on the understanding that the issues and situations for the person who has suffered trauma (psychological injury) were due *to something done to them* and not something inherently wrong with them (Salter, 2019). In responding to the impact of trauma, they emphasised physical, psychological, and emotional safety (Hopper et al., 2009). A primary task in Phase 1 was to help the survivor 'tolerate emotion (i.e. self-soothe; regulate affect)' (Kezelman & Stavropolous, 2019, p. 42) before embarking on the second phase of processing trauma memories.

For trauma-specific services, such as SASs, it was necessary for therapies, such as those discussed above, to sit within a trauma-informed organisational structure (Elliot et al, 2005). As Wall et al. (2016) noted, 'trauma-informed care is a framework for human service delivery

that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage' (p. 2). Elliot et al. (2005) argued that:

> To provide trauma-informed services, all staff of an organization, from the receptionist to the direct care workers to the board of directors, must understand how violence impacts the lives of the people being served, so that every interaction is consistent with the recovery process and reduces the possibility of retraumatization' (p. 462).

Wall et al. (2006) defined trauma-specific services as 'clinical services or programs designed to treat and ameliorate the actual symptoms and presentations of trauma' (p. 4). As with feminist therapy, trauma-informed therapy involved 'a collaborative approach which respects client choices' (Kezelman & Stavropolous, 2019, p. 43). Elliot et al. (2005) highlighted the connection between choice in therapy and the sense of control and self-determination in the service-user's life. Quadara and Hunter (2016), in their review of trauma-informed care in Australia, noted it was 'emergent' and 'piecemeal'. They observed that a major challenge was the capacity for leadership and management to hold consistent understandings and approaches to that of the services providing the trauma-specific delivery as 'the systems-level architecture to support trauma-informed care as a systems-level intervention is not sufficiently emphasised' (Quadara & Hunter, 2016, p. 8).

Conclusion

This chapter examined the personal impacts of sexual assault, the influence of feminist- and trauma-informed perspectives, the nature of sexual assault counselling, and the range of interventions and therapeutic approaches available to counsel survivors and treat associated symptoms. It began with a discussion of the development of feminist therapy and its focus on inclusion (Brown, 2008) and the importance of counsellors collaborating with service users to choose the best treatment approach. It suggested a broad-based intervention was required to

meet the complex needs of, and issues faced by, service users. These needs included safety, medical care, legal responses, education and information, and psychological support. An awareness of a range of therapies enabled counsellors to provide a holistic, comprehensive therapeutic service to address individual survivors' unique needs.

The chapter demonstrated the meshing of feminist and trauma-informed perspectives in contemporary counselling practice. The former centred on a value-based approach and understood sexual assault as a gender-based crime. The latter focused on psychological and neurobiological impacts and understood sexual assault as a traumatic experience. Importantly, the discussion showed that, to adequately understand the effects of trauma on survivors' lives, their service needs, and service engagement, trauma-specific services, such as SASs, needed a trauma-informed *organisational structure* (Wall et al., 2016), where staff throughout the organisation had an understanding and knowledge base to ensure service consistency and avoid re-traumatisation (Elliot et al., 2005). Underscoring this point, Australian research had shown a gap in leadership and management's awareness and understanding of a trauma-informed perspective and related therapeutic approaches (Quadara & Hunter, 2016). The following two chapters discuss the policy and service context of this study respectively; they provide a political and social backdrop to the development of SASs and counselling responses and provide an understanding of the service- delivery system in NSW.

CHAPTER 4

National policy context

But when I've used the sexual assault service, the buildings that they have used, feel like death to me, which have made them almost near impossible to get out the information that you need to get out (Jackie)

Feminists fought hard to have a feminist, a female-only service to provide, for the type of counselling that we are doing … is it a disservice not to work from that? (C11)

Chapters 4 and 5 outline the national and state policy contexts respectively. This chapter examines the changes in understanding of sexual assault since the 1970s through a historical analysis of legislation and policies to deal with sexual offences. While Chapter 2 highlighted microlevel (individual, family, and group) clinical interventions and Chapter 3 discussed therapeutic approaches, this, and the following, chapter examines the macro (policy) context, while Chapter 6 turns to the mezzo (service) level. This chapter structuring mirrors the ecological framework used in social work and the public health model undergirding sexual assault policy. The public health approach stresses early intervention and prevention that rests on accurate information on, and public awareness of, sexual violence in all its forms. It rests on the belief that everyone has a right to safety, especially in the home, given the foundational role of the family in society. The following overview of national and NSW state policy discussed in this and the following chapter describes Australia's policies designed to ensure

family wellbeing through addressing issues relating to family violence and sexual assault. They fall into four categories of legislation and policy to address sexual assault and its aftermath:

- At the national level, family law dealing with the consequences or fallout of family and domestic violence and sexual assault, including distribution of assets and ongoing financial and parenting arrangements, notably the custody of children, following relationship breakdown, separation, and divorce, and national policies relating to violence against women and children.
- At the state level, criminal law relating to judicial and forensic matters and the charging, investigation, conviction, and punishment of perpetrators for sexual assault crimes and state policies and legislation relating to violence against women and children, including procedures and guidelines for service provision and community engagement, discussed in Chapter 5.

First, however, this chapter examines the feminist influence on early policy development to address family violence and sexual assault, given their disproportionate impact on women and children.

Feminist influence on policy development

Feminists placed violence against women on the social agenda in the 1970s (Brown, 2008; Boxall et al., 2014; Carmody & Carrington, 2000; Eisenstein, 1984; Maguire, 2019; Salmelainen & Coumarelos, 1993). They highlighted that patriarchal structures in society marginalised and oppressed some groups of women more than others and put them at greater risk of violence (Hill, 2019). Violence, in turn, was a potential method of sustaining male superiority (Khan, 2015). Feminists connected contemporary violence to the history of male dominance over women and 'systematic male power and privilege' (Hill, 2019, p. 109). Through protesting against men's violence against women and children, 1970s second-wave

feminists broke the silence on this growing social issue (Boxall et al., 2014; Carmody, 2009; Wall, 2014). They fought for the recognition of violence against women as a political issue and advocated for the state to provide gender-sensitive policies and funding for feminist services to address the needs of women, children, and men. As a result, the UN recognised Australia as a model of good practice (Sawer, 2007). Summers (2003) noted 'we were the envy of some parts of the world for the innovative approach we had adopted towards women's policy' (p. 15).

Australia had followed international developments that grew out of the second-wave radical feminism with the women's liberation movement characterised by direct action, policy-oriented mobilisation, and political confrontation (Gray Jamieson, 2006). Its pro-woman stance 'led to a concentration on the central importance of gender, the intimate domination of women under patriarchy and a consideration of its institutional and ideological forms' (Dobash & Dobash, 1992, p. 75). Due to feminist consciousness raising, the period between the 1970s and 1980s saw an expanded understanding and awareness of sexual violence against women and children that led to many major changes to family violence and sexual assault legislation. Feminists held that power and gender were 'central features of sexual and domestic violence' (Breckenridge & Laing, 1999, p. 21). They also emphasised the voice of the victim and encouraged women and children to speak out about their experiences. By so doing, they attempted to broaden and strengthen community understanding about *gender-based violence* and its impacts. Further, feminists challenged professional discourses that had hitherto blamed women, interrogating their behaviour leading to the assault, implying that they were lying about their experience. They highlighted the lack of adequate and comprehensive responses to meet the needs of victims and survivors. As Breckenridge and Laing (1999) noted, 'the women's movement had confronted the unhelpful legacy of professional discourses … this very challenge influenced and reshaped professional discourse' (p. 22). Gray Jamieson (2012) noted

that through the 1970s and 'the golden years' (p. 14) of policy achievement for the women's movement in the 1980s, feminists worked to extend the movement through the development of women's services, including refuges and women's health centres. The National Women's Health Policy (NWHP) (Commonwealth of Australia, 1989) was the high point, despite the rising conservatism and neoliberal streamlining and privatisation of services (Chappell, 2001). (NSW government SASs arose from the women's health movement).

Due to feminist campaigns, rape law reform gained the government's attention and there were many significant changes to sexual assault legislation in the 1980s (Boxall et al., 2014; Mason & Monaghan, 2019; Salmelainen & Coumarelos, 1993). In 1983, a group of feminist bureaucrats (femocrats) and workers from rape crisis centres, refuges, and women's health centres established the Women Against Incest Collective in NSW, which called for a government task force (Sawer, 1990). Its recommendations led to major law reforms and massive increases in services for victims and their families. Hence, feminist agitation led to government funding for 'programs in the public and community sectors to provide services for victims … predominantly underpinned by a feminist analysis' (Breckenridge & Laing, 1999, p. 1). On the strength of this, the Australian government proclaimed itself a world leader in advancing women's rights (Gleeson, 2013).

As discussed in Chapter 2, feminist understanding of the influence of intersecting factors, such as gender, age, culture, ability, and sexuality on the experience of sexual assault, grew in the 1980s. As Andrew (2014) observed, as well as 'a feminist critique of the patriarchal–hierarchical nature of existing arrangements … [came] an understanding that the problems with which women were struggling were structural and interconnected' (p. 368). Thus, through the 1990s, feminists examined gender differences between men and women taking account of the intersection and impact of other systemic elements like class, race, and culture, and feminist community education campaigns included women from culturally and

linguistically diverse communities (Carmody, 2009; Salmelainen & Coumarelos, 1993; Sawer, 1990). Andrew (2014) observed that the focus on intersectionality and diversity marked a shift from 'the Women's Liberation ethic of grounding all political action in one's personal experience' (p. 371). As a result:

> The dominant understanding of Australian feminism is marred by an overemphasis on practical, externally focused action, and disconnection from the personal-transformative methods and [personal is political] elements of the movement … Many feminists perceived themselves as committed to a total transformation in gender relations, while expressing a need to make practical changes (Andrew, 2014, p. 372).

With these changes, Sawer and Gray Jamieson (2014) noted that 'the women's movement became less visible from the 1990s onwards and governments lost interest in responding to its demands' (p. 403). They attributed this, among other things, to 'a changed discursive environment that constructed the welfare state and women's reliance on it as a problem' (p. 403).

Breckenridge and Laing (1999), too, noted regressive steps in the 1990s with attempts to silence victims and survivors resurfacing. They cited the example of the 'false memory syndrome' controversy, where there were many stories of women who, years later, remembered sexual abuse experiences they had long 'forgotten'. In response, the 'popular press, legal system and therapeutic discourse' (Breckenridge & Laing, 1999, p. 1) discredited, dismissed, and ridiculed women with false memory syndrome and the professionals who worked with them. Breckenridge and Laing (1999) described the 1990s as a time of 'backlash' marked by attempts 'to reinforce old, and reimpose new, practices of subjugation and silences in relation to sexual and domestic violence' (Breckenridge & Laing, 1999, p. 23). They referred to Bettina Arndt's (1995) argument that domestic violence policy reflected a 'narrow ideological radical-

feminist perspective' (Breckenridge & Laing, 1999, p. 24) that supported legal sanctions rather than therapeutic interventions.

During the previous decades and into the 1990s, feminists expressed concern about the movement's alignment with the state given the regulatory powers tied to government funding. Sawer and Gray Jamieson (2014) noted 'working with government has … been blamed for depleting the energies of the modern women's movement in Australia and for de-radicalising it' (p. 404). With funding, came state regulation of previously autonomous feminist-influenced women's services (Breckenridge & Laing, 1999). State power would grow given the 'concurrent fragmentation' of the women's movement that had diminished its:

> Capacity to emerge with a cohesive and collective voice in public forums because of unresolvable issues around diversity within and between different 'groups' of women … Together these difficulties have allowed the greater intensity of 'backlash' politics that so often follows substantial cultural change (Breckenridge & Laing, 1999, p. 25).

Helped by the rise of neoliberal ideology, 'the policy impact created in the 1970s by the combination of a visible women's movement, receptive political parties and effective women's policy agencies within government had largely dissipated by the mid-1990s' (Sawer & Gray Jamieson, 2014, p. 405). Consequently, 'women's policy hubs were moved out of their central locations in Premiers' Departments by both conservative and Labor governments and into line departments dealing with families or community services' (Sawer & Gray Jamieson, 2014, p. 406). Other contributing factors to 'feminist fading' (Sawer & Gray Jamieson, 2014) or 'pragmatic compromise' (Magarey, 2014, p. 379) included 'the gradual disappearance from public view of an autonomous, active and oppositional women's movement' (Andrew, 2014, p. 367) and scepticism about the 'self-interested nature of social justice advocacy groups (redesignated as "special interest groups")' (Andrew, 2014, p. 375). Also, third- and fourth-wave feminists highlighted the diversity of women's experiences as well as men's issues; they

drew attention to the position of men and their vulnerabilities within a system that prescribed men's roles and responsibilities yet did not always meet their needs (Hill, 2019). In this way, they deflected attention away from the primary focus on women.

Nevertheless, 'feminist organisations retained a distinctive approach to organising and leadership, taking more care to ensure opportunities for all voices to be heard and with more recognition of the emotion work required to maintain organisations' (Sawer & Gray Jamieson, 2014, p. 407). Feminists continued their call for a coordinated and holistic response to end violence against women through legal reform, policy development, public education, and service provision. Their work in providing understanding of, and community responses to, this growing issue had paved the way for change in the political, legal, therapeutic, and community spheres. Sawer and Gray Jamieson (2014) observed that the element of 'feminist fading' did not affect the women's health movement as much as it did the wider women's movement noting:

> Ironically, in terms of social movement theory predictions, this may be because the women's health strand of the movement has had the longest and strongest engagement with government … On the whole, women working in women's services have not become depoliticised (Sawer & Gray Jamieson, 2014, p. 415).

Further, though structures inside government had weakened, those established outside had 'mostly survived and feminist principles have been sustained through to the second and third generation of activists' (Sawer & Gray Jamieson, 2014, p. 416). Consequently:

> The Australian women's movement looked very different in the twenty-first century than [it did] 40 years previously. It had adapted and survived with fundamental values intact, particularly a belief in the responsibility of government to ensure that women,

> regardless of background, were able to achieve their full potential (Sawer & Gray Jamieson, 2014, p. 411).

Feminists had spearheaded the anti-rape movement calling for services for, and public education campaigns to raise awareness of, sexual violence and its social impacts (Carmody et al., 2009; Maguire, 2019). They brought attention to the treatment of victims and survivors of sexual violence that resulted in progressive policy development at the national and state levels, as the following discussion shows.

National policy development

In Australia, federal (also referred to as national, Australian, or Commonwealth) and state governments assumed responsibility for social policy to address and respond to violence against women (Chappell, 2001). The Commonwealth led the way in policy development and legislative reform and facilitated cooperation between the federal and state and territory governments and various sectors and levels of governments. The states and territories bore responsibility for state policy development, legislation, criminal justice, and policing (Carrington & Phillips, 2003).

1970s-1980s: Whitlam to Fraser

Much of the policy of the 1970s reflected a feminist understanding of the origins of violence against women and attendant social issues. The entry of the second wave of women's liberation into the political sphere had introduced a gender perspective on policy development. Feminist research and advocacy highlighted the way in which men developed and implemented social policy and the law and defined sexual assault in a way that perpetuated stereotypes about women (ALRC, 2010; Sawer, 1990, 2007). In turn, key legal players, such as the police, prosecutors, defence lawyers, and judicial officers, reinforced myths surrounding violence

against women (ALRC, 2010). Feminist politicians and community activists worked to keep these issues on the political agenda and ensure the development of appropriate polices to address violence against women (Chappell, 2001; Maguire, 2019). Formed in 1976, the feminist lobby group, Australian Women Against Rape, coordinated reform efforts (Maguire, 2019), while feminists used social campaigns, such as the first Australian *Reclaim the Night* march held in Sydney and Perth in 1978, to raise awareness of, and protest against, men's violence against women. (*Reclaim the Night* was an international political movement, which began in Germany and Britain in 1977) (Maguire, 2019).

Andrew (2014) noted that feminist bureaucrats 'took advantage of political receptivity, especially from the Whitlam [1972-1975] and Hawke [1983-1991] federal Labor governments, entering the public service in roles explicitly created to advance gender equality' (p. 367). This had begun in 1972, when a group of feminists developed the Women's Electoral Lobby (WEL). Magarey (2014) noted that this marked the moment when the Women's Movement became involved with the state. The convergence of WEL and the newly appointed Whitlam government, the first Federal Labor government in 23 years, led to progressive reforms and policies for women (Dowse, 2014; Magarey, 2014). Gray Jamieson (2006) described this window in the 1970s and 1980s as an 'opportunity era' (p. 10), when the work of feminists within and outside formal political institutions led to the development of comprehensive, tailored strategic actions that produced positive outcomes and advancements for women and the broader community.

As part of the second-wave women's movement, WEL formed prior to the 1972 federal election to bring a feminist influence to bear on public policy and electoral politics (Andrew, 2014; Sawer & Gray Jameson, 2014). It conducted a candidate survey and canvassed potential electoral candidates to determine their views on issues affecting women and ways in which to address them (Sawer, 1990, 2007). It effectively translated 'the slogans of the movement into

concrete public policy demands' (Sawer, 1990, p. 1). This achievement was revolutionary; it was a first because the major parties had entered the election campaign believing women's policies were unnecessary (Sawer, 1990). Sawer and Gray Jamieson (2014) noted that WEL 'followed local social movement traditions of "looking to the state" and sought to institutionalise feminist agendas within government' (p. 405). Societal expectations at the time held that the government was there to provide support and assistance, which was necessary in a harsh geographically vast country with large distances between rural and metropolitan areas. These expectations went unchallenged until the 1980s (Dowse, 2014). Magarey (2014) described this social democratic period as one open and amenable to the idea of social provision through government support and benefits, though feminists believed the system privileged men over women.

The groundwork laid at this time led to the Women's Affairs Branch (WAB), headed by Elizabeth Reid, adviser to Whitlam. In 1977, it became the Office of the Status of Women (OSW) within the Canberra bureaucracy 'to take an ever-increasing role in the development of women's policy' (Dowse, 2014, p. 393). During Fraser's Liberal Government (1975-1983), the WAB 'sat at the hub of a number of women's units in key government departments' (Dowse, 2014, p. 400). Dowse (2014) observed that Fraser 'proved more sympathetic to women's aspirations than we had ever thought' (p. 400). Renamed the Office of Women's Affairs, the WAB 'returned to the [prime minister's] department in 1983 [under the Hawke government] and remained there until 2004, when Howard sent it to his Family and Community Services portfolio' (Dowse, 2014, p. 393). Dowse (2014) recalled that in June 1975:

> Elizabeth Reid was the star of the United Nations Conference for International Women's Year, the prime mover in drafting its world plan of action and getting it adopted. Her speech to the plenary session introduced the word 'sexism' to the official UN lexicon, thus incorporating it in languages around the world. It was a stunning

> achievement, and many women left Mexico City in the laughably mistaken belief that Australia was some kind of feminist paradise. In only a matter of weeks this illusion would be dispelled dramatically (p. 394).

Thus, it was that the UN noted Australia as an example of good practice, and international researchers saw its achievements as worthy of emulation (Sawer, 1990, 2007).

In 1974, the federal government called for an inquiry into human relationships, which became the Royal Commission on Human Relationships with a remit 'to inquire into and report upon the family, social, educational, legal and sexual aspects of male and female relationships' (Australian Government, 1977, p. ix) that included sexual assault (Carmody, 1990). The final report noted that family violence was a problem the community appeared reluctant to face and recommended, *inter alia*, legislative reform, improved victim care, and training for police officers and medical staff (Carmody, 1990).

Another important social policy initiative of the 1970s was the equal pay for equal work campaign. With the assistance of WEL, the federal government introduced legislation in 1974 that extended the minimum wage to women ending 'nearly seven decades of institutionalised wage discrimination in Australia' (Dowse, 2014, p. 395) and, along with this, the concept of the '(male) family wage' (Magarey, 2014, p. 385). Further, in the 1976 WEL state conference, there was a strong push for the reform of sexual assault legislation and improved services for victims (Carmody, 1990).

Family Law Act

The main piece of legislation introduced during this period was the *Family Law Act 1975* (Cth) to respond to private matters relating to divorce. Coming into effect in 1976, the Act introduced the concept of a 'no-fault divorce', which eliminated the need for separating parties to justify marital breakdown on one or other of the party's wrongdoing, such as adultery (ALRC, 2019).

At the time, safeguarding children and family violence and child sexual abuse was not yet on the radar of the family law system. Considered public matters, these issues were also historically the province of the states and territories. Hence, the original *Family Law Act 1975* (Cth) did not contain a definition of family violence until 1996, when the 'definition focussed on conduct that caused a person to fear or be apprehensive about their safety or property' (Alexander, 2015, p. 319). Further, Alexander (2015) observed that the Family Law Court did not have a gendered understanding of family violence in the 1970s and 1980s. Successive amendments to the Act ensued, as Alexander (2015) explained:

> In 2006, the notion of 'reasonably fear' was put into the definition [of family violence] leading to different interpretations as to what 'reasonably' entailed. This was widely criticized as devaluing women's experiences and ignoring reliable social science as to the ongoing effects of family violence … Section 4AB of the 2011 amendments replaced this with a broad new definition of family violence [as] … violent, threatening or other behaviour by a person that coerces or controls a member of the person's family (the family member), or causes the family member to be fearful (p. 319).

Figure 4.1 shows the definition of family violence on page 28 of the *Family Law Act 1975* (Cth).

Figure 4.1: Definition of family violence in the *Family Law Act 1975*

For the purposes of this Act, **family violence** means violent, threatening or other behaviour by a person
that coerces or controls a member of the person's family (the ***family member***), or causes the family
member to be fearful.
(2) Examples of behaviour that may constitute family violence include (but are not limited to):
(a) an assault; or
(b) a sexual assault or other sexually abusive behaviour; or
(c) stalking; or
(d) repeated derogatory taunts; or
(e) intentionally damaging or destroying property; or
(f) intentionally causing death or injury to an animal; or
(g) unreasonably denying the family member the financial autonomy that he or she would

> otherwise have had; or
> (h) unreasonably withholding financial support needed to meet the reasonable living expenses of the family member, or his or her child, at a time when the family member is entirely or predominantly dependent on the person for financial support; or
> (i) preventing the family member from making or keeping connections with his or her family, friends or culture; or
> (j) unlawfully depriving the family member, or any member of the family member's family, of his or her liberty.

As described below, Table 4.1 (on p. 148) shows the successive inquiries into, reports on, and changes to the difficult and contested terrain of family law as prescribed in the *Family Law Act 1975* (Cth) and implemented by the Family Court of Australia and the Federal Circuit Court of Australia (*Federal Circuit Court of Australia Act 1999* (Cth)). Nevertheless, these changes have not rectified the problems identified with the complexity and multiplicity of issues faced by families, including family violence and sexual abuse (Derrington, 2019). While the push for these reviews and inquiries arose in response to unresolved problems, they also reflected the political mood driving government priorities, as the following discussion shows. The ALRC (2019) noted that many of these changes had aimed to clarify and simplify the Act. Instead, however, it had become extremely cumbersome.

1980s-1990s: Fraser to Hawke

Persistent pressure from community-based women's organisations exerted a strong influence on policy initiatives in the 1980s and early 1990s. Continuing the momentum of the 1970s, the Australian Government made ongoing attempts to tackle the problem of violence against women through this period, still with a strong feminist influence (Chappell, 2001). To this end, it introduced three major legislative initiatives. First, in 1981, the Fraser Liberal Government instituted the Human Rights Commission (HRC), a national body to monitor and investigate human rights issues under the *Human Rights Commission Act 1981* (Cth). Secondly, in 1984, the Hawke Labour Government, following its anti-discrimination electoral campaign, recorded its 'signature achievement for women … the enactment of the Sex Discrimination and

Affirmative Action Acts (of 1984 and 1986, respectively)' (Dowse, 2014, p. 401). In 2013, Australia included gender identity and intersex status as forms of discrimination under the *Sex Discrimination Act 1984* (Cth) and the *Affirmative Action Act 1986* (Cth) required certain employers to provide equal opportunity in the workplace.

During this decade, the Federal government shifted funding responsibility for women's health centres, refuges, and rape crisis centres to the states (Sawer, 1990). Under pressure, the states agreed to locate monies from their treasuries (Gray Jamieson, 2006). This decade also saw the formation of several organisations and peak bodies, such as the NSW Immigrant Women's Resource Centre in 1982 and the National Association of Non-English-Speaking Background Women of Australia in 1986 (Sawer, 2007).

Organisations formed specifically to promote women's issues, such as women's legal services, health services, and sexual assault services. Each sector developed peak bodies to agitate and advocate for government reform (Sawer, 2007). Sawer and Gray Jamieson (2014) noted that 'the Women's Emergency Services Network and the National Association of Services against Sexual Violence (NASASV), represented large numbers of services (around 300 and 150, respectively)' (p. 408).

In 1984, the Hawke Labor government (1983-1991) established the Women's Emergency Services Program (WESP), providing funding for, and the payment of award wages to those who worked in, women's services (Sawer, 1990). In 1985, the combined Commonwealth and state Supported Accommodation Assistance Program (SAAP) incorporated WESP. Feminists resisted this move initially, claiming refuges were about domestic violence not homelessness. Gray Jamieson (2012) explained that:

> The advent of SAAP funding brought a measure of stability, in the form of five-year funding agreements. Perversely, perhaps, the end of the 'annual scramble for bitterly contested money' rendered the refuges invisible in a political sense. No longer forced

> to draw attention to themselves and to make their arguments public, there was less debate about domestic violence and the homelessness it caused (p. 113).

While the SAAP brought increased funding for women's refuges and rape crisis centres, it reduced the visibility of the women's movement (Sawer, 1990).

In 1986, the Hawke government established the Human Rights and Equal Opportunity Commission (HREOC) to process the anti-discrimination policies still outstanding due to the cessation of the AHRC by the Expenditure Review Committee of Cabinet (Sawer, 1990). However, despite increased engagement with Aboriginal women in policy circles, ultimately attempts to create a peak body for Indigenous women's issues were unsuccessful. This was due to tension within the Aboriginal community, and the perceived racist notions of the white women's movement's arguments about the high rates of family violence and sexual assault in indigenous communities (Sawer, 2007).

By the end of the 1980s, the focus had shifted to domestic violence, a priority for the Hawke government (Murray, 2005; Murray & Powell, 2011; Theobald, 2011). Building on the women's refuge movement of the 1970s, it instituted a National Agenda for Women in 1986 (OSW, 1988). Its purpose was to develop a national response to domestic violence to ensure violence-free homes in Australia (Alexander, 2015; Carrington & Phillips, 2003).

In 1989, the Hawke government introduced the National Women's Health Policy (NWHP), following four years of campaigning and policy development, and Australia became the 'first and only country to implement a national policy on women's health' (Gray Jamieson, 2012, p. 13). Gray Jamieson (2012) outlined the six principles underpinning the NWHP:

> A social view of health; a lifespan approach without undue focus on the reproductive years; participation by women in decision making as consumers and providers; women's rights as healthcare consumers, including privacy, confidentiality, informed consent and the right to be treated with dignity; the right to accessible information in

> order to make informed decisions; and the need for accurate data and research, including women's views about health (p. 14).

The NWHP identified seven key principles, including violence against women and the health effects of sex-role stereotyping (Gray Jamieson, 2012). There followed many innovative initiatives: additional women's health centres, information and referral services, and special projects (Gray Jamieson, 2006). While there remained federal support for these developments, NSW was withdrawing theirs through the late 1980s and early 1990s when Labor was not in power (Gray Jamieson, 2006).

Ullman (2010) observed that, during the social movements of the late 1960s and early 1970s in the USA, including second-wave feminism, feminists saw structural inequality and power as the major explanation for social problems like rape. But, in the 1980s, US society had returned to its strong individualistic roots and psychologistic responses and explanations of violence against women. Instead of focusing on social explanations of rape, the focus shifted to the psychology of perpetrators, viewing them as mentally ill or out of control and victims as 'asking for it or helpless' (Ullman, 2010, p. 33). The feminist risk-avoidance discourse that followed made women responsible for their own safety and urged them 'to stay away from certain places, and dress conservatively' (Carmody et al., 2009, p. 13). Many of the organised attempts to develop violence prevention programs 'primarily targeted women to reduce their risk of experiencing sexual assault' (Carmody et al., 2009, p. 15). More radical feminists argued, however, that the stranger-danger view of rape did little to prevent sexual assault by known perpetrators in marriage, ongoing intimate relationships, or the family.

In Australia, Carmody et al. (2009) noted the continued role of radical feminists in raising awareness about sexual assault through public education campaigns:

> This movement has always been committed to stopping violence happening in the first instance; at the level of what is referred to in public health discourse as primary

> prevention … the political activity of feminist bureaucrats (or femocrats) has been instrumental from the 1980s onward in shaping government policy and legal reform in the area of gender violence (p. 13).

For example, in 1987, under the Hawke government, there was a three-year media campaign and national survey on community attitudes to violence against women (Carrington & Phillips, 2003). Hence, the 1980s saw the continued push of women into parliament and policy arenas as they continued to subject policy proposals and impacts to a critical gender analysis (Gleeson, 2013; Sawer, 1990). Throughout this period, feminists maintained their connection to the international women's movement and used this avenue to advocate and protest for women's issues and reforms. To this end, they worked to align Australia with UN conventions and charters that addressed violence against women. Thus, Australia became a signatory to the UN Convention to Eliminate Discrimination Against Women (CEDAW), among other conventions. As Australia wished to maintain its well-regarded international reputation, these platforms contributed to the development of domestic policy reforms. Sawer (2007) observed that, 'by 1988, Australian women had won a growing international reputation for the kind of policy mechanisms they had developed' (p. xvi), despite the 'rightwards movement of the political spectrum … [and] the rise of economic rationalism based on the traditional gender-blindness of neo-classical economics' (p. xvii). These ideological solutions were inconsistent with the reality of women's lives and, for feminists, a backward step in advancing the position of women in society (Sawer, 1990).

1990s-2000s: Hawke/Keating to Howard

From the late 1980s and into the 1990s, neoliberal ideology gained traction with successive Liberal and Labor governments alike (Sawer, 2007). The 1990s saw Australia promote its vision of a productive economy based on competitive individualism. Welfare groups portended

the disenfranchisement of support and advocacy organisations for marginalised, vulnerable groups in the community. Cutbacks in government provision and privatised services promoted neoliberal consumer policy (Sawer, 2007). There was a growing economic climate, from the 1980s onwards, of neo-conservative economics and globalised capitalism, with a deregulation of the market and a redirection of resources from the public to the private sector (Jamieson Gray, 2006; Magarey, 2014).

At the same time, the differing issues of women's organisations and groups formed in the previous decades led to competition between them with several branching into independent peak and national bodies. For example, the formation of the peak body, Women with Disabilities Australia, in 1995 and similar developments rendered the feminist platform less visible, vocal, and influential in political and policy arenas (Sawer, 2007).

In March 1990, the Hawke/Keating Labor Government (1983-1991) introduced a National Committee on Violence Against Women, a Commonwealth-State government initiative of the National Agenda for Women (OSW, 1988). It ran for three years until 1992. Its aim was 'to develop a national strategy on violence against women, including sexual assault, which would guide research, policy development, legislation, law enforcement, community services and community education' (Salmelainen & Coumarelos, 1993, p. 10). The Committee's terms of reference included the aim to enable all levels of government – State, Territory, and Federal – to share experiences and policy responses on violence against women and assist in the coordination and development of policy, programs, legislation, and law enforcement on a national level (Chappell, 2001). It found that 'the degree to which many Australians condone violence is one of the fundamental impediments to achieving a non-violent society … [It] recommended that a national strategy to promote non-violent attitudes be adopted' (Salmelainen & Coumarelos, 1993, p. 11). To this end, under the Keating Labor Government (1991-1996), the Committee delivered the National Strategy on Violence Against

Women (NSVAW) (Australian Government, 1992). Informed by a strong feminist ideology with gender inequality at its core, the Strategy recognised violence against women as a human rights violation and sought redress through the government (Carrington & Phillips, 2003; Chappell, 2001; Murray, 2002). However, while there was no funding attached to the National Strategy for state and territory implementation, it remained in place from 1992 until 1996, when John Howard's Liberal-Coalition government came to power. Chappell (2001) observed that:

> The NSVAW was very much a product of its time. In keeping with developments in feminist and international discourse, it employed the more expansive term 'violence against women' in preference to 'domestic violence' to mark out the policy arena ... It also reflected a concern of government to engage with experts and interested members of the community in developing policy in the area (pp. 63-64).

Alexander (2015) noted that the Commonwealth government also contributed internationally, pledging its commitment to the Declaration on the Elimination of Violence Against Women (CEDAW) passed by the United Nations General Assembly in 1993 (UN, 1993). This obligated the government to demonstrate its actions to address and prevent violence against women as a social and human rights issue (Chappell, 2001). Thus, the ALRC (1994) *Equality before the Law* inquiry took CEDAW as its starting point and found that the legal system failed women in five key areas by:

- Leaving them in the dark, noting women often had difficulty finding relevant information.
- Brutalising victims by not taking them seriously, even when they were aware of their rights.
- Giving poor, wrong, or misleading professional advice with women claiming their solicitors lied to, intimidated, and threatened them.

- Prohibitive legal costs; because women were generally poorer than men, cost was a greater barrier to seeking help.
- Barriers to access, including childcare arrangements, physically intimidating court waiting areas, and inappropriate courtroom procedures, especially for women with special needs, such as Indigenous women and non-English speaking women.

It recommended the creation of a National Women's Justice Program (NWJP) to improve access for women and an Equality Act to remove gender bias and prescribe equal sharing rights to property upon separation, where previous legislation had favoured male interests (ALRC, 1994). However, changes afoot once Howard came to power in 1996 followed a very different course than that recommended by the ALRC (1994) that centred on women's interests.

The Keating Government continued with the measurement of community attitudes towards, and incidence of, violence against women with the follow-up Community Attitudes to Violence Survey (ANOP Research Services, 1995) and the Women's Safety Survey (ABS, 1996). Childcare, an area femocrats had prioritised for action and for which they had campaigned diligently for many years, became part of the government policy fabric under Keating (Dowse, 2014). However, to meet high demands for childcare, Keating introduced commercial operations to bolster community child-care centres, which expanded rapidly. Privatisation continued under the Howard Government overtaking the social policy focus of community-run centres; child-care costs resultantly increased (Dowse, 2014; Summers, 2003).

For feminists, things took a step back with the election of John Howard in 1996 (Liberal Coalition Government 1996-2007) and ensuing antifeminist backlash. Summers (2003) described Howard as Australia's 'most reactionary prime minister … a self-confessed social conservative who believes women belong in the home' (p. 125). Once in power, the Howard government removed the Office for Multicultural Affairs and OSW from the Department of the Prime Minister and Cabinet and abolished the Aboriginal and Torres Strait Islander

Commission (Sawer, 2007; Sawer & Gray Jamieson, 2014; Summers, 2003). It reduced the budget of the OSW and HREOC and failed to appoint a Sex Discrimination Commissioner for more than a year. It abolished several policy units established in prior decades, including the Office of Indigenous Women, Migrant Women's Advisor, Equal Pay Unit, Work and Family Unit, and the Women's Health Unit (Sawer, 2007; Summers, 2003). Feminists and welfare advocates criticised the Howard government's position on violence against women, its policies' lack of gender analysis, and its suppression of the study into the economic costs of domestic and family violence. The study had reported the economic cost of domestic violence was AUD 8.1bn and 98% of perpetrators were male. However, the powerful men's lobby had caught the government's attention with its claims that women were just as violent as men (Sawer, 2007) and emphasis on men's interests as separated fathers 'gained access to government and obtained substantial changes to the Child Support Scheme, the Family Law Act and family tax benefits' (Sawer & Gray Jamieson, 2014, p. 409).

From the mid-1990s, men's rights groups agitated against domestic violence policies, family law provisions, and parenting payments claiming they disadvantaged men. Sawer (2007) explained: 'The men's rights movement positions men as the new victims of feminist elites and of gender bias in the state' (p. 23). Several men's groups, formed during this time, emphasised unfair treatment and attitudes towards men, including 'Dads in Distress, Dads against Discrimination, Dads on the Air, Men's Confraternity, Parents without Partners, Parents without Rights, and the Men's Rights Agency' (Gleeson, 2013, p. 387). These competing interests focused on perpetrators of violence against women, rather than on its female victims, as policies reflected an increased emphasis on family values and a pushback towards family responsibility for domestic violence (Chappell, 2001).

Sawer and Gray Jamieson (2014) noted that these attempts by men's groups and various other agencies, supported federally by the Howard government, promoted violence as a non-

gendered issue. Men's groups, such as the Lone Fathers Association, argued that men were equally victims of domestic violence. The introduction into policy of gender-neutral terms, such as 'family violence', was a case in point. Covington (2008) argued that 'in most of the world today, the male gender is dominant, and its influence is so pervasive that it often is unseen. One result is that programs and policies called "gender neutral" are actually male based' (p. 378). Further, Summers (2003) observed that Howard was more interested in the needs of boys and men, and had an expressed focus on the current lack of male role models for boys, due to the existence of single mothers, the large number of women in the teaching profession, and the influence of the family law system.

At the same time, Australia's closer alignment with the US government apparatus coincided with a decline in UN influence internationally. In this environment, the Howard government disregarded the UN's criticism of Australia's treatment of Indigenous Australians and asylum seekers (Sawer, 2007).

Within a year of taking office, the Howard government convened a National Domestic Violence Summit, which resulted in the Partnerships Against Domestic Violence (PADV) initiative with a focus on prevention (Australian Government, 1997; Carmody & Carrington, 2000; Murray, 2002). While it retained the policy focus on domestic violence, it withdrew funding and disbanded services established under earlier policies (Chappell, 2001; Gleeson, 2013). The language used in the title reflected the obfuscation of power analyses and the gendered nature of domestic and family violence and sexual assault (Morgan, 2011).

Heather Nancarrow, a Queensland policy maker, saw the symbolic importance of PADV (Chappell, 2001). She believed that, by locking state and territory premiers into a commitment to address domestic violence, it demonstrated the government's seriousness about the issue at the national level, while giving state and territory governments the autonomy to deliver program responses (Chappell, 2001). The government developed the National Clearing

House on domestic violence and related policy areas and introduced emergency crisis payments to female victims of domestic violence through Centrelink. Based on 'pro-family' conservative values (Chappell, 2001), rather than a women's perspective, its 'neoliberal ideological orientation towards individualism and self-reliance' (Theobald, 2011, p. 6) came under criticism from feminists and critical policy analysts. Its gender-neutral focus on mutual obligation and dual responsibility constituted a vastly different analysis that minimised or disregarded feminist understandings of the unequal positions of men and women in society and the way in which this sustained violence against women. In removing a feminist gender analysis, the policy reintroduced 'victim-blaming' by focusing on the individual victim and her responsibility in avoiding victimisation (Carmody, 2009; Carmody & Carrington, 2000). Further, the PADV policy platform reflected a narrow focus on domestic violence to the detriment of policy responses to sexual assault that had 'all but disappeared' (Carmody & Carrington, 2000, p. 342). PADV's prevention focus centred on women as victims (and as campaigners) with little attention given to men's responsibility to end sexual violence against women. Further, it targeted those who had already offended to promote attitudinal and behaviour change rather than prevent future harm (Carmody & Carrington, 2000).

Multiple interest groups vying for attention added to the complexity of the policy landscape the government and service lobby were seeking to address. They included men's rights groups calling for recognition of male victims of violence, focused on physical rather than sexual violence. However, some men were involved in progressive political action and prevention. For example, Bob Pease formed Men Against Sexual Assault (MASA) in Melbourne in 1989 to educate men about rape, the 'dominant model of masculine sexuality and the prevalence of sexual assault in society' (Pease, 1995, p. 259). Pease (1995) counteracted the argument that all men were prone to sexual violence and that this was an innate male tendency. Instead, he held that men's violence was 'socially constructed and individually

willed' (p. 259). Pease (1995) brought the White Ribbon Campaign (WRC), which had originated in Canada, to Australia from Chicago, USA, in 1991, and established campaigns via MASA in several states for the next five years. The Federal Government, through the OSW, became involved in 2000 and the WRC became a central feature of national and international programs to prevent violence against women. White Ribbon Australia (n.d.b) introduced its history as follows:

> The White Ribbon social movement to engage men in preventing men's violence against women we see today lends itself to many fore-bearers from many countries and from a variety of voices. White Ribbon Australia's ability to be the movement it is today comes from a recognition it has been built on the tireless efforts of women and women-led organisations throughout history, internationally and in Australia (n.p.).

2000-2010: Howard to Rudd

In 2001, the Howard government introduced the National Initiative to Combat Sexual Assault (NICSA) to build on the achievements of the PADV. It 'established partnerships with states and territories to develop strategies and address the incidence of sexual assault in the community' (Carrington & Phillips, 2003, n.p.). This policy remained in place through the early 2000s.

In 2002, the Sex Discrimination Commissioner and HREOC conducted the first national telephone survey on sexual harassment (AHRC, 2004). The AHRC (2018a) conducted national sexual harassment phone surveys then every five years 'to provide robust evidence on the prevalence, nature and extent of sexual harassment in Australian workplaces' (n.p.).

Funding for the PADV program ended in 2003 and the Women's Safety Agenda (WSA) replaced it in July 2005. The WSA addressed four broad themes: prevention, health, justice, and services. It aimed to build on the achievements of the PADV and NICSA and gave

increased attention to preventing violence and providing early intervention and support for those affected by domestic violence and sexual assault. At the time, the Office of Women issued a statement that there were many forms of domestic violence, including:

> Physical violence, sexual abuse, emotional abuse, intimidation, economic deprivation or threats of violence. Domestic violence occurs in all geographic areas of Australia and in all socioeconomic and cultural groups, although domestic violence is a more significant problem for certain groups, such as regional and rural Australia and Indigenous communities (Carrington & Phillips, 2003, n.p.).

In its submission to the Inquiry into Crime, the OSW (2002) reported on crimes of violence against women, including domestic violence and sexual assault. It stated that, 'overwhelmingly the message heard from Australian women through research conducted by the Commonwealth Partnerships Against Domestic Violence (PADV) program, is '*we want the violence to stop* [original emphasis], but not necessarily by ending the relationship' (p. 2). Carrington and Phillips (2003), in their parliamentary e-brief, wrote that:

> The role of the Commonwealth has grown over time, through the implementation of the 1992 National Strategy on Violence against Women, the 1996 Women's Safety Survey, the 2005 Personal Safety Survey, and the Partnerships against Domestic Violence and the Women's Safety Agenda programs (n.p).

In 2003, the United Nations Development Fund for Women (UNIFEM) re-established the White Ribbon Campaign in Australia, with Andrew O'Keefe as the first White Ribbon Ambassador (White Ribbon Australia, n.d.b). In 2004, there was a national media campaign *Violence Against Women - Australia says no* (Alexander, 2015). However, the funding for this ceased a year later (Carrington & Phillips, 2003). Men's rights views were prominent at this time, supported and articulated by social commentator Bettina Arndt, sex therapist and men's

rights champion (discussed below). She was part of the parliamentary committee charged with reviewing family law legislation. Despite evidence to the contrary, 'populist discourse of men being systematically disadvantaged by the Court came to prevail' (Gleeson, 2013, p. 377). Thus, the ALRC (2019) noted that several amendments to the *Family Law Act* in 2006 diluted feminist understandings of the role and nature of domestic violence in family breakdowns and provided further evidence of a feminist backlash. These amendments included:

- The addition of the term 'reasonably fear' to the definition of family violence, which met with criticism, due to the various interpretations this notion raised, its inconsistency with social science research about the impact of family violence, and its disregard for, and minimisation of, the experience of women (Alexander, 2015).
- The introduction of the 'rebuttable presumption of shared parental responsibility' (Gleeson, 2013, p. 377) related to the support and care of children following divorce and the requirement that parties undertake genuine efforts to resolve disputes about parenting matters prior to application through the Family Law Court (ALRC, 2019).

The first in a series of four papers in the AIC's Violence Against Women Community Attitudes Project was Taylor and Mouzos' (2006) Violence Against Women Survey. They found persistent negative attitudes and stereotypes towards violence against women despite some positive changes over the prior decade and that, to varying degrees, these negative community attitudes influenced judges, jurors, and legal practitioners, to some extent. Though conducted in Victoria, the findings mirrored those reported in other jurisdictions and discussed herein.

In May 2008, the Australian Government established the National Council to Reduce Violence against Women and their Children (known as the National Council) 'to advise on measures to reduce the incidence and impact of violence against women and their children' (p. 3). The primary focus was family violence (Alexander, 2015). The National Council produced

the *Time for Action* background paper (Australian Government, 2009b), contained a review of the main policies and programs in operation across Australia in 2009 and acknowledged over-stretched services and long waiting lists for specialist services, including SASs. Its follow-up report in March 2009, entitled *Time for Action: The National Council's Plan for Australia to Reduce Violence Against Women and their Children, 2009-2021: A snapshot,* noted the fragmented service system:

> The first door must be the right door for women and their children seeking support as a result of violence. The sector responsible for delivering services to women and their children shows great flexibility, adaptability and responsiveness. The sector's workforce, however, needs strengthening and strategic planning for the future so that services can attract and retain the right workers with the right skills. Services also need to be confident about sustained and adequate funding to support their delivery of high quality and tailored responses that meet the holistic, often complex and multi-dimensional physical, practical and emotional needs of victims and their families (p. 9).

It claimed that 'significant barriers to effective collaboration and partnership impede genuine implementation of … [cross-departmental and inter-agency] approaches and no mechanisms to monitor and evaluate these whole-of-government approaches appear to be in place' (Australian Government, 2009c, p. 4). It recommended *inter alia* the establishment of 'a professional national telephone and online crisis support service for anyone in Australia who has experienced, or is at risk of, sexual assault and/or domestic and family violence' (p. 10). The Commonwealth supported its recommendations in April 2009, announcing that:

> It would invest $42 million immediately to address urgent recommendations. These included the establishment of a new national domestic violence and sexual assault telephone and online counselling service, the implementation of respectful relationships

> programs in schools and other youth settings and the development of a social marketing campaign targeted at young people and parents (Australian Government, 2011, p. 3).

It forwarded its responses to the state and territory governments for implementation. The National Council's work set the platform for the *National Plan to Reduce Violence against Women and their Children* (Australian Government, 2011), described further below. At the end of this period, opposition Labor campaigns too, contained little reference to women and had no clear direction or plan to challenge the influence of broader gender inequalities in society (Theobald, 2011). Chappell (2001) summarised developments as follows:

> Since the 1970s, particularly where Labor governments have been in office, the discourse around domestic violence reflected a feminist conceptualisation of the issue. In the 1980s and 1990s it was commonplace to read feminist-inspired statements in a range of federal and state ALP government documents … From the late 1980s, a competing discourse ran parallel to that used by feminists, especially where Coalition governments were in office (p. 63).

Chappell (2001) believed this competing discourse reflected conservative views on 'the importance of family values, and the need to reallocate resources from survivors to perpetrators of domestic violence' (p. 63). Carmody and Carrington (2000) observed:

> While we recognise that responsibilising victims and individualising offenders is consistent with wider global shifts in social policy calling upon individuals to manage their own risk, we argue that the increasing reliance on such neo-liberal social policy is especially problematic in preventing rape (p. 341).

Policy changes, particularly with a conservative government at the helm and its push to privatise public services, had further limited the influence of the feminist voice in and outside

political circles to encourage the implementation of reform. This was particularly so when the Government no longer held a social justice framework or gender and structural lens to its policy analysis as it had done through the 1970s and 1980s (Chappell, 2001; Sawer, 1990, 2007; Summers, 2003).

2010-2020: Rudd/Gillard/Rudd to Abbott/Turnbull/Morrison

National Plan to Reduce Violence against Women and their Children

Under the Rudd (2007-2010) and Gillard (2010-2013) Labor governments, several new initiatives brought *gender-based violence* to the fore, undoing the gender-neutral focus on 'family violence', under the Howard government. Established in 2008, the National Council to Reduce Violence against Women and their Children (National Council) led to the first commonwealth and state and territory government response to address violence against women with the announcement of the 12-year *National Plan to Reduce Violence against Women and their Children 2010-2022* (Australian Government, 2011; NSWLC, 2012). In the build-up to the development and implementation of the National Plan, Prime Minister Kevin Rudd made a speech at the annual White Ribbon Campaign in 2008, in which he noted the government's intentions to challenge men's behaviour, as this was paramount in ending violence against women. He highlighted the need for a whole-of-community response in acknowledging the influence of negative attitudes and behaviours towards women and posited zero-tolerance of violence against women (Carmody, 2009).

Overseen by the Office for Women, the Plan set out the Department of Social Services' responsibility for the Australian Government's work to achieve a sustained reduction in levels of violence against women and their children. It acknowledged that, 'at every level of society, gender inequalities have a profound influence on violence against women and their children. Building greater equality and respect between men and women can reduce the development of

attitudes that support or justify violence' (Oberin, 2011, p. 20). It focused on prevention and the provision of a coordinated framework for all governments to work together to reduce violence in the community (Australian Government, 2011; NSWLC, 2012).

The Plan included the first (of four) three-year action plans, *Building a Strong Foundation 2010-2013,* which laid an important foundation for long-term change. It established critical, national-level infrastructure to inform future policy and service delivery, including ANROWS, and engage the community in reducing violence against women and their children. Imbued in the strategy to tackle domestic violence and sexual assault (Australian Government, 2011) was the understanding that men's negative attitudes towards, and beliefs about, women were the underlying cause of male violence against women.

The Second National Action Plan (2013-2016) *Moving Ahead* had six national priorities relating to: keeping communities safe and free from violence; respectful relationships; strengthening indigenous communities; ensuring services met the needs of women and their children experiencing violence; effective justice responses; and making perpetrators accountable for their behaviour (Australian Government, 2013). The Abbott Government allocated AUD100m towards a Women's Safety Package to tackle family violence as part of the Second National Plan (Australian Government, 2015).

In 2016, the Turnbull Government supported several initiatives focused on violence against women. For example, the primary prevention campaign *The Line* and the media campaign *Let's stop it at the start* linked disrespectful attitudes and gendered behaviours in boys to later violence against women (AIHW, 2018). In addition, the Council of Australian Governments (COAG) Advisory Panel produced its final report *Reducing Violence against Women and their Children* to inform the Third Action Plan (Australian Government, 2016). The report emphasised the need for national leadership to challenge gender inequality and transform community attitudes; stressed the importance of choice for victims of violence; and

proposed an integrated, trauma-informed service response for victims and survivors, particularly for Aboriginal and Torres Strait Islander communities (COAG, 2016).

The Third Action Plan (2016-2019) outlined six national priorities focused on: prevention and early intervention; Aboriginal and Torres Strait Islander women and their children; greater support and choice; sexual violence; responding to children living with violence; and keeping perpetrators accountable across all systems (Australian Government, 2016). However, without an implementation plan with clear targets or action goals (Commonwealth of Australia, 2019), the plan merely popularised vague and immeasurable statements about keeping communities free from violence (Hill, 2019). ANROWS (2017) assessed the plan's progress through the National Community Attitudes towards Violence against Women Survey (NCAS). It showed that, while community attitudes surrounding male violence towards women were changing for the better and understanding about these types of crimes and behaviours had improved, particularly between 2013 and 2017, the incidence of domestic and family violence was increasing. Gilmore (2019) noted that, while feminists and activists had been working hard for many decades, the survey had attributed improvements in community attitudes to a series of events of male violence against women that had occurred and the accurate and reliable way in which the mainstream media had reported these events. They included the murder of Eurydice Dixon, a well-known Melbourne comedian, the abduction and rape of a woman in Carlton, murder-suicides in Western Australia and Sydney, and the murders of two women in Melbourne in a single weekend. However, the survey also showed that further work was required to improve community attitudes. Gilmore (2019) noted, for example, that there were:

> Only small shifts in the overall support for gender equality, which hovered at around 64 to 66 per cent … [while] research from all over the world has shown that one of the

most critical factors in reducing men's violence against women is intrinsic support for gender quality (sic) and a concurrent rejection of traditional gender roles (p. 158).

Gilmore (2019) compared the government's response to terrorism and domestic and family violence. In 2017, the Australian government declared its intention to establish a Home Affairs Office to target terrorism, at a cost of millions of dollars. Though terrorism was an important international and national issue, data at the time relating men's violence against women showed that 'around seventy Australian women are murdered each year, more than 80 per cent of them by men who claimed to love them' (Gilmore, 2019, pp. 218-219). In contrast, data from the Global Terrorism Database identified that 'six people were killed in terrorist incidents in Australia over the last twenty years' (Gilmore, 2019, p. 219) with three of the six also being the perpetrator. Overall, the number of people directly injured in terrorism-related incidents was 10. Despite this evidence, the federal government dedicated around AUD35bn each year to target terrorism and only AUD160m to address domestic and family violence. Gilmore (2019) saw this as a reflection of the Australian government's stance on men's violence against women and its push, or lack thereof, to make significant changes in this arena.

Nevertheless, there were several initiatives in the next three years that addressed issues related to sexual violence. First, in 2017, the national government requested, via the Attorney-General, that the ALRC conduct the first independent comprehensive inquiry into the Family Law Act since its commencement in 1976. The ALRC's (2019) final report, Family Law for the Future: An Inquiry into the Family Law System made 60 recommendations, one of which was the abolition of the federal system of management for family law matters and their transfer to the states (Derrington, 2019). Secondly, in August 2017, the AHRC released a research report *Change the Course* on sexual assault and sexual harassment at Australian universities. It recommended the need for improvement in responding to complaints, a greater commitment to prevention, and better processes for ongoing monitoring and evaluation (NSW Government,

2018a). Thirdly, in June 2018, the Australian Sex Discrimination Commissioner, Kate Jenkins, declared the formation of a national inquiry into workplace sexual harassment. This was the first time a country had implemented such an initiative (Leser, 2019). Fourthly, in 2018 the Turnbull/Morrison government released the *Family, Domestic and Sexual Violence in Australia* report that aimed to provide accurate and reliable data for the development of informed and responsive policies in this area (AIHW, 2018).

Liberal Coalition Government Prime Minister Malcom Turnbull (2015-2018) supported the thrust to address violence against women, as evidenced by his backing for policy initiatives in this area He declared that, though disrespect for women did not always result in violence against them, all violence against women began with disrespecting women (in Hill, 2019). Similarly, Victorian premier, Daniel Andrews, wrote 'in a series of tweets on 15 June 2018 … that violence against women would not change until men changed. Elaborating later on ABC Radio, he said it was time to reflect on the "appalling attitudes" many men held towards women' (Leser, 2019, p. 13).

The annual progress report on the Third Action Plan had shown that 'the estimated prevalence of partner violence against women has remained relatively stable since 2005. The trend in sexual assault against women is on a slight upward trajectory' (Australian Government, 2019d, p. 14). The Auditor-General's 2018-19 Performance Audit noted the failure to develop an implementation plan for the Third Action Plan had created difficulties in assessing its progress and recommended that 'the Department of Social Services, in consultation across governments, develop a National Implementation Plan for the Fourth Action Plan' (Commonwealth of Australia, 2019, p. 10). The Morrison Government's Fourth Action Plan 2019-2022 (Australian Government, 2019b) focused on frontline services, prevention, provision of safe places, and the 24/7 online counselling line. The Government committed

AUD328m to support the plan's implementation with the Department of Social Services providing AUD263.5m to fund these measures accordingly:

- AUD57.6m for frontline services
- AUD63.5m for prevention strategies
- AUD78.4m to provide safe places for people affected by domestic and family violence
- AUD64m million to support 1800RESPECT (Australian Government, 2019c).

In addition, the Prime Minister of Australia's (2019) media release reported the funding of AUD7.8m for 'dedicated' men's support workers in Family Advocacy and Support Services.

There were several initiatives planned in 2020 to extend policy development. The Morrison Government established the Women's Safety Council to oversee the implementation of the National Plan and to develop and implement the next national plan post-2022. Further, in February 2020, the government called an *Inquiry into Domestic Violence* to assess delivery of services, policies, and programs and to identify areas for improvement. However, there was scathing criticism of the Inquiry conducted by the Legal and Constitutional Affairs References Committee (LCARC), which delivered its report three months earlier than the expected date of August 2020 (LCARC, 2020). Critics condemned the outcome because the process undertaken did not include public submissions or hearings; they considered it a review rather than an inquiry. With one recommendation, Senator Rex Patrick's dissenting report, *Inquiry, without Inquiry*, demonstrated the strong negative response to the inquiry: 'The committee should take a long hard look at itself and then resolve to bring a motion to the Senate that would direct it to revisit the issue and do the job properly on the second pass' (LCARC, 2020, p. 44).

Family Law Act: Recent developments

As already discussed, the *Family Law Act 1975* (Cth) was the main law on matters involving divorce, property settlement after marital or de facto relationship breakdown, and issues relating to parenting arrangements following separation. The courts with jurisdiction to hear and dispense matters under this Act were the Family and Federal Circuit Courts. Recent developments regarding the family law system included the creation of a research organisation on women's safety, a further amendment to the Act, and two related reviews. In 2006, as part of the Family Law Act amendments, it introduced the requirement for parties to undertake genuine efforts to resolve dispute about parenting matters prior to application through FLC (ALRC, 2019). In 2010, the Commonwealth and all state and territory governments of Australia established ANROWS to produce, disseminate, and assist in applying evidence to inform policy and practice addressing violence against women and their children (Alexander, 2015). Sawer and Gray Jamieson (2014) noted that, 'in 2011, a long campaign by Women's Legal Services bore fruit when changes to the Family Law Act were enacted that prioritised safety of children over the shared parenting principle introduced by the Howard government' (p. 413). The *Family Law Legislation Amendment (Family Violence and Other Measures) Act 2011* (Cth) added a 'renewed emphasis on the relevance of family violence in parenting orders' (Alexander, 2015, p. 313). From 2019, the *Family Law Amendment (Family Violence and Cross-Examination of Parties) Act 2018* (Cth) prohibited personal cross-examination in family law matters, where there were allegations of family violence (Family Court of Australia, 2019).

Review of the family law system

In 2017, the national government requested, via the Attorney-General, that the ALRC conduct an extensive independent review of the family law system. In its final report, *Family Law for the Future,* the ALRC (2019) noted there had not been a comprehensive inquiry into the Family

Law Act since the 1980 Report of the Joint Select Committee on the Family Law Act chaired by the Hon Philip Ruddock (Parliament of the Commonwealth of Australia, 1980). It also noted that the Federal Circuit Court had been established in 1999 and commenced operation in 2000, initially to handle backlog from Family Court of Australia and then to hear less-complex matters; it was a 'simple and accessible alternative to litigation in the Family Court' (ALRC, 2019, p. 58). It heard both general federal law and family law and did not require judges specifically trained in family law issues (ALRC, 2019). In making its 60 recommendations, it took account of repeated recommendations for improved coordination and collaboration between the different levels and sectors of government, including the family law, child protection, health, police, and services responding to domestic and family violence termed a whole-of-government response and refocused attention on restructuring the entire family law and services sectors. One of its recommendations was the abolition of the federal system of management for family law matters and their transfer to the states. The ALRC (2019) recommended the transfer of family law jurisdiction to state and territory governments, noting that:

> Although careful economic modelling of any proposal needs to be undertaken, it is not envisaged that the abolition of a federal family court structure will result in any savings to the Commonwealth. The Commonwealth will be required to provide adequate resources for the exercise of family law jurisdiction by the state and territory courts. In the longer term, however, the creation of a one-court model within each state and territory should yield significant benefits (both fiscal and health-related) to those who are required to use the courts to resolve their family law disputes and, most importantly, their children (p. 138).

Derrington (2019) observed that this controversial recommendation did not include devolving legislative power in relation to family law to the states and territories:

> The Family Law Act 1975, and a consistent set of family court rules, would provide the overarching legislative framework within all States and Territories. The recommendation also contemplates the retention of a federal family court of appeal to ensure consistency in the development of family law jurisprudence (p. 431).

Observing problems with the fragmented court system, Derrington (2019) noted limited investigative powers of the federal family courts:

> To follow up allegations made in family law proceedings that indicate potential risks to the parties, their children and third parties. The federal family courts are thus reliant on receiving information from State and Territory courts and agencies about risks to families and children to inform decision-making and better protect against risk. In particular, the federal family courts often require information from child protection departments and police in order to arrive at appropriate orders. There are, however, significant barriers to information sharing between systems at present (pp. 432-433).

Review of the family court system

In 2008, the Senate referred two bills aimed at reforming the family court system to the Legal and Constitutional Affairs Legislation Committee (LCALC, 2019) for review: The Federal Circuit and Family Court (Consequential Amendments and Transitional Provisions) Bill and Federal Circuit and Family Court of Australia Bill (Australian Government, 2019a). These bills would provide improved measures to protect victims of family violence by bringing together and unifying the administration of the federal circuit and family courts to be known as the Federal Circuit and Family Court of Australia (FCFC):

> The structural reform would … provide the impetus to: help Australian families resolve their disputes faster by improving the efficiency of the existing split family law system; provide appropriate protection for vulnerable people; and ensure the expertise of

> suitably qualified and experienced professionals supports those families in need (Australian Government, 2019a, p. 2).

The LCALC (2019) commended the Australian Government's proposal to reform the family court system noting this would be 'the first major reform of the family court system since the inception if the Family Law Act in 1975' (p. 53). It noted, too, that:

> The reforms … have been introduced at a time when the family court system is under significant pressure due to case backlogs causing further inefficiencies and delays. The committee therefore supports the bill's attempt to address the issues facing the courts and, ultimately, the users of the court system (p. 53).

However, the Labor Senators did not agree with the LCALC and opposed the bills. They believed that 'consideration of the bills should occur after the ALRC [2019] review' (p. 57). Senator Rex Patrick noted the severe under-resourcing of the Family Court system and believed the government was 'ignoring a basic reality that more resources are needed as part of the solution mix' (p. 59). Regarding the LCALC's (2019) proposals, the ALRC (2019) noted:

> The structure of the current federal family court system is, however, not within the terms of reference for this Inquiry and the ALRC has not inquired into the Federal Circuit and Family Court of Australia Bill 2018 and the Federal Circuit and Family Court of Australia (Consequential Amendments and Transitional Provisions) Bill 2018. Both of those Bills were the subject of an inquiry by the Legal and Constitutional Affairs Legislation Committee which reported in February 2019 (ALRC, 2019, p. 112).

Nevertheless, the President of the ALC, Hon Justice SC Derrington noted the significant magnitude of the consequences of the LCALC's (2019) proposals. However, he believed that:

> The difficulty of pursuing fundamental structural change does not alter the imperative to do so. Fundamental – or indeed 'radical' – change is ultimately required to address the unacceptable risk to children under the current framework. It will not become any easier in another 40 years to redesign a system that is already unfit for purpose (Derrington, 2019, p. 433).

Other significant events

There were several significant events during this period, which enhanced public awareness of sexual violence. They included the Royal Commission, #MeToo movement, and Bettina Arndt's contentious honorary award, discussed below, with the policy developments discussed in this chapter summarised in Table 4.2 on page 153.

Royal Commission into Institutional Responses to Child Sexual Abuse

Professor Warwick Middleton in *Practice Guidelines for Clinical Treatment of Complex Trauma* cited Kezelman and Stavropolous (2019), who noted that:

> In November 2012, then Australian Prime Minister, Julia Gillard announced the establishment of a national Royal Commission into Institutional Responses to Child Sexual Abuse. On 15th December 2017, the Hon Justice Peter McClellan AM, head of the Royal Commission handed over his final report to Sir Peter Cosgrove, the Australian governor general. The inquiry ran for five years and it held 444 days of public hearings. It conducted private sessions with nearly 8,000 witnesses and it heard evidence relating to 3,489 institutions. The six commissioners who had started out were all there at the end. In reality, the world had never seen anything quite like it (p. 14).

The Royal Commission reported that, during the five-year inquiry (2012-2017), it contacted 16,953 people who were within the terms of reference; heard from 7,981 survivors

of child sexual abuse in 8,013 private sessions; received 1,344 written accounts; and referred 2,562 matters to police (Commonwealth of Australia, 2017). It drew 'attention to the victimisation of boys in institutional settings' (Commonwealth of Australia, 2017, p. 5). That is, almost two in three survivors were male (63.6%) and more than one in three survivors were female (36.1%) (Commonwealth of Australia, 2017). When the Commission examined the nature of the abuse, and the forms it took, it recognised that more females disclosed penetrative acts of abuse than males: 63.1% females and 51.5% males (Commonwealth of Australia, 2017).

The Royal Commission delivered its final report to the Governor-General in December 2017. In Volume 9 entitled 'Advocacy, support and therapeutic treatment services', it listed nine recommendations. They included:

- Address existing specialist sexual assault service gaps by increasing funding for adult and child sexual assault services in each jurisdiction, to provide advocacy and support and specialist therapeutic treatment for victims and survivors, particularly victims and survivors of institutional child sexual abuse (Recommendation 9.6).
- Ensure relevant policy frameworks and strategies recognise the needs of victims and survivors and the benefits of implementing trauma-informed approaches (Recommendation 9.8) (Commonwealth of Australia, 2017, pp. 31-32).

In June 2018, the NSW Government responded to the recommendations and, with Victoria, became the first states to join the National Redress Scheme for survivors harmed in institutions. It also announced wide-ranging reforms to strengthen child sexual abuse laws in response to the Royal Commission's recommendation relating to justice for survivors and perpetrators being held to account for the abuse through 'sentences that reflect community understanding of child sexual abuse and the harm it causes' (NSW Government, 2018c, p. 1). These included civil litigation reforms to simplify the process for survivors to sue relevant institutions, where sexual harm had occurred (NSW Government, 2018c).

Table 4.1: Progression of the Family Law Act 1975 (Cth)

Year	Policy	Change
1976	*Family Law Act 1975* (Cth)	Established the Family Court and Family Law Council and Australian Institute of Family Studies (established in 1979) to provide research on family matters. This is the main law on matters involving divorce, property settlement after marriage or *de facto* relationship breakdown, and issues relating to parenting arrangements after separation. The courts that exercise jurisdiction under the *Family Law Act* are the Family Court and the Federal Circuit Court. The Act introduced the concept of a 'no-fault divorce', where the only ground for divorce is the irretrievable breakdown of the relationship, demonstrated by 12 months of separation
1980	*Family Law in Australia: Joint Select Committee Report on the Family Law Act* (Parliament of the Commonwealth of Australia, 1980)	Chaired by Hon Phillip Ruddock, the committee recognised the paramount importance of the family with children a primary concern in the event of marital breakdown, thus recommended the consolidation of the Marriage Act and Family Law Act, and revised conditions surrounding custody decisions (ALRC, 2019)
1984	*Family Law Regulations 1984*	Introduced regulations to *Family Law Act 1975*
1987	Inquiry into Matrimonial Property (ALRC, 1987)	Report recommended that equal sharing rights to property values be the starting point for discussion (ALRC, 1987, 2019)
1989	Child Support Scheme	Introduced child support payments (Gleeson, 2013)
1994	*Equality before the Law* Report (ALRC, 1994)	ALRC report recommended equal sharing rights to property upon separation and led to the inclusion of a definition of family violence in *Family Law Reform Act 1995* (Cth)
1995	Family Law Act amended	Amended to include 'the need to ensure safety from family violence' (ALRC, 2019); changed terminology from 'custody and access' to 'residence and contact'; parental responsibilities rather than rights; emphasised children have contact with both parents (Gleeson, 2013)
1999	*Federal Circuit Court of Australia Act 1999* (Cth)	Established the Federal Circuit Court as a 'simple and accessible alternative to litigation in the Family Court' (ALRC, 2019, p. 58). Hears both general federal law and family law and does not require judges specifically trained in family law issues (ALRC, 2019). Commenced operation in 2000, initially to handle backlog from Family Court of Australia and then to hear less-complex matters (Legal and Constitutional Affairs Legislation Committee (LCALC), 2019)

2001	Federal Circuit Court Rules	Provided rules for Federal Circuit Court
2001	*Out of the Maze: Pathways to the Future for Families Experiencing Separation* (Family Law Pathways Advisory Group, 2001)	Proposed an integrated family law system; training for legal personnel, including judges and magistrates; code of conduct for family lawyers; improved communication between levels of government so matters involving family violence, child abuse, and family law could be heard in one court (ALRC, 2019) and promoted a 'one stop shop' with court a last resort (Gleeson, 2013)
2002	Family Law Council (FLC) *Family Law and Child Protection: Final Report* (Commonwealth of Australia, 2002)	Major purpose was 'to examine the interaction of Commonwealth family law with other child and family legislation' (Commonwealth of Australia, 2002, p. 6). Recommended the creation of a national child protection service with collaboration and cooperation between state and national systems
2003	House of Representatives Standing Committee on Family and Community Affairs Report *Every Picture Tells a Story* (Commonwealth of Australia, 2003)	Inquiry into child custody arrangements in the event of family separation proposed changes to the FLC to be non-adversarial and noted the complexity of matters not adequately dealt with when family violence and child protection concerns were present (ALRC, 2019); its remit was to explore the idea of 'joint custody' advocated by men's rights groups (Gleeson, 2013)
2004	Family Law Rules	Timely resolution of family law matters at reasonable cost to each party (ALRC, 2019)
2005	*A New Family Law System: Government response to Every picture tells a story* (Australian Government, 2005)	Adopted most recommendations; allocation of AUD397.2m over four years in the 2005-2006 budget; Family Relationship Centres established to focus on domestic and family violence; funding for Men's Line Australia; new presumption of joint parental responsibility, except in cases of family violence and child abuse, including sexual abuse (Australian Government, 2005; Gleeson, 2013)
2006	Family Law Act amendments	Introduced the term 'reasonably fear' to the definition of family violence (Alexander, 2015; Gleeson, 2013); presumption of 'shared parental responsibility'; and requirement for parties to undertake genuine efforts to resolve dispute about parenting matters prior to a FLC application (ALRC, 2019)
2008	*Family Law (Family Dispute Resolution Practitioners) Regulations 2008*	Introduced regulations for family dispute practitioners, including accreditation standards
2009	*Family Courts Violence Review* (Australian Government, 2009a)	Proposed amendments in relation to family violence and family law; sought to clarify and simplify the law and 'focus the attention of parties on the interests of children' (ALRC, 2019, p. 69)
	Family Law Act amendments	Included provisions to enable separating *de facto* couples to make decisions regarding child-related and financial issues in one proceeding (ALRC, 2019)

2009	*Report on Improving responses to family violence in the family law system: An advice on the intersection of family violence and family law issues* (FLC, 2009)	Noted inconsistency between family court orders and state and territory family violence orders in relation to children; recommended training for personnel in family violence issues; and sought simplification of equal shared parental responsibility (ALRC, 2019; FLC, 2009)
2010	*Family Violence: A National Legal Response, Final Report* (ALRC & NSWLRC, 2010)	Reviewed interaction between state and territory laws and the FLC in relation to family violence and child protection
2011	*Family Law Legislation Amendment (Family Violence and Other Measures) Act 2011* (Cth)	Added a definition of family violence and established a primary focus on family violence in considering and assessing the best interests of the child in parenting orders (Alexander, 2015; Gleeson, 2013) where the principle of 'protection' was for 'safety' (ALRC, 2019, p. 114)
2012	*Improving the Family Law System for Culturally and Linguistically Diverse Clients* (FLC, 2012a) and *Improving the Family Law System for Aboriginal and Torres Strait Islander Clients* (FLC, 2012b)	Two FLC reports produced recommendations for the Family Law system to better meet the needs of these two groups (ALRC, 2019)
2013	Government Response to the ALRC and NSWLRC's (2010) *Family Violence: A National Legal Response*	Response included reference to a collaborative project between the government and states and territories 'to improve the interface between the child protection and family law systems' (ALRC, 2019, p. 118)
	Information-Sharing in Family Law and Child Protection: Enhancing Collaboration (Commonwealth of Australia, 2013)	Report by Richard Chisholm to provide advice and guidance on the development of a best practice framework for information-sharing between the government systems of family and child protection; produced 30 recommendations with final one relating to family violence (Commonwealth of Australia, 2013)
2014	*The Sharing of Experts' Reports between the Child Protection System and the Family Law System* (Commonwealth of Australia, 2014)	A supplementary report by Richard Chisholm to the 2013 report for the Attorney-General's Department of Australia; produced 11 recommendations (Commonwealth of Australia, 2014)
	Productivity Commission's (2014) Inquiry Report into *Access to Justice Arrangements*	One chapter of the report focused on access to justice in the FLC, with particular attention to matters involving family violence: 'The Productivity Commission noted that jurisdictional fragmentation continued to present a barrier to justice for families experiencing family violence and child safety issues' (ALRC, 2019, p. 72)

2016	FLC *Families with Complex Needs and the Intersection of the Family Law and Child Protection System: Final Report* (Commonwealth of Australia, 2016)	Recommended greater collaboration and information sharing between levels of government and implementation of recommendation from the FLC 2012 in relation to Aboriginal and Torres Strait Islander families and families from culturally and linguistically diverse backgrounds (ALRC, 2019)
2017	Inquiry into the *Family Law Act 1975* (ALRC, 2019)	The national government requested, via the Attorney-General, that the ALRC conduct an independent inquiry into the Act. It was the first comprehensive inquiry into the Family Law Act since its commencement in 1976
	Social Policy and Legal Affairs Committee *Family Violence Report* (ALRC, 2019)	Recommendations on 'how the family law system can better support and protect those affected by family violence' (ALRC, 2019, p. 74); promoted the abolition of the equal shared responsibility presumption and proposed the implementation of recommendations for clients from a Culturally and Linguistically Diverse (CALD) background (FLC, 2012b) and Aboriginal and Torres Strait Island families (FLC, 2012a)
2018	*Family Law Amendment (Family Violence and Cross-Examination of Parties) Act 2018* (Cth)	Prohibited personal cross-examination in family law matters where allegations of family violence had been raised (Family Court of Australia, 2019)
2019	*Federal Circuit and Family Court of Australia Bill 2018* and *Federal Circuit and Family Court (Consequential Amendments and Transitional Provisions) Bill 2018* (Australian Government, 2019a)	The LCALC (2019) reported on these bills proposing the unification of the federal circuit and family courts into the Federal Circuit and Family Court of Australia (FCFC) noting this would be the biggest reform to the *Family Law Act* since its inception. This structural reform would 'help Australian families resolve their disputes faster by improving the efficiency of the existing split family law system' (Australian Government, 2019a, p. 2). Labor opposed the bills
	Family Law for the Future: An Inquiry into the Family Law System (ALRC, 2019)	Recommended the abolition of the federal system of management for family law matters and their transfer to the states (ALRC, 2019) though did not examine the Family Law court system and structure itself (LCALC, 2019)
	Pauline Hanson push for inquiry (current at time of writing)	Morrison government supported One Nation and Centre Alliance push for inquiry that Labor and the Greens opposed. Chaired by conservative Victorian Liberal Kevin Andrews and One Nation Pauline Hanson to examine court timeframes and costs, custody arrangements and child support

#MeToo movement

The story about powerful US movie producer and media mogul, Harvey Weinstein, was the catalyst for the #MeToo movement in which women around the world collectively voiced their distress and concern about the continued abuse of women by men. First published in October 2017, the story about the sexual harassment and abuse allegations against Weinstein led to many women telling their stories under the hashtag #MeToo (Gates, 2019; Kantor & Twohey, 2019; Leser, 2019). Worldwide, there was a 'growing consensus that all sorts of previously tolerated practices were wrong' (Kantor & Twohey, 2019, p. 182). It spread through businesses and companies in all industries and saw multiple high-profile men lose their positions and, in some instances, face legal charges. In Australia, this included well-known actors Craig McLachlan (charges still pending at the time of writing with a defamation case instigated against the accusations), John Jarratt (subsequently acquitted), and Geoffrey Rush (acquitted), and media personality and celebrity gardener, Don Burke (who won the case and subsequently sued for defamation) (Hornery, 2019; Leser, 2019). In the USA, famous actors like Bill Cosby (sentenced in 2018 to three to 10 years in prison) and Kevin Spacey (for alleged misconduct against men and boys), and well-known comedians, producers, television hosts, journalists, photographers, and politicians were also in the headlines (Kant & Twohey, 2019; Leser, 2019).

Also caught in this social media response, with allegations of sexual misconduct against him, was US president Donald Trump (Kantor & Twohey, 2019). In Australia, the misconduct of 2018 NSW State Opposition Leader, Luke Foley, came to the public's attention, as allegations of sexual harassment (in fact, indecent assault), were made known from two years prior. Luke Foley subsequently resigned from his position. In addition, the world was hearing about multinational companies, such as McDonalds, encounter protests against its limited sexual harassment policies, of a Fortune 500 Chief Executive Officer (CEO), who had to resign, and of related issues covered up at Google (Kantor & Twohey, 2019).

Table 4.2: Progression of national policies relating to sexual assault

Year	Policy	Description	Government
1975	*Family Law Act 1975* (Cth)	Dealt with the consequences or fallout of family and domestic violence and sexual assault; introduced the concept of 'no-fault divorce' (ALRC, 2019)	Whitlam Labor Government 1972-1975
1977	Royal Commission on Human Relationships, Final Report (Australian Government, 1977)	Terms of reference was to examine relationships in Australia; recognised family violence as a social problem	
1981	Human Rights Commission Act (Commonwealth of Australia, 1981)	Established the Human Rights Commission to act as the national body to monitor human rights issues in Australia	Fraser Liberal Government 1975-1983
1984	*Sex Discrimination Act 1984* (Cth)	Established to eliminate discrimination on the grounds of sex	Hawke Labor Government 1983-1991
1986	National Agenda for Women (OSW, 1988)	Formed to develop a national response to ensure violent-free homes in Australia	
	AHRC abolished; replaced by the Human Rights and Equal Opportunity Commission (HREOC)	Established to process outstanding anti-discrimination cases due to the cessation of the AHRC by the Cabinet Expenditure Review Committee (Sawer, 1990)	
1987	Three-year media campaign and national survey on community attitudes to violence against women	Conducted by the OSW (Carrington & Phillips, 2003)	
1989	National Women's Health Policy (Australian Government, 1989)	The first country to establish such a policy; violence against women was one of the seven priority areas (Gray Jamieson, 2012)	
1990	National Committee on Violence Against Women	Established to get all levels of government to pursue a national strategy on violence against women (Salmelainen & Coumarelos, 1993)	
1992	National Committee on Violence Against Women, National Strategy on Violence against Women (never implemented) (Australian Government, 1992)	Recognised violence against women as a human rights violation and sought government redress (Carrington & Phillips, 2003; Chappell, 2001; Murray, 2002)	Keating Labor Government 1991-1996

1995	Community Attitudes to Violence Against Women Survey (ANOP Research Services, 1995)	Detailed report for the Office of the Status of Women, Department of the Prime Minister and Cabinet	
1996	Women's Safety Survey (ABS, 1996)	Commissioned by the Office of Women and Commonwealth Department of Family and Community Services to inform policies relating to women	
1997	Partnerships Against Domestic Violence (PADV) initiative (Australian Government (1997)	This program sought to find better ways of preventing and addressing domestic violence in the community	Howard Liberal Coalition Government 1996-2006
2000	White Ribbon Campaign	Supported by the OSW (White Ribbon Australia, n.d.b)	
2001	National Initiative to Combat Sexual Assault (NICSA)	Part of the OSW, established to build partnerships with states and territories to develop strategies to address the incidence of sexual assault in the community, consolidating the achievements of the PADV (Carrington & Phillips, 2003)	
2002	First national telephone survey on sexual harassment (AHRC, 2004)	Instigated by Sex Discrimination Commissioner and HREOC	
	OSW (2002) submission to the Inquiry into Crime in the Community: Victims, Offenders and Fear of Crime	Submission on violence against women to the House of Representative Standing Committee on Legal and Constitutional Affairs	
2004	National Elimination of Violence Campaign *Violence against women Australia says no*	Funding for this NICSA public education campaign ceased in 2005 to make way for the ABS Personal Safety Survey 2005 (Carrington & Phillips, 2003)	
2005	Women's Safety Agenda	Replaced PADV (Carrington & Phillips, 2003)	
	Personal Safety Survey (ABS, 2005)	Funding for the women's component of the 2005 Personal Safety survey was provided through NICSA & PADV administered by the Office for Women	
2006	Community Attitudes to Violence Against Women Survey (Taylor & Mouzos, 2006)	A full technical report by the AIC and Social Research Centre (SRC) funded by VicHealth	
2008	National Council to Reduce Violence against Women and their Children	To advise on measures and strategies to reduce violence against women; priority was family violence (Alexander, 2015)	Rudd Labor Government

2009	*Time for Action: The National Council's plans for Australia to reduce violence against women and their children, 2009–2021, Background Paper* (Australian Government, 2009b)	Contained a review of the main policies and programs in operation across Australia in 2009 and acknowledged over-stretched services, including SASs	2007-2010
	Time for Action: The National Council's Plan for Australia to Reduce Violence Against Women and their Children, 2009-2021, A Snapshot (Australian Government, 2009c).	It noted the fragmented service system and barriers to collaboration across the sector	
2011	National Plan to Reduce Violence against Women and their Children 2010-2022, including First National Action Plan 2010-2013 (Australian Government, 2011)	The first three-year Action Plan: *Building a Strong Foundation 2010-2013* laid an important foundation for long-term change establishing critical, national-level infrastructure to inform future policy and service delivery and engage the community in reducing violence against women and their children	
	ANROWS established	National research organisation on women's safety (Alexander, 2015)	
2012	Royal Commission into Institutional Responses to Child Sexual Abuse	Five-year Commission (2012-2017) announced by Prime Minister Julia Gillard	Gillard Labor Government 2010-2013
	Workplace Gender Equality Act 2012 (Cth)	Established the Workplace Gender Equality Agency (WGEA) to promote and improve gender equality in Australian workplaces (WGEA, 2018)	
2013	Second Action Plan 2013-2016 *Moving Ahead* to Reduce Violence against Women and their Children	Outlined six national priorities (Australian Government, 2013)	
2015	Women's Safety Package	AUD100m, part of the National Plan (Australian Government, 2015)	Abbott Liberal Government 2013-2015
2016	COAG (2016) Advisory Panel on Reducing Violence against Women and their Children, Final Report	Report to inform the Third Action Plan (see below) (COAG, 2016)	Turnbull Liberal Government 2015-2018
	Third Action Plan 2016-2019 to Reduce Violence against Women and their Children (Australian Government, 2016)	Outlined six national priorities; criticised for not having clear goals or targets (Commonwealth of Australia, 2019)	

	Personal Safety Survey 2016 (ABS, 2017a)	Showed that sexual violence against women had not declined	
	The Line primary prevention program (AIHW, 2018)	Promoted respectful relationship for young people; run by Our Watch, funded by Department of Social Services (AIHW, 2018)	
	Let's Stop it at the Start media campaign (AIHW, 2018)	Linked disrespectful attitudes and gendered behaviours in boys to later violence against women (AIHW, 2018)	
2017	Final Report of the Royal Commission into Institutional Responses to Child Sexual Abuse (Commonwealth of Australia, 2017)	Drew attention to the number of boys as victims of sexual abuse	
	National Community Attitudes towards Violence against Women Survey (Webster et al., 2018)	Assessed progress of National Plan (ANROWS, 2017)	
	AHRC (2017) report *Change the Course*	On sexual assault and sexual harassment at Australian universities	
2018	AIHW (2018) *Family, Domestic and Sexual Violence in Australia* report	Data report to provide accurate and credible information and statistics to inform policy development	
	National Inquiry into Workplace Sexual Harassment (AHRC, 2018a, 2018b)	Called by the Sex Discrimination Commissioner, this was the first time a country had implemented an initiative of this nature (Leser, 2019)	
2019	Fourth Action Plan 2019-2022 to Reduce Violence against Women and their Children (Australian Government, 2019b)	Focused on frontline services, prevention, provision of safe places, and the 24/7 online counselling line	Morrison Liberal Government 2018-present
	Report on *Inquiry into Domestic and Family Violence: Policy approaches and responses* (Standing Committee on Justice and Community Safety, 2019)	Inquiry into domestic violence services, policies, and programs. Report delivered in May 2020 to criticism that there were no public hearings or submissions, thus considered a review not an inquiry (LCARC, 2020)	
2020	Women's Safety Council	Oversee the implementation of the Fourth National Action Plan and develop the next National Plan post-2022 (LCARC, 2020)	
	Inquiry into domestic violence	Further inquiry called in February 2020 following criticisms of prior inquiry on services, policies, programs, and areas for improvement	

Gilmore (2019) drew attention to the *New York Times* report the year after the tweet about the impact of the #MeToo movement on men. It showed that 'at least 920 people had to come forward to bring down the 201 men who lost their jobs [and that] one third of those men were from news media, a quarter from government, and a fifth from entertainment and the arts' (p. 238).

The #MeToo slogan had originated in 2006, when Tarana Burke used it as part of her community action and support work to 'promote empathy and healing for victims of sexual violence' (Gates, 2019; Kantor & Twohey, 2019, p. 185; Leser, 2019; Maguire, 2019). However, it only caught on following the 2017 Weinstein reports in the media, when actor Alyssa Milano used the slogan in a tweet to her followers and encouraged them to speak out against sexually inappropriate conduct (Gilmore, 2019; Leser, 2019). In its more contemporary form, women were outlining more than sexual violence but complaints of a sexual nature that encompassed a wide spectrum 'from verbal abuse to uncomfortable dates' (Kantor & Twohey, 2019, p. 185). Such an outpouring resulted in some confusion about what constituted appropriate behaviour between men and women, with some people claiming that men were becoming the victims (Gilmore, 2019) and that the '#MeToo movement [had] gone too far' (Leser, 2019, p. 50). Others referred to a backlash against the movement, where women who raised allegations were stigmatised and blamed (Bongiorno et al., 2020). However, the extensive and substantial response to the initial tweet posted by Milano, and the subsequent tweets, disclosures, and legal action, had been described as 'the most influential social movement since the clamour for civil rights in the 1960's' (Leser, 2019, p. 63). Indeed, almost one million people had responded to the initial tweet in the first 48 hours (Leser, 2019), and in one day Facebook had recorded 12 million related comments and posts (Gates, 2019; Leser, 2019). Seen through this time, however, was an avalanche of inappropriate behaviour in numerous contexts, including criminal behaviour, by men towards women that had largely been

condoned or hidden for fear of disbelief or retribution (Gilmore, 2019; Hill, 2019). Indeed, CBS News reported that the tweet was 'shared on Facebook more than twelve million times in the first twenty-four hours' (Gilmore, 2019, p. 236). Social attitudes changed and new policies and organisational systems came in to manage this new understanding of the world:

> In a way, those who felt #MeToo had not gone far enough and those who protested that it was going too far were saying some of the same things. There was a lack of process or clear enough rules. The public did not fully agree on the precise meaning of words like *harassment* or *assault* [original emphasis], let alone how businesses or schools should investigate or punish them (Kantor & Twohey, 2019, p. 188).

As Hill (2019) stated, 'critically, aside from proving to women that the patriarchy still exists, #MeToo also proved it to some *men*' [original emphasis] (p. 136). In so doing, this movement enabled the system of patriarchy to become visible to women and men. It also invited men and women to question why such behaviours occurred, challenge prescribed roles expected in society, and note the privileges and advantages generally given to one gender (Hill, 2019). Stemming from the wave created by the #MeToo movement, the organisation Time'sUp was established by Hollywood celebrities (Lester, 2019; Maguire, 2019) 'to promote safe and fair workplaces' (Kantor & Twohey, 2019, p. 248). In Australia, the international momentum led to the formation of NOW in 2018, which held similar aims and developed the slogan '#MeToo is the movement. NOW is the moment' (Maguire, 2019, p. 217).

Contentious award

In 2020, the Governor-General of Australia awarded male rights activist and sex therapist, Bettina Arndt an Order of Australia Medal (OAM) for her fight for 'gender equity'. Known as a strong advocate for men's rights and for employing victim-blaming attitudes, shortly after the award there followed a horrific death of a woman and her three young children by her ex-

partner and the children's father. Arndt argued, on social media, for understanding of the perpetrator's actions saying the situation in which he found himself with his ex-partner might have influenced his behaviour. Her statements met with widespread criticism and condemnation and led to calls from some government politicians and public groups for the revocation of the award. At the time of writing, the matter was still under review with the Council of the Order of Australia. However, this incident highlighted the need for ongoing feminist vigilance, as setting a mother and her three children alight in her car was never justifiable on any grounds. To have the view supported by a well-known commentator set forward victim blaming with its correspondingly ill-informed shift of responsibility, and hence a dangerous path that feminists have been challenging for years, as already discussed.

Feminism then and now

Despite a government focus on family violence, early legislation lacked a gendered understanding. The influence of the women's movement and femocrats, as they gained a voice on government policy-making platforms, facilitated progressive reform. There began an understanding of the gendered nature of domestic and family violence and acceptance of the need for strategic interventions to benefit women affected by it. A feminist perspective informed policy discussion and guided policy development and law reform for several years until the late 1980s and 1990s when neoliberal managerialism gained traction in the political and economic realms. In this climate, governments pursued a privatisation and 'mainstreaming' agenda that led to a decline in, and the abolition of, many progressive outcomes and achievements. A backlash from men's interest groups also halted feminist advances as the influence of women's groups declined (Gleeson, 2013).

Further, concerning the Family Law Act, copious amendments over the years had seen it grow from 80-800 pages in length and it had become extremely difficult to navigate (ALRC,

2019). The ALRC (2019) reported that subsequent reviews, reports, and inquiries had produced very similar outcomes. They found a fragmented system: There was a clear disconnect between the federal family law and state child protection and family violence systems; increasing complexity in matters related to the sustained and growing issue of family violence and abuse; lack of government resources to address these issues; and a loss of community faith in the family law system itself. The ALRC (2019) noted:

> What is most significant about these previous inquiries is that they have all identified substantially the same fundamental issues and have all made substantially the same suite of recommendations over a period now of almost two decades. Apart from minor tinkering, the fundamental challenges and difficulties have not attracted sufficient political will to solve the problems that differently constituted inquiry bodies continue to identify (p. 111).

Despite the ALRC's (2019) 60 recommendations, Pauline Hanson (One Nation Party) instigated an additional inquiry and Prime Minister, Scott Morrison, approved the formation of a joint select committee inquiry in September 2019 (Stregone, 2019). Hanson claimed reforms were necessary due to systemic faults where one parent could allege domestic violence by the other to prevent access to their children. Martin (2019) noted men's rights groups had made complaints of this nature in the absence of research supporting these claims. Senator Hanson had made an election promise to seek an inquiry into the treatment of men in matters before the family law court (Molloy, 2020). Hanson had a history of supporting and advocating for men's rights, often against women's issues. For example, in 1998, the One Nation party carried the election platform to abolish the Family Court and family law legislation and campaigned against single mothers and the Child Support Payment (Gleeson, 2013).

Conclusion

In examining the national policy context, the chapter showed that feminist agitation influenced, informed, and embedded gender analysis in legal and policy reform. Feminists made sexual assault, and violence against women in general, a political issue of gender by raising awareness of its impact on women. Thus, policy incorporated an acknowledgement of the impact of patriarchy and subsequent structures disempowering women. The discussion showed the declining influence of feminism and parallel growing interest in men's rights groups. This was visible in the historical analysis of Commonwealth policies in this chapter, which exposed the sways in political will with changes from favourable progressive governments to less favourable conservative neoliberal government responses that could be seen as a backlash against feminist interpretations of violence against women. Thus, for feminists, progress was slow and gradual, due to obstacles encountered and counter views on the advancement of women and services for survivors of sexual assault and violence. As Dowse (2014) emphasised, 'for all the backsliding since, it is salutary to be reminded just what we did achieve then, and what needs to be built upon again' (p. 401). Magarey (2014) argued that the women's movement, with its diverse distinctions and imperatives, including tensions about involvement with the state (Gray Jamieson, 2006; Smart & Quarty, 2014), had remained vigilant and flexible through the years. It had proved that it could withstand and rally against the changing political climate to advance women's issues and sexual assault reform. When feminists perceived that policy changes were having negative impacts for women, the progressive feminist movement went into action pursuing the goals of safety and equity for all. However, feminists were seen to privilege female over male interests. This resulted in a backlash from men's interests groups, especially during the Howard government, due to its push for greater inclusivity. The Howard government responded favourably to men's rights groups agitating against domestic violence policies, family law provisions, and parenting payments on the grounds they disadvantaged

men. Men's rights groups positioned men 'as the new victims of feminist elites' (Sawer, 2007, p. 23) by focusing on perpetrators of violence against women, rather than female victims. They emphasised *family* values and *family* responsibility for domestic violence. Thus, the political game changed and weakened the feminist agenda. As Gray Jamieson (2006) observed, 'incremental advances, movement maintenance and "institutionalised" actions' (p. 1) replaced direct feminist action. Feminists adapted pragmatically, using well-worn strategies of political lobbying, information dissemination, awareness raising, and service provision in line with the opportunities offered within the changing political environment (Gray Jamieson, 2006). More recently, these efforts had resulted in government recognition of the primary need to acknowledge and change gender inequalities and build greater equality and respect between men and women to achieve a sustained reduction in levels of violence against women (Oberin, 2011). The contemporary Australian Government response also acknowledged the underlying cause of men's violence against women being negative attitudes towards, and beliefs about, women and that, to tackle domestic violence and sexual assault, these attitudes had to change. It also simultaneously acknowledged the need for national leadership to transform community attitudes though had not provided funding for the required responses. Connected to this examination of the policy and legal context was the nationally important Royal Commission into Institutionalised Responses to Child Sexual Abuse (2012-2017), the international #MeToo movement, and the continued challenge to feminist agendas as seen by the Bettina Arndt OAM award. This broad and interwoven backdrop is important, as feminists created awareness of sexual violence as a women's issue and instituted services to respond to it. It showed the ability of feminists to weather political and community opposition to its stance on women and feminism's continued undergirding of the services and responses that form the subject of this study. There were similar trends at the state level, as discussed in the following chapter examining the NSW policy context.

CHAPTER 5

NSW state government policy development

There was no other ... options [than a male counsellor], I mean there were but they were too far away (Becky)

The need for counselling service has increased dramatically so that [there is a] lack of resources (C14)

This chapter examines state government policy and legislation relating to sexual assault summarised in Table 5.4 on page 188, following the discussion. As Sawer (1990) explained, the state government bore:

> Primary responsibility for many areas of major concern to women. In the years after the fall of the Whitlam government, it was at the state level that much innovative program development was taking place – for example, in the areas of rape law reform, child sexual abuse and domestic violence. State women's advisers played a major role in bringing women's experience of life on to the public policy agenda – issues at first treated by male policy-makers with disbelief (e.g. the extent of domestic violence and of child sexual assault) (p. 141).

Hence, the NSW state government was responsible for criminal law relating to sexual assault crimes and policies to prevent and address violence against women and children, including those relating to service provision. The chapter discusses the efforts of successive

administrations from the 1970s, when 'substantial reforms were made in the area of sexual assault … as a result of the women's movement against rape' (Salmelainen & Coumarelos, 1993, p. 1), onwards to legislate for the protection of women and children. The major legislation was the *Crimes Act 1900* (NSW), of which Section 61, Division 10 dealt with sexual offences against adults and children.

1970s-1980s: Askin/Lewis/Willis to Wran

Early legislation relating to sexual assault conformed to the philosophy that women were the property of men, namely, their father and then their husband (Cossins, 2019; Fileborn, 2011; Salmelainen & Coumarelos, 1993). This premise underscored the development of the original laws pertaining to sexual assault (Salmelainen & Coumarelos, 1993). This was demonstrated most clearly in the English legal principle from 1736 that Australia inherited in the formation of the nation: 'A husband cannot be guilty of rape upon his wife for by their mutual matrimonial consent and contract the wife hath given up herself in this kind to her husband which she cannot retract' (Maguire, 2019, p. 115). However, the period between the 1970s and 1980s saw an expanded understanding of, and awareness about, sexual violence against women and children that led to major changes to sexual assault legislation. For example, in NSW, as in other states, there were changes to the definition of sexual assaults, types of offences that the law recognised and requirements relating to forensic medicals (Boxall et al., 2014).

A significant influence during this decade was the Women's Coordination Unit (WCU), which the government established in the Premier's Department in 1977, along with women's units connected to each department to facilitate communication to the WCU and thence to the Premier. Also established in 1977 was the Women's Advisory Council (WAC) that served as a conduit for the communication of community views to the government (Gray Jamieson, 2012).

At the time, NSW sexual offence legislation used a narrow definition of sexual assault, based on common law offences of rape and attempted rape that incorporated gendered language, such as 'penile penetration of the vagina of a non-consenting woman' (Salmelainen & Coumarelos, 1993, n.p.). Boxall et al. (2014) explained that this meant 'charges could only be brought against male offenders who sexually abused female victims. A notable exception to this general rule was the offence of indecent assault upon a male' (p. 30). Salmelainen and Coumarelos (1993) noted that the crime of rape had a maximum penalty of life imprisonment and there were no restrictions to the inclusion of the victim's sexual history in court evidence.

Salmelainen and Coumarelos (1993) further noted the broadening of the legal definition of sexual assault 'to include assaultive acts involving fellatio or cunnilingus, and … the possibility of sexual assault in marriage' (p. 10) and:

> A sexual incident no longer requires physical resistance by the victim to constitute sexual assault; information identifying sexual assault victims may not be published without court approval; there are now restrictions on the admission of evidence of the victim's sexual experience; and the judge is no longer required to warn the jury against convicting on the uncorroborated testimony of the victim (Salmelainen & Coumarelos, 1993, p. 10).

By 2000, changes to the legislation had removed all gendered language to ensure it was gender-neutral and, therefore, applied to all victims and offenders (Boxall et al., 2014; Salmelainen & Coumarelos, 1993).

1980s-1990s: Wran/Unsworth to Greiner

The Wran Labor Government's (1976-1986) NSW Interdepartmental Task Force on the Care of Victims of Sexual Offences (1978) recommended 24/7 crisis counselling and medical care (Carmody, 1990). Gray Jamieson (2012) noted that the establishment of health policy

machinery and the development of policy progressed steadily in NSW under the Wran Labor Government, which established the NSW Sexual Assault Committee (1985, 1988) within the WCU that reported on the coordination of state responses to sexual assault. A 1984 inquiry into women's health by the Women's Health Policy Review Committee resulted in the establishment of a women's unit in the Health Department in 1985 along with several new women's health centres and additional funds directed to rural and public hospital-based SASs (Gray Jamieson, 2006, 2012). Gray Jamieson (2012) noted that, 'by the mid-1980s, the Wran Government had made a clear commitment to women's health action' (p. 216) and supported refuges by filling the funding gap left by the Commonwealth and funding new refuges from its own resources.

The Greiner Liberal Government (1988-1992), which replaced the Labor Government in 1988, though it disbanded many women's policies, including some relating to sexual assault (Chappell, 2001; Sawer, 1990), continued to promote domestic violence policies. As in federal politics, the 1990s saw the entry of competing discourse on measures for victims of sexual violence, spurred on by men's groups. With the conservative focus on family values beginning to inform social policy, there were calls to reallocate resources towards men (perpetrators) (Chappell, 2001). Some parliamentarians, particularly from the National Party, agreed with men's argument that women were getting too much and supported the withdrawal of government support (Sawer, 1990). Hence, the Greiner Government instituted a review of all Health-funded NGOs in its focus on 'mainstreaming' and 'streamlining', which meant dismantling women's policy instruments. Nevertheless, the Premier endorsed the principles of the NWHP in 1990 (Gray Jamieson, 2012).

Table 5.1 shows the changes to criminal law relating to sexual assault during this decade. NSW was the first State to introduce legal reform to improve the options available to women experiencing violence with the *Crimes (Domestic Violence) Amendment Act 1982*

(NSW) following the 1981 Task Force on Domestic Violence's recommendations. The 1982 Act was the first recognition of domestic violence as a distinct problem though did not introduce a new offence of domestic violence, instead, it defined domestic violence as including a range of existing offences, including common assault (Griffith, 1995). It defined a domestic violence offence, introduced Apprehended Domestic Violence Orders (ADVOs), required spouses to give evidence in domestic violence proceedings, and empowered the police to enter properties to investigate complaints (Griffith, 1995). Further legislative reform in NSW extended the definition of domestic violence in 1987 to encompass family violence.

Table 5.1: NSW legislative changes in the 1980s

Year	Legislation	Description of change and source
1981	*Crimes (Sexual Assault) Amendment Act 1981* (NSW)	Introduced a series of graduated sexual assault offences and changes to court procedure and evidence laws and abolished marital immunity to rape (Fileborn, 2011; Griffith, 1995; Mason & Monaghan, 2019; Salmelainen & Coumarelos, 1993)
1982	*Crimes (Domestic Violence) Amendment Act 1982* (NSW)	The first recognition of domestic violence in law and first NSW State legal reform to improve legal options for women experiencing violence (Griffith, 1995)
1984	*Crimes (Amendment Act) 1984* (NSW)	Expanded the definition of sexual intercourse to include 'homosexual sexual intercourse' to 'refer to anal sexual intercourse involving males' (Boxall et al., 2014, p. 2)
1989	*Crimes (Amendment) Act 1989* (NSW) (came into force in 1991)	Increased penalties and replaced sexual assault laws with three categories of offences (sexual assault, indecent assault, and acts of indecency), each with aggravated and non-aggravated versions, including an additional offence of 'assault with intent to have sexual intercourse' (Boxall et al., 2014, p. 27)
	Crimes (Apprehended Violence) Amendment Act 1989 (NSW)	Apprehended Violence Orders (AVOs) replaced Apprehended Domestic Violence Orders (ADVOs) and applied to all persons who feared personal violence, harassment, or molestation (Griffith, 1995)

Changes instituted between 1987 and 1988 meant children could give evidence via closed-circuit television instead of in an open courtroom with the defendant present. Further, magistrates could direct offenders to a pretrial diversion program, comprising a two-year

treatment response. Sawer (1990) argued that both these changes were 'firmly based on feminist analysis' (p. 159) in which blame rested with the offender not the family.

The legislative changes shown in Table 5.1 brought 'the sexual assault laws into line with community expectations by increasing the penalties, extending their scope, and introducing a new, simplified scheme of offences to clarify the law' (Salmelainen & Coumarelos, 1993, p. 1). The *Crimes (Sexual Assault) Amendment Act 1981* (NSW) introduced a series of graduated sexual assault offences and changes to court procedure and evidence laws (Mason & Monaghan, 2019; Salmelainen & Coumarelos, 1993) and abolished marital immunity to rape by confirming that any sexual act performed without consent was a criminal act (Fileborn, 2011; Maguire, 2019). They removed the necessity for anatomical characteristics of the assault and evidence about the victim's sexual history in court proceedings and required judges to advise juries that delays in reporting sexual assault crimes were not indicators of false allegations (Maguire, 2019).

The *Crimes (Amendment Act) 1984* (NSW) expanded the definition of sexual intercourse to include homosexual intercourse involving males thus decriminalising 'homosexual sexual acts between consenting males who were 18 years or older' (Boxall et al., 2014, p. 30). The *Crimes (Amendment) Act 1989* (NSW), which came into force in 1991, introduced increased penalties for sexual assault (Salmelainen & Coumarelos, 1993) and introduced three categories of sexual offences (sexual assault, indecent assault, and acts of indecency), each with aggravated and non-aggravated versions, including an additional offence of 'assault with intent to have sexual intercourse' (Boxall et al., 2014, p. 27). The *Crimes (Apprehended Violence) Amendment Act 1989* (NSW) empowered courts to: (i) make Apprehended Violence Orders (AVOs), which replaced ADVOs, and applied to anyone who feared personal violence, harassment, or molestation (Griffith, 1995); and (ii) exclude the person against whom the order is made from a shared residence. It regulated the types of

conduct that constituted domestic violence, the relationships covered, and the penalties for breaching an AVO (Gray Jamieson, 2012).

Simultaneously with these legislative changes, services for women and children expanded exponentially. The Women's Housing program, which was established in 1984, provided medium-term housing support for homeless women and their children, particularly those transitioning from refuges (Sawer, 1990). By 1989, there were 53 women's refuges, including three for Aboriginal women and one for Muslim women, as well as a Domestic Violence Advocacy Service to support and assist women in the legal system (Sawer, 1990). Sawer (1990) noted that, by 1989, there were 28 government-funded SASs in NSW, with the state coordinator of these services 'in the Women's Health Unit of the Health Department' (p. 159). Also in 1989, the police force introduced a new six-month program called Initial Response Officers Course (IROC) that provided specialised training to officers for their work with sexual assault victims, including taking statements and networking with sexual assault workers (Boxall et al., 2014; Salmelainen & Coumarelos, 1993).

1990s-2000s: Greiner/Fahey to Carr

Table 5.2 shows the legislative changes during this decade. The *Crimes (Domestic Violence) Amendment Act (1993)* (NSW) created the criminal offence of stalking or intimidation with intent to cause fear for personal safety in domestic relationships (Griffith, 1995). The *Crimes (Threats and Stalking) Amendment Act* 1994 (NSW) extended stalking beyond domestic relationships (Griffith, 1995). In response to increased identity politics surrounding the inclusivity of transgender victims of sexual assault, the *Transgender (Anti-Discrimination and Other Acts Amendment) Act 1996* (NSW) amended the definition of sexual intercourse to include surgically constructed vaginas (Boxall et al., 2014). As already mentioned, the *Crimes (Amendment) Act 1989* (NSW) came into force in 1991. Other changes included the *Criminal*

Legislation (Amendment) Act 1992 (NSW) amending the definition of sexual intercourse and the (NSW) *Classification (Publications, Films and Computer Games) Enforcement Act 1995* (NSW) with clauses relating to the publication of indecent articles and advertising or displaying products associated with sexual behaviour in response to technological changes.

Table 5.2: NSW legislative changes in the 1990s

Year	Legislation	Description and source
1992	*Criminal Legislation (Amendment) Act 1992* (NSW)	Definition of sexual intercourse amended
1993	*Crimes (Domestic Violence) Amendment Act (1993)* (NSW)	Created criminal offence of stalking or intimidation with intent to cause fear for personal safety in domestic relationships (Griffith, 1995)
1994	*Crimes (Threats and Stalking) Amendment Act 1994* (NSW)	Extended stalking beyond domestic relationships (Griffith, 1995)
1995	*Classification (Publications, Films and Computer Games) Enforcement Act 1995* (NSW)	Included publishing indecent articles and advertising or displaying products associated with sexual behaviour
1996	*Transgender (Anti-Discrimination and Other Acts Amendment) Act 1996* (NSW)	Definition of sexual intercourse amended to include surgically constructed vaginas (Boxall et al., 2014)

With its continued support for domestic violence, in 1991, the Greiner government developed the *NSW Domestic Violence Strategic Plan* to coordinate the relevant government responses to domestic violence (Gray Jamieson, 2012). Following the introduction of NWHP, with increased government support for women's health, by 1994, there were 55 publicly funded, women-run health centres, most of which provided medical services and a full range of education, counselling, support, and information services. Additionally, there were 262 publicly funded services for women escaping domestic violence (Gray Jamieson, 2006). Despite the threat from non-Labor governments between 1988 and 1995, this proliferation of services had grown into a fragmented service-delivery system.

In 1993 and 1996, the NSW Standing Committee on Social Issues produced Parts I and II of the *Sexual Violence: The Hidden Crime* report respectively. Part I reported on the incidence of sexual offences in NSW with summary of estimates on sexual assault up until that year (NSW Standing Committee on Social Issues, 1993) and Part II provided an overview of explanations for sex offending and described treatment programs in NSW (NSW Standing Committee on Social Issues, 1996). The impetus for the reports was the outcome of the European Committee 1989 Crime Survey, which showed that Australia had the highest rate of sexual incidents (sexual assault and offensive sexual behaviour) against adult women out of the 14 countries surveyed. Part I reviewed international and national data and conducted statistical analysis with an outcome that the 1989 crime survey was methodologically flawed. The NSW Committee (1993) found that, while:

> The International Crime Survey could not justify the claim that Australia is the most sexually violent nation surveyed, the Committee nevertheless remains very concerned about this issue. Sexual violence can be very destructive for its victims – and there are far too many victims (p. xi).

Hence, the NSW Committee found that the data was 'unfounded and invalid' and recommended that the Government disregard the Crime Survey results when formulating policy initiatives in this area. However, the NSW Committee highlighted the low reporting of sexual assault incidents to the police and the impact of this on the ability to record accurate data. It, nevertheless, acknowledged the high rates of sexual assaults committed and recommended ongoing surveys and research into this area, as well as improved mechanisms to enable victims to report the crime (NSW Standing Committee on Social Issues, 1993).

The mid-1990s saw a change from a Liberal to a Labor administration when Carr (1995-2005) assumed the premiership in NSW. Following the reports in the first half of the 1990s on the uncoordinated nature of the response to violence against women, in 1996, the Department

for Women and the Premier's Council for Women released a further report. The *New Directions in Reducing Violence Against Women* and the *NSW Strategy to Reduce Violence Against Women* (VAW Strategy) was an effort 'to provide a coordinated, whole-of-government response, focusing on prevention' (Gray Jamieson, 2012, p. 232).

2000s-2010: Carr/Iemma/Rees/Keneally

The 2000s was a decade of Labor Party dominance in NSW, with three rapid successive changes in leadership when Carr's 10-year premiership ended in 2005. The *Strategic Framework to Advance Women's Health* released in 2000 provided strategic direction to 2003 and confirmed the government's social (population and preventive rather than individual and biomedical focused) and holistic view of health and intersectoral cooperation (Gray Jamieson, 2012). Inherent in the women's health movement and subsequent policy directions and outcomes was the core belief of the need to consider both men's and women's health. Gray Jamieson (2012) explained: 'While the women's health movement has championed a social view of health and illness, this is equally relevant to men's health. Gender, which is one of the social determinants, helps shape the conditions of men's lives, just as it does those of women' (p. 41). The Gender Equity in Health statement released in 2000 recognised gender as an important element of health status and provided a framework that considered both men's and women's health needs. In 2002, the newly developed Women's Health Outcomes Framework provided a guide to the measurement and monitoring of health outcomes and prioritised the issue of prevention of violence against women (Gray Jamieson, 2012).

Table 5.3 shows the changes to NSW legislation during this decade, including amendments to the *Crimes Act 1900* (NSW) relating to sexual offences and domestic and family violence, and sexual assault as a separate policy issue. There were positive advancements in sexual assault legislation and service delivery, with greater awareness of the

relationship between the type of crime perpetrated on vulnerable groups, such as people with a cognitive disability and mental illness and their need for protection, as prescribed in the *Crimes Amendment (Cognitive Impairment – Sexual Offences) Act 2008* (NSW) (Boxall et al., 2014).

Other changes detailed in Table 5.3 included life imprisonment for aggravated sexual assault in company, whereby there had to be proof that the sexual intercourse occurred while in the company of another person , i.e., 'in the company of one or more other person' (Stubbs, 2008, p. 11). The *Crimes Amendment (Sexual Servitude) Act 2001* (NSW) considered the safety needs of those who provided sexual services to ensure they were free from threats or force and established penalties for the use of such threats or force.

Table 5.3: Changes to NSW legislation 2001-2010

Year	Legislation	Description and source
2001	*Crimes Amendment (Aggravated Sexual Assault in Company) Act 2001* (NSW)	Established a maximum penalty of life imprisonment for aggravated sexual assault in company
	Crimes Amendment (Sexual Servitude) Act 2001 (NSW)	Considered the safety needs of those who provided sexual services and established penalties for the use of threats or force
2002	*Crimes (Sentencing Procedure) Amendment (Standard Minimum Sentencing) Act 2002* (NSW)	New provisions imposing minimum sentences of five to 15 years for sexual assault offences depending on the charge laid (Stubbs, 2008)
2003	*Crimes Amendment (Sexual Offences) Act 2003* (NSW).	Included the removal of gendered language from the *Crimes Act 1900* (NSW) (Boxall et al., 2014)
2007	*Crimes Amendment (Consent-Sexual Assault Offences) Act 2007* (NSW)	Definition of consent revised with premise of positive consent (Boxall et al., 2014; Fileborn, 2011)
	Crimes (Domestic and Personal Violence) Act 2007 (NSW)	Principal domestic violence legislation in NSW included key definitions of the family and criteria for AVOs (NSWLC, 2012)
2008	*Crimes Amendment (Sexual Offences) Act and Crimes Amendment (Cognitive Impairment – Sexual Offences) Act 2008* (NSW)	Included voyeurism and filming offences and victims with cognitive impairment and their vulnerabilities (Boxall et al., 2014) respectively

The *Crimes (Sentencing Procedure) Amendment (Standard Minimum Sentencing) Act 2002* (NSW) introduced minimum sentences of five to 15 years for sexual assaults depending on the charge laid (Stubbs, 2008) and *Crimes Amendment (Sexual Offences) Act 2003* (NSW) removed gendered language 'from the Crimes Act 1900 with the repeal of sections 65 and 66' (Boxall et al., 2014, p. 28). Finally, the *Crimes Amendment (Sexual Offences) Act 2008* (NSW) included filming and voyeurism offences (Boxall et al., 2014). A later 2017 amendment to the *Crimes Act 1900* (NSW) made:

> It an offence in NSW to intentionally record or distribute, or threaten to record or distribute, an intimate image of a person without their consent. Intimate images include photographs and videos of a person's private parts or of a person engaged in a private act such as undressing, showering or engaged in sexual activity (NSW Government, 2018a, p. 12).

At the end of 2004, the NSW Attorney General announced the establishment of the Criminal Justice Sexual Offence Taskforce (CJOST) (2005) 'to examine issues surrounding sexual assault in the community and the prosecution of such matters within the criminal justice system' (p. iii). Its brief was to evaluate alternate models for the prosecution of sexual assault offences and proposals for legislative and procedural change in sexual assault prosecutions and to identify areas of possible reform in relation to the provision of services for sexual assault victims. In its final report *Responding to Sexual Assault*, the Taskforce recommended the need for research and data collection on 'why sexual assault complaints made by both adults and children do not proceed through the criminal justice system' (CJOST, 2005, p. 1). It also recommended immediate action 'to ensure there is consistent and accurate information in a variety of formats given to victims from the outset by service providers about their rights and the criminal justice process' (CJOST, 2005, p. 1). Recommendation five concerned serious consideration of the development of 'one-stop units' to provide coordinated service delivery

for adult sexual assault victims that could be established within SASs, and recommendation six, the prioritisation of funding to sexual assault counselling services, NSW Health and relevant NGO funding, and the training of Sexual Assault Nurse Examiners (CJOST, 2005).

With Iemma (2005-2008) as Premier, the NSW Parliament passed the *Crimes Amendment (Consent – Sexual Assault Offences) Bill 2007* (NSW), which included changes to the definition of consent such that 'a person "consents" to sexual intercourse if the person freely and voluntarily agrees to the sexual intercourse' (Cossins, 2019, p. 468). Thus, a person was guilty of sexual assault if they had no reasonable grounds on which to believe that a person consented to sexual activity (Cossins, 2019; Mason & Monaghan, 2019; NSW Government, 2018a). The statute listed cases where the person could not provide consent, for example, a person was unable to consent when one person was in a position of trust or authority over the other or if they were intoxicated, asleep, or unconscious, or coerced or intimidated at the time of the sexual assault (Boxall et al., 2014). These changes showed a marked move away from prior understandings of an offence committed forcibly against the will of the person:

> Under this [previous] conceptualisation of sexual assault and rape, these offences occurred 'against the will' of the woman. Consent became relevant to the case in that it was believed that a woman who was not consenting would show active resistance. This resistance would be illustrated by physical injury. Likewise, physical injury would provide evidence of use of force by the defendant, thus providing insight into his awareness of the complainant's non-consent (Fileborn, 2011, p. 7).

With the changes in legislation, the premise became that of 'positive' consent: a person who agreed to engage in sexual activity would communicate this either verbally or through body language (Fileborn, 2011). These changes 'overturned the infamous Morgan 'defence' (DPP v Morgan), which excused a defendant if he held an honest belief that the complainant was consenting, however unreasonable that belief might have been' (Mason & Monaghan,

2019, p. 28). The legislation thereby introduced an objective element into the consideration and assessment of consent (Mason & Monaghan, 2019).

The NSW Government introduced its principal domestic violence legislation, the *Crimes (Domestic and Personal Violence) Act 2007* (NSW). It defined offences and what fit the definition of 'domestic' and family violence to clarify who fits the definition of 'family', as well as conditions for issuing Apprehended Domestic Violence Orders (ADVOs) (NSWLC, 2012). However, confusion on these terms and conditions remained. The NSWLC (2012) noted its inquiry presented 'an opportunity for the NSW Government to rethink its approach to domestic violence, particularly with regard to what relationships should and should not be classified as 'domestic' in the *Crimes (Domestic and Personal Violence) Act 2007*' (p. xxxvi). A lack of clarity regarding which relationships fit the classification of 'domestic' caused confusion. The NSWLC (2012) Standing Committee on Social Issues believed the NSW Government should adopt a strategy acknowledging that 'at its core, domestic violence occurs between people in family or family-like relationships. A new definition should make the presumption that relatives and people in intimate relationships are in domestic relationships' (NSWLC, 2012, p. xxxvi). Relatedly, the NSWLC (2012) identified problems with the AVO system, the primary legal mechanism to protect individuals from domestic violence, which included ADVOs and Apprehended Personal Violence Orders (APOs) for non-domestic relationships. Given the courts issued tens of thousands of ADVOs annually, it was essential that this system worked effectively to protect victims of domestic violence (NSWLC, 2012). Therefore, the NSWLC (2012) recommended changes to the definition of domestic violence in the *Crimes (Domestic and Personal Violence) Act 2007* and amendments to conditions for the issuing of ADVOs within the Act.

In 2008, the Government produced a discussion paper, *NSW Domestic and Family Violence Strategic Framework*, to inform the development of a new strategic framework (NSW

Department of Premier and Cabinet, 2008). In January 2010, NSW Health released the interim *Women's Health Plan 2009-2011* with violence a priority action area. It planned a full review of NSW policies for women in 2012 (NSW Department of Health, 2010).

In 2009, the Rees Government (2008-2009) introduced *A Way Home: Reducing Homelessness in NSW – NSW Homelessness Action Plan 2009-2014.* A key priority of this plan was to provide safe and secure long-term accommodation for people who experienced homelessness, particularly those escaping domestic and family violence (NSWLC, 2012). Further, the Rees Government released the *Interim Women's Health Plan 2009-2011*, which prioritised the area of violence against women and focused on the needs of women from rural, regional, and remote areas (Gray Jamieson, 2012).

2010-2020: Keneally to O'Farrell/Baird/Berejiklian

In 2010, under Keneally's premiership (2009-2011), the NSW Labor Government launched the NSW Domestic and Family Violence Action Plan *Stop the Violence, End the Silence* that included the Sexual Violence Prevention Plan, providing AUD50m over a five-year period (NSW Office for Women's Policy & NSW Department of Premier and Cabinet, 2010; NSWLC, 2012). Following the launch of the 2010 Action Plan, the Minister for Family and Community Services and Minister for Women (Pru Goward) referred an *Inquiry into Domestic Violence Trends and Issues in NSW* to the NSWLC Standing Committee on Social Issues on 18 June 2011:

> The establishment of the inquiry was shortly followed by significant developments in domestic violence policy with the announcement of an independent review of the whole of government domestic violence policy, the *NSW Domestic and Family Violence Action Plan*, to examine whether it remained current and effective (NSWLC, 2012, p. xix).

Then, in November 2011, the NSW Auditor-General released a report on *Responding to Domestic and Family Violence*. The report followed a performance audit of the key government agencies responsible for prevention, early intervention, and tertiary responses to domestic violence, namely, the Department of Family and Community Services (FACS), the Department of Attorney General and Justice (DAGJ), the NSW Police Force, and the NSW Ministry of Health (NSW Audit Office, 2011). It was highly critical of state service responses to domestic violence, which lacked a coordinating strategy, a shared understanding of organisational roles, and strong leadership to drive change. It recommended a framework to promote agreement between key state agencies and nongovernment organisations and urged comprehensive structural reform (NSWLC, 2012). Subsequently, the NSW Government announced that it was preparing the *NSW Domestic and Family Violence Framework* for release in early 2013 (NSWLC, 2012).

Inquiry into Domestic Violence Trends and Issues in NSW

The NSWLC (2012) *Inquiry into Domestic Violence Trends and Issues in NSW* included an examination of the NSW Health Policy and Procedures for Identifying and Responding to Domestic Violence introduced in 2003 (NSW Health, 2003). Evans (2003) noted their second-wave feminist construction of gender inequality as the cause of domestic violence and their 'minimal attention to the oppressive systems of class and race in informing this issue' (p. 1). She continued: 'NSW Health's story about domestic violence [was] women are the victims and men are the perpetrators' (p. 2) and it was 'a gendered phenomenon' (p. 2). She drew attention to several truisms conveyed by NSW Health:

- It was possible to separate interpersonal violence from the other parts that make up people's lives. Hence, it was possible for health workers to intervene in the other

parts, such as drug use and depression, while steering clear of a patient's use of violence.

- Working with perpetrators, i.e., men who used violence required the involvement of the legal system and a level of specialisation outside the reach of Health workers.
- Domestic violence was the sole responsibility of the perpetrator.
- Perpetrators of domestic violence (men) held all the power and 'used sophisticated scheming in the abuse of their partner' (Evans, 2003, p. 2).

The NSWLC inquiry also examined the second edition of the Guidelines for the Promotion of Sexual Safety in NSW Mental Health Services developed in 2004 (NSW Health, 2004). The mental health guidelines highlighted that sexual assault could, and did happen, in mental health services and recognised that many women accessing mental health services would have experienced childhood sexual abuse, which, increased their vulnerability to further sexual assault (Keel, 2005). Revised in 2013, the *Sexual Safety of Mental Health Consumers Guidelines* were designed to support mental health services in meeting their responsibilities relating to the sexual safety of mental health consumers by providing practical advice and strategies. They aimed to promote sexual safety to key stakeholders, such as health staff and managers, consumers, and their families and carers. Among other things, this involved clear information for consumers and their families and carers about their rights and obligations and improving collaboration and strengthening relationships between mental health services and SASs (NSW Health, 2013).

The review canvassed services responding to women and children who had experienced domestic and family violence and found that NSW Health counselling services, like others in the sector, were fragmented and poorly understood (NSWLC, 2012). In addition, the NSWLC inquiry noted NSW Health's focus on interagency service responses and keen desire to avoid service duplication with the nongovernment sector and recommended that the department

'expand the availability of counselling services to victims of domestic violence and their children' (NSWLC, 2012, p. 153). A submission from the men's group, One in Three, informed the inquiry that one in three men were victims of domestic violence. While this remained a controversial claim, the group's submission included a request for domestic violence and sexual assault services to employ men. Its belief was that this would enable increased and responsive access to therapeutic services for male victims; hence, they called for a shift in the feminist emphasis on the gendered basis to sexual violence (NSWLC, 2012). The inquiry did not provide any recommendations on the employment of men in these services.

NSWLC (2012) reported that NSW was no longer the leading state in policy development and reform in this area and expressed criticism that the *Action Plan to Reduce Violence Against Women and Children* (Australian Government, 2011) did not have substance or strategic direction. It agreed on the need for a thorough change to the structure of service delivery that included non-government organisations as equal partners, with the government providing strong leadership, and a long-term, strategic commitment to this issue. It found that people were unaware of the limited therapeutic services and suggested their incorporation into the larger health and community service system (discussed below) (NSWLC, 2012).

At the same time, the Liberal O'Farrell government (2011-2014) committed itself to reforming the homelessness sector with its introduction of the *Going Home Staying Home* policy direction, which included the privatisation of shelters and refuges (NSW Government, 2012). Maguire (2019) observed that there were less than 20 dedicated refuges for women escaping domestic violence, with others being general homelessness shelters. The *NSW Homelessness Action Plan 2009-2014: A Way Home,* as part of its aim to reduce homelessness in NSW, provided funding for refuges for women leaving violent relationships (NSWLC, 2012). Relatedly, the NSW Government's (2013) *Domestic and Family Violence Framework*

discussed below focused on domestic and sexual violence against women with a primary goal of reducing the occurrence of these crimes against women and their children.

NSW Domestic and Family Violence Framework

In 2013, the *NSW Domestic and Family Violence Framework* (NSW Government, 2013) replaced the 2010 Action Plan. The Framework aimed to deliver an integrated, whole-of-government response to domestic violence, focused on primary prevention, offender accountability, and the long-term reduction of domestic and family violence. It advocated a core policy principle that services respond to individual victim's needs rather than the prior focus on the criminal justice system and service requirements. It took an ecological perspective to the cause and necessary responses to violence against women and recognised the complex, multilayered systemic basis to the unequal power distribution between men and women, which influenced negative attitudes to the position of women and, in parallel, privileged men's position (NSW Government, 2013).

In October 2015, NSW Minister for the Prevention of Domestic Violence in the Liberal Baird Government (2014-2017), Pru Goward, announced AUD60m to tackle serious domestic violence problems. It included AUD15m for High Risk Offender Teams, AUD4.1m for 24 new domestic violence liaison officers, AUD19.5m for treatment for perpetrators (in drug and alcohol addiction programs), AUD20m for housing for those affected, AUD2.3m for police partnerships with other organisations, and AUD1.3m over four years to increase the number of Sexual Assault Nurse Examiners in rural areas (NSW Government, 2015).

In 2016, NSW Premier, Mike Baird, introduced the *Domestic Violence Disclosure Scheme (DVDS)*, adopting Clare's Law that had been successful in the UK and piloted it in four NSW Police Force Areas. It allowed disclosure of offences including physical and sexual assault, intimidation and stalking, and breaches to ADVOs (NSW Government, 2018b). In the same year, the NSW government released the NSW Domestic and Family Violence Blueprint

for Reform 2016-2021, *Safer Lives for Women, Men and Children* ('the Blueprint'). It highlighted the government's five-year plan to respond to domestic and family violence through prevention, early intervention (particularly with vulnerable communities), and support for victims and, in so doing, to reduce domestic violence repeat offences (NSW Government, 2016a).

In 2016, the Liberal Berejiklian Government (2017 to the present) released the *NSW Domestic and Family Violence Prevention and Early Intervention Strategy 2017-2021* ('the Strategy') as part of the Blueprint. The Strategy presented the state's vision and explained its informed approach to domestic and family violence, which included sexual assault:

- Though the product of complex, yet modifiable, social and environmental factors, violence against women and their children is not an inevitable or intractable social problem.
- Gender inequality sets the social context for, and condonation of, domestic and family violence.
- Investment in primary prevention and early intervention as part of addressing underlying causes and drivers is essential to achieving an overall reduction in the rate of domestic and family violence and the demand for crisis services (NSW Government, 2016b).

In 2018, the NSW Premier (Gladys Berejiklian) and Attorney-General (Mark Speakman) responded to the Royal Commission into Institutional Responses to Child Sexual Abuse with the announcement that the government would accept most of the recommendations for the criminal justice sector, including maximum life penalty convictions for persistent child sex offenders (NSW Government, 2018a). Further, there were changes to the *Criminal Legislation Amendment (Child Sexual Abuse) Act 2018* (NSW), which replaced s 61HA with s 61HE. This introduced a change in offence terms from indecent assault, act of indecency, and

aggravated versions to the new offences of sexual touching, aggravated sexual touching, sexual act, and aggravated sexual act (NSWLRC, 2018).

Inquiry into Consent in Relation to Sexual Offences

In May 2018, the Minister for Prevention of Family Violence and Sexual Assault (Pru Goward) and Attorney General (Mark Speakman) initiated the NSWLRC to conduct an inquiry into *Consent in Relation to Sexual Offences*. As seen with the legislative changes already described, consent was a core feature of the definition of sexual assault and was at the centre of many contested rape trials (Bronitt, 1992; Flynn & Henry, 2012; Quilter, 2011). The inquiry followed a high-profile court case, known as the Lazarus case (Dyer, 2019; Mason & Monaghan, 2019). The complainant Saxon Mullins publicly pushed for legislative reform on the issue of consent and the accused's awareness (or not) of non-consent (Dyer, 2019). As specified in the Sexual Assault Strategy 2018-2021:

> The review will determine if the law needs to be amended to better protect victims and survivors of sexual assault. It is considering sexual assault research and expert opinion, as well as community views, and developments in law, policy and practice in Australia and internationally (NSW Government, 2018a, p. 11).

As Mason and Monaghan (2019) noted, 'the concept of consent continues to frustrate feminist endeavours to rewrite the legal rape script' (p. 25). They further observed that the 'criminal law still struggles to accommodate the ways in which the nuances of gender inequality play out in the sexual domain' (Mason & Monaghan., 2019, p. 36). Stubbs (2008) argued that the feminist agenda and agitation for law reform had had limited impact on sexual assault legislation. She pointed to the dominant discourse of heterosexual normality, coercive sexuality, gender stereotypes, and rape mythologies that had combined to undermine feminist recommendations for change. She cited the example of the poor government response to the

Heroines of Fortitude report (NSW Government, 1996) on the experiences of court for female victims of sexual assault, with only a few recommendations implemented six years on. Stubbs (2008) called for a more adequate response to the problem of sexual assault and sought remedies through other means than just law reform and the criminal justice system. Her plea stood in the context, as discussed in Chapter 2, of the limited number of sexual assaults reported to police, and the even more limited number that made it to court. She stated:

> The criminal justice system has a significant place in responding to sexual assault. However, it is important to recognise that the vast majority of sexual assaults do not come to the attention of the criminal justice system and that the responses available within that system are limited and unlikely to address the problem (Stubbs, 2008, p. 4).

Again, as discussed in Chapter 2, while a person known to the victim perpetrated most sexual assaults, it appeared that those cases where the offender was a stranger were more likely to proceed legally. Further, Stubbs (2008) noted that, in understanding the nature of the sexual assaults reported, the statistics pointed to these being atypical:

> It is important to keep these characteristics in mind when we come to consider recent public discourse about sexual assault, and some legislative initiatives. It is sometimes the case that it is the atypical case that captures attention and may inform the development of legislation and policy (p. 3).

However, Dowse (2014) noted that legislative reform was not the ultimate aim but seen rather as 'a stage in that long, more important revolution in attitudes' (p. 394).

NSW Sexual Assault Strategy 2018-2021

Women NSW led the NSW Sexual Assault Strategy with the support of the Domestic and Family Violence Reform Delivery Board and NSW Domestic and Family Violence and Sexual

Assault Council. The first phase of the Strategy commenced in 2016 with an audit of services, a literature review, and the establishment of the NSW Sexual Assault Strategy Expert Group to provide advice and guidance. This review found a 'need for a comprehensive and integrated prevention and response strategy that addresses the diverse forms of sexual victimisation that occur over the life course of individuals' (NSW Government, 2016c, p. 10). It suggested a public health approach; a gendered understanding of inequality, including the influence of cultural norms and attitudes about masculinity and femininity and the intersection of other forms of power and oppression; and a whole-of-system response, including specialist, therapeutic, and non-therapeutic trauma-informed services (NSW Government, 2016c).

The NSW Government (2018a) highlighted ANROWS's focus on 'building the limited evidence base about the effectiveness of treatment of perpetrators of sexual assault' (p. 28) and the influence of the Royal Commission's findings on the Strategy's recognition of 'the hurt often deeply felt by adult survivors and the importance of effective supports for both women and men' (p. 5). Informed by growing evidence, comprehensive state-wide consultation, and expert advice from frontline workers, nongovernment service providers, peak organisations, and government agencies, the NSW Government launched the next phase, the NSW Sexual Assault Strategy 2018-2021. This complementary Strategy sat alongside the *National Plan to Reduce Violence Against Women and their Children 2010-2022* (Australian Government, 2019b) and the *NSW Government Response to the Royal Commission into Institutional Responses to Child Sexual Abuse* (NSW Government, 2018c). Its continued aim was to improve the prevention of, and response to, sexual assault by which it meant all types of sexual offences, ranging from sexual harassment to aggravated sexual assault. Its goal was to deliver the first three-year, whole-of-government approach to sexual assault and to improve the service system for adults and children who experienced sexual assault, while holding perpetrators to account. It also sought to raise community awareness of sexual violence, while improving

prevention and education measures in families and the wider community. For example, it implemented the #makenodoubt (2019) social media campaign to raise awareness about consent in sexual relationships. It set out its reform initiatives across five key areas: Prevention and early intervention; education; supporting victims and survivors; holding perpetrators accountable; and reshaping the service system.

NSW Health Integrated Framework

Aligned with the NSW Sexual Assault Strategy, in 2019, NSW Health introduced the *NSW Health Integrated Prevention and Response to Violence, Abuse and Neglect Framework* (the Framework) for the redesign and strengthening of its person-centred approach to violence, abuse, and neglect. It defined its integrated service response as 'seamless care across multiple services' (NSW Health, 2019, p. 13), which:

> Adopts a multidisciplinary and trauma-informed approach, and is designed around the holistic needs of the individual throughout the life course. This approach supports the systems integration necessary to shift the paradigm from volume to value care that NSW Health is advancing (NSW Health, 2019, p. 13).

This Framework outlined the vision, principles, and objectives of service delivery over the next two years. It sought to 'promote a cultural shift across all NSW Health services towards person-centred and trauma-informed care and practice, based on recognition that all health workers have a responsibility to contribute to the prevention of and response to interpersonal violence' (NSW Health, 2019, p. 12).

NSW Health Sexual Assault Policy and Procedures

Officially titled *Responding to Sexual Assault (adult and child) Policy and Procedures*, this policy provided an update from the previous 2005 version. It 'provides policy and practice

guidance for NSW Health services in responding to children, young people and adults who have, or may have been, sexually assaulted, along with their families/significant others' (NSW Health, 2020, p. 15). It 'details the functions and governance of NSW Health Sexual Assault Services including relating to crisis response, medical and forensic assessment and management and ongoing interventions and support' (summary page). While primarily for specialist Health SASs, it also targeted related health services and sectors, such as emergency departments, mental health, and child protection. It noted that:

> In NSW, there is currently a fragmented response, with each issue [violence, abuse and neglect] having its own history, philosophies, policies, services, practices and cultures. As a result, policy and service responses to violence, abuse and neglect have historically operated as silos for which there have been meetings at some intersections but not a consistent integrated response (NSW Health, 2020, p. 18).

Informed by a structural, gender, and intersecting power analysis, the policy and guidelines followed the socio-ecological and public health model promoted by the World Health Organisation (NSW Health, 2020). They further stated:

> NSW Health is undertaking substantial work to integrate and reorient services, policies and clinical practice to ensure consistent and comprehensive responses to all forms of violence, abuse and neglect from violence, abuse and neglect-specific and mainstream health services, as well as child and adult services. This is part of a broader cultural shift towards person-centred, family-focused, trauma-informed, strengths-based and collaborative care and practice in NSW Health. This cultural shift recognises the important role that health systems play in addressing the adverse impact of violence, abuse and neglect on people's safety, health and wellbeing (NSW Health, 2020, p. 19).

Table 5.4: Progression of NSW state policies relating to sexual assault

Year	Policy	Description	Government
1977	NSW Interdepartmental Task Force on Care for Victims of Sexual Offences (1978)	Recommended 24/7 crisis counselling and a focus on victim care	Wran Labor Government 1976-1986
	Women's Coordination Unit (WCU)	Established in the Premier's Department, with women's units connected to each department to communicate issues to the WCU and Premier (Gray Jamieson, 2012)	
	Women's Advisory Council (WAC)	Facilitated communication from the community to government (Gray Jamieson, 2012)	
1984	Women's Housing Program	Led to the provision of medium-term housing, especially for women leaving violent relationships (Sawer, 1990)	
	Community awareness media campaign 'no-one ever deserves to be raped' (NSW Department of Health, 1984)	Aimed to raise awareness of the needs of sexual assault victims and promote improved service responses	
	Women's Health Policy Review Committee	Charged with identifying women's major health needs, assessment of service responses, and funding mechanisms for such services (Gray Jamieson, 2012)	
1985	NSW Sexual Assault Committee (1985, 1988)	Based in the Premier's Department, the committee reported on the coordination of state responses to sexual assault	
	Women's Health Unit	Headed by the Women's Health Advisor (Gray Jamieson, 2012)	
1987	NSW Government Violence Against Women and Children Law Reform Task Force (1987)	A consultation paper from the Women's Coordination Unit in the NSW Premier's Department	Unsworth Labor Government 1986-1988

1990	Premier endorsed the NWHP (Australian Government, 1989)	Principles of the NWHP endorsed (Gray Jamieson, 2012)	Greiner Liberal Government 1988-1992
1991	NSW Domestic Violence Strategic Plan	Plan to coordinate fragmented government responses (Gray Jamieson, 2012)	
1993	NSW Standing Committee on Social Issues (1993) *Sexual Violence: The Hidden Crime, Part I*	This inquiry into the incidence of sexual offences in NSW report contains a summary of estimates on sexual assault up until that year	Fahey Liberal Government 1992-1995
1996	NSW Standing Committee on Social Issues (1996) *Sexual Violence: The Hidden Crime, Part II*	This inquiry into the incidence of sexual offences provides an overview of explanations for sex offending and describes treatment programs in NSW	Carr Labor Government 1995-2005
	Heroines of Fortitude report (NSW Government, 1996)	Documented the court experiences of female victims of sexual assault; found that 11% of complainants appearing in court were Aboriginal women and most reports of sexual assault did not proceed to trial with guilty pleas achieved in about 20% of cases that did (Stubbs, 2008)	
2000	Strategic Framework to Advance Women's Health	Provided strategic direction; confirmed government's social view of health and intersectoral cooperation (Gray Jamieson, 2012)	
	Gender Equity in Health (NSW Department of Health, 2000)	Recognised gender as an important element of health status; and considered men's and women's health needs (Gray Jamieson, 2012)	
2002	Women's Health Outcomes Framework	Provided a guide to measurement and monitoring of health outcomes; prioritised prevention of violence against women (Gray Jamieson, 2012)	
	NSW Council on Violence Against Women (2002) Status Report on *Heroines of Fortitude*	Noted most of its recommendations had not been implemented six years on (Stubbs, 2008)	
2003	NSW Health (2003) *Policy and Procedures for Identifying and Responding to Domestic Violence*	Evans (2003) observed the foregrounding of gender inequality as the cause of domestic violence with minimal attention paid to class and race: 'NSW Health's story about domestic violence [was] women are the victims and men are the perpetrators (p. 2) and it's a 'gendered phenomenon' (p. 2)	
2004	NSW Health (2004) *Guidelines for the Promotion of Sexual Safety in NSW Mental Health Services*	Highlighted that sexual assault can, and does happen, in mental health services; provided guidelines for health workers; and recognised many women will have experienced childhood sexual abuse (Keel, 2005)	

2005	Criminal Justice Sexual Offence Taskforce (CJSOT) (2005) *Responding to Sexual Assault: A way forward*	Report on the Taskforce's examination of 'issues surrounding sexual assault in the community and the prosecution of such matters within the criminal justice system' (CJSOT, 2005, p. iii)	
2009	*A Way Home: Reducing Homelessness in NSW* (NSW Government, 2009)	NSW Homelessness Action Plan 2009-2014 outlined strategic directions to reduce to homelessness in NSW (NSWLC, 2012)	Rees Liberal Government 2008-2009
	Interim Women's Health Plan 2009-2011	Included priority area of violence against women, and a focus on the needs of women from rural, regional, and remote areas (Gray Jamieson, 2012)	
2010	*Stop the Violence, End the Silence* (NSW Office for Women's Policy & NSW Department of Premier and Cabinet, 2010)	NSW Domestic and Family Violence Action Plan, including a Sexual Violence Prevention Plan, was a 10-year plan aimed to see a reduction in crimes of sexual assault and domestic violence against women (NSWLC, 2012)	Keneally Labor Government 2009-2011
2011	Minister for Community Services initiated an independent review of the 2010 Action Plan	Criticised the 2010 Action Plan for lack of substance or strategic direction (NSWLC, 2012)	O'Farrell Liberal Government 2011-2014
	Responding to Domestic and Family Violence (NSW Audit-Office, 2011)	This report released in November by the Auditor-General informed the 2013 NSW Domestic and Family Violence Framework	
2012	*Domestic Violence Trends and Issues* (NSWLC, 201)	Report of the NSWLC informed the 2013 framework; the inquiry included an examination of NSW Health service responses to domestic violence	
	Going Home Staying Home Reforms (NSW Government, 2012)	Program to reform the specialist homelessness services system that *inter alia* aimed to move the homelessness sector away from a domestic violence focus and privatised women's refuges in a funding overhaul	
2013	NSW Domestic and Family Violence Framework (NSW Government, 2013)	*It stops here!* Standing together to end domestic and family violence in NSW: The NSW Government's Domestic and Family Violence Framework for Reform replaced the 2010 Action Plan (NSWLC, 2012)	
	Sexual Safety of Mental Health Consumers Guidelines (NSW Health, 2013)	Aimed, *inter alia,* to improve collaboration and strengthen relationships between mental health and sexual assault services	
2016	*Safer Lives for Women, Men and Children* (NSW Government, 2016a)	NSW Domestic and Family Violence Blueprint for Reform 2016-2021 focused on prevention, early intervention, and crisis responding	Baird Labor Government

	Domestic Violence Disclosure Scheme (DVDS) (NSW Government, 2018b)	First state to provide this pilot scheme to disclose perpetrator's violent history and provide a stronger response to sexual assault matters	2014-2017
2017	NSW Domestic and Family Violence Prevention and Early Intervention Strategy 2017-2021 (NSW Government, 2016b)	Part of the 2016 Blueprint's focus on prevention and early intervention	Berejiklian Liberal Government 2017-present
2018	NSW LRC review of *Consent in Relation to Sexual Offences*	Review of consent in sexual offences following high profile media cases (NSWLRC, 2020)	
	Criminal Legislation Amendment (Child Sexual Abuse) Act 2018 (NSW) Schedule 1 [6], inserting *Crimes Act 1900* (NSW) s 61HE	s 61HE replaced s 61HA; changed terms from indecent assault, act of indecency and aggravated versions to new offences of sexual touching, aggravated sexual touching, sexual act and aggravated sexual act (NSWLRC, 2018)	
	NSW Sexual Assault Strategy 2018-2021 (NSW Government, 2018a)	Complementary to the National Plan to Reduce Violence Against Women and their Children 2010-2022 (Australian Government, 2019b) and the NSW Government (2018c) response to the Royal Commission	
	Phase one #makenodoubt (2019) social media campaign	Aimed to raise awareness about sexual consent (website National Plan to Reduce Violence Against Women and their Children). Part of the Sexual Assault Strategy (makenodoubt, 2019)	
	NSW Government National Redress Scheme (NSW Government, 2018c)	Announcement that will commit to National Redress Scheme as recommended by the Royal Commission into Institutional Responses to Child Sexual Abuse (Commonwealth of Australia, 2017)	
2019	NSW Health Integrated Prevention and Response to Violence, Abuse and Neglect Framework (NSW Health, 2019)	Outlined principles and objectives to strengthen Health service response in relation to violence, abuse and neglect; promoted a cultural shift towards person-centred and trauma informed whole of Health service delivery	
2020	NSW Health Sexual Assault Policies and Procedures (NSW Health, 2020)	Guidelines for NSW Health services responding to child and adult survivors of sexual assault	

Conclusion

This chapter examined state government policy and legislation related to sexual assault and violence against women generally, and demonstrated the need for informed, comprehensive, multilayered responses that were difficult to achieve. The historical analysis showed the changes in philosophy that informed sexual assault legislation, beginning when women were considered the property of men. The evolution of legislation had been the result of feminist agitation and awareness raising. The state political apparatus and health policy machinery used feminist perspectives and analyses to guide legal and policy responses to sexual assault. The momentum for legislative reform through the 1980s to the early 2000s might be returning with an important review once again underway on the integral concept of consent in sexual assault legislation. NSW was the last state to examine this issue. As in the national context discussed in Chapter 4, the 1990s saw the entry of competing discourses focused on men's rights and conservative family values. Also reflected in the state context was evidence of sways in political will and subsequent responses, or lack thereof, to the issue of violence against women. Changes and developments in sexual assault legislation signified a more inclusive and nuanced understanding of this type of crime against women, men, and children (e.g., gender-neutral terminology, creation of specific Acts related to transgender concerns, and understandings of consent). From the 1990s onward, state government administrations recognised and acknowledged the uncoordinated service-delivery response to the issue of violence against women. The 2000s saw determined movement in organisational development and service delivery to target domestic and family violence with the understanding that this could include sexual assault. Gray Jamieson (2012) observed that:

> In the 1970s, both domestic violence and sexual assault were buried in the private sector from whence they were extracted by feminist crusades. Yet, of the two issues, it has

> been much more difficult to keep sexual violence on policy agendas and to change attitudes towards it, even among professionals (p. 243).

The early 2000s saw labor governments that promoted a strategic service-delivery response that emphasised a preventive, holistic, cooperative, intersectoral approach rather than an individual biomedical model (Gray Jamieson, 2012). Integral to the women's health movement and subsequent policy directives were considerations of women's *and men's* health needs based on a gender analysis (Gray Jamieson, 2012). The government's examinations of policy directives had shown the absence of a structural and intersectional approach in previous understandings and responses (Evans, 2003). Further, where once NSW had been a leading state in policy development and reform in this area, by 2012, this was no longer the case (NSWLC, 2012). The government sought to remedy this by incorporating an ecological perspective that pointed to the complex, multilayered systemic basis to entrenched gender inequalities that disempowered and subjugated women and privileged men's position in society (NSW Government, 2013). Since 2018, there had been a targeted focus on sexual assault service delivery with a cultural shift towards integrated, person-centred, whole-of-system, trauma-informed responses. Despite the implementation of positive legal and organisational reforms and policies to guide service delivery, data showed that community attitudes had not shifted; victim-blaming, judgement, and a lack of responsibility placed on the offender still influenced community responses. Campaigns to increase social awareness of the crimes of domestic violence and sexual assault had been productive, to some extent; however, they had not resulted in a reduction in this type of criminal behaviour. Indeed, the sitting premier noted that gender inequality set the social context for the condonation of violence against women. Further, despite legal advancements, sexual assault criminal legislation still struggled to accommodate the nuances of gender inequality in the sexual domain (Mason & Monaghan, 2019), while the issue of consent remained a contested area of legislation in NSW. Thus, the

discussion demonstrated the importance of a strong, clear, long-term policy focus that attended to the centrality of gender inequality and attitudes towards women, within a socio-ecological and public health model. It showed the connection between state government policy developments and subsequent service responses. Against this policy backdrop, the following chapter examines the service context**.**

CHAPTER 6

Sexual assault services

There is common knowledge, connection with a female counsellor when walking in, she will understand regarding power (Patricia)

In general, we are working with [a] trauma focus a lot more (C11)

This chapter discusses the service context within which to view the findings presented in forthcoming chapters. Though NSW SASs included services for children, young people, and adult survivors of sexual abuse, as well as their non-offending parents or carers, partners, families, and other supporters, the focus of this study and this chapter was government services for adult female survivors of sexual assault (NSW Health, 2018). The chapter provides an overview of the development and nature of sexual assault services for women specifically and shifting trends in provision over the years, including the shift from feminist to trauma-informed care, and the increasing awareness of the risk of vicarious trauma for practitioners; greater inclusivity; multisectoral approach; multilevel interventions; and focus on prevention. Thereafter, the discussion turns to the nature of sexual assault services and sexual assault counselling for women. It ends with a case study that demonstrates the counselling process.

Development of SASs

Sexual assault counselling services in Australia originated from the feminist movement in the 1960s and 1970s at a time of growing awareness of the disproportionate effects of sexual

assault and domestic violence on women (Astbury, 2006; Carmody, 1990, 1997; Gottschalk, 2009; Hill, 2019; Khan, 2015; Pack, 2011). They formed part of the fight for community and government services to respond to violence against women on the premise that domestic violence could happen to any woman.

Through the 1970s and 1980s, women's collectives established voluntary, community-based services to support and assist women and children, who had experienced violence (Astbury, 2006; Boxall et al, 2014; Egan, 2019; Egan & Hoatson, 1999). They established the Elsie Women's Refuge in Sydney in March 1974. Shortly thereafter, in October that year, a group of feminists, called the Sydney Rape Crisis Collective, were actively involved in political protests and public campaigns. They established the first organised centre named the Sydney Rape Crisis Centre (SRCC). Staffed by volunteers, they offered support to women who had experienced sexual violence, with counselling, medical support, and legal services (Maguire, 2019). With funding from the Whitlam government (1972-1975), they developed a 24-hour phone line and remained the only sexual assault support service in NSW until the end of the 1970s (Egan, 2019; Sawer, 1990). With much input from social workers over the years, sexual assault counselling assumed a significant role from 1979 onwards when the NSW state government located SASs in teaching hospitals. Indeed, it was determined that the best location for these innovative services, named Sexual Offences Referral Centres (SORCs), was within the social work department of the major teaching hospitals in NSW (Carmody, 1990). This did not change pre-existing nongovernment services, such as the Rape Crisis Centre in Sydney.

The focus of SASs at that time was largely on the provision of crisis counselling and medical care for victims of sexual assault (Carmody, 1997) with liaison between police, health, and statutory child protection agencies also required to provide coordinated care (Carmody, 1990). However, there was much angst from social workers at the time, due to the lack of consultation on this new role for the profession and the advent of 24-hour crisis care. Carmody

(1990) argued that, notwithstanding the lack of consultation and increased budget to allow for the increased workload, the particular elements of social work training and service provision made it 'well-suited to working with the complex needs of a victim of sexual assault' (p. 11). Despite this, at the time, there was consternation in the wider women's movement with the tension between those who saw value in government involvement and those who saw this as capitulating to the patriarchy (Carmody, 1990). Due to confusion of the intent of the service, the name changed from SORCs to HELP Centres shortly after their formation (1979-1984), however, this change had not remedied the issue (Carmody, 1990). In line with naming the issue and breaking the secrecy of sexual assault, the name was changed in 1984, following consultation between coordinators (created in 1979), to Sexual Assault Services (Carmody, 1990).

The NSW rape crisis network established Dympna House in 1984. It was a nongovernment agency for female survivors of child sexual assault until 2009. According to Egan (2019), 'the 1980s was the decade in which incest emerged as a major political concern as women began contacting sexual assault and women's health centres in relation to experiences of sexual victimisation in childhood' (p. 172). Following the NSW Taskforce into Child Sexual Assault (1987), the NSW government established combined child and adult SASs in government-run community health centres and provided funding for community-based child sexual assault centres (Egan, 2019). It established some services in communities, linked to hospitals for crisis care and after-hours presentations (Carmody, 1990). Further, a child sexual assault network established Child and Adolescent Sexual Assault Services in nongovernment organisations that explicitly claimed feminist territory.

The government also established SASs in nine metropolitan public hospitals throughout the state in the 1980s (Carmody, 1990; Egan, 2019). As Egan (2019) explained, 'from a single organisation in 1974, the NSW sexual assault services sector now encompasses a complex

assemblage of overlapping and hierarchically organised bodies typical of contemporary social services provision in welfare states' (p. 172).

Policy and procedural guidelines were first developed in 1982 by the then NSW Department of Health and revised in 1984 following interagency consultations between the police, the Women's Co-ordination Unit, hospitals where SASs were located, and the then Department of Youth and Community Services. The NSW Department of Health (1984) guidelines focused on the crisis medical and psychosocial response. The simultaneous State media campaign *No-one ever deserves to be raped*, aimed to raise community awareness on the needs of sexual assault victims and to promote improved service responses (NSW Department of Health, 1984). Carmody (1990) reported that, in 1988, NSW Health further developed its policy and guidelines, which external counsellors and practitioners, including those from interstate where such policies did not exist, welcomed (Carmody, 1990).

By the end of the 1980s, these services saw increased funding with state and federal grants and 'had become increasingly professional' (Boxall et al., 2014, p. 9). Though feminists favoured a consensus model (Weeks, 1994), Broom's (1991) in-depth analysis of women's services in Australia revealed they were, at times, a contested terrain:

> Industrial conflict between management and workers; interpersonal conflict among the women involved with the centres; political conflict between centres and their funding bodies and institutional conflict between centre and other community organisation or professional bodies (p. xii).

However, a key strength of these feminist services was 'their commitment to working co-operatively with like-minded organisations, a strength that initially mobilised the funding of feminist services' (Weeks, 1994, p. 148). Hence, feminists played a major role in agitating for the establishment of government support services for women and children affected by sexual abuse and domestic violence (Boxall et al., 2014; Sawer, 1990).

As the demand for women's services increased with growing social awareness in the 1980s, these voluntary organisations turned to the government for support, which would, in time, test the feminist ethos and independent nature of this female-dominated service sector (Carmody, 1990; Egan & Hoatson, 1999; Mason, 2008). In particular, economic-rationalist policies tied to market mechanisms exposed these services to competitive contracting and restricted programs to government priorities, which, at times, were out of step with service-user needs and the structural ideology of feminists running the services (Egan & Hoatson, 1999; Martin, 2005; Ullman & Townsend, 2008). As Egan and Hoatson (1999) observed, once 'reliant on government funding, feminist services have to conform with government agendas which stem from an ideology which individualises problems' (p. 6). Hence, the economic rationalist perspective, regardless of which side of politics was in power, was at odds with feminist philosophy and reduced the ability for sexual assault agencies to provide the holistic and wide-ranging services provided earlier in their development (Egan & Hoatson, 1999). While services continued to 'act as sites of ongoing resistance to dominant beliefs about rape that hold women responsible for the crimes' (Carmody, 1997, p. 455), there were priorities they were required to follow, one of which delegated counselling for adult survivors of childhood abuse to the lowest priority. As Fraser (2005) stated, 'this situation has arisen because services to survivors of abuse do not neatly fit into the economic rationalist equation of brief health and welfare intervention' (p. 28). This led to cuts to groupwork and community education and action, and interagency and partnership work, once a key strength of feminist services, as they were no longer valued (Egan & Hoatson, 1999).

Government service provision comprised NSW Health SASs (50 at the time of Egan's (2015) study) in urban and rural areas throughout NSW, a network of 16 nongovernment Child and Adolescent Sexual Assault Counselling Services, and the NSW Rape Crisis Centre, formerly the SRCC (Egan, 2019). While Egan (2019) claimed there were 'no private, privately

funded or for-profit sexual assault services in NSW' (p. 172), this study found there were private therapy services providing sexual assault counselling for those that could afford to pay for them, or through government-funded services, such as Victims Services.

Carmody (1997) observed that 'working in sexual assault services is a specialist area of social work practice' (p. 464). In a study she conducted with sexual assault counsellors, she acknowledged the difficulties and complexity of this work:

> Because of the highly conflicting values surrounding rape and sexual assault in the community, the workers have a sense that they bear some of the stigma that the victims experience. By its very nature, the work is confronting, whether it involves working directly with survivors or challenging the beliefs of administrators and legislators (p. 464).

Trends in the development of SASs

Over the years, there have been constant changes in service philosophy and practice approaches as follows:

- Historical feminist focus
- From community-based services to health sector
- Competing feminist and psychopathology models
- From feminist to trauma- and violence-informed care
- Towards greater inclusivity
- Multisectoral approach
- Multilevel interventions
- Focus on prevention

Historical feminist focus

The feminist approach to therapy and care of women who had experienced sexual assault, as discussed in Chapter 2, characterised the work of sexual assault services, a key strength of which was their holistic individual, group, and community level interventions, as well as their interagency and partnership work. Although, in time, other influences (discussed below), diminished community and interagency engagement and competed with feminist-informed frameworks and concepts, the latter still held currency in contemporary SASs (Carmody, 2009; Egan, 2019; Egan & Hoatson, 1999).

From community-based social services to health

As the government increasingly privatised community services, NSW Health shifted its focus from community-based to mainstream institutional health services connected to hospitals. The government recognised the 'substantial work' that would be required to carry out an integration and reorientation of health services, and connected policies and clinical practice guidelines. The goal was to achieve a health service that provided 'consistent and comprehensive responses' to all forms of violence and abuse (in its violence prevention and mainstream health services, and the child and adult services). Further, it acknowledged that such change would require a cultural shift 'towards person-centred, family-focused, trauma-informed, strengths-based, and collaborative care and practice' (NSW Health, 2020, p. 19). In support of these changes, the NSW government firmly positioned the health sector as instrumental in responding to people, of all ages, who had experienced violence against them and in addressing their safety, health, and wellbeing needs (NSW Health, 2020).

The 1990s led to a different approach to managing sexual assault based on a medicalised and individualistic understanding of violence against women in intimate relationships. This approach held women accountable and emphasised medical and

psychological treatments. In time, this led to 'a redistribution of funding away from "prevention, education or advocacy"' (Langan & Morton, 2009, p. 173) and 'a public, political and organizational reframing of roles and responsibilities' (Lavis et al., 2005, p. 447). With the concern and backlash about the appropriateness of therapists' practice amid the 'false memory syndrome' controversy came the push for 'professionalising' therapy services. However, this also raised the issue of whether such a focus on 'professionalising', while acknowledging the need for appropriate, well-informed and effective therapeutic approaches, moved the issue more into the private realm of the counselling room rather than also in the sociopolitical space. This shift raised the issue of whether this was a move again to silence victims and to remove their voices from the public's awareness; to make sexual assault a private, and not public, issue once again (Breckenridge & Laing, 1999). Carmody (1997) argued that SASs located in mainstream hospitals challenged the dominance of the medical discourse and invited an alternative awareness of the social and political lens to the issue of sexual assault.

Competing feminist and psychopathology models

In attempts to make sense of male violence against women, theories emerged from the 'feminist' and 'psychopathology' models (Hill, 2019, p. 100). However, the two strands of psychopathology and feminism understood and addressed this complex social issue in different ways (Hill, 2019). Feminists did not like the psychopathology model and were eager to prove it was neither useful nor effective in understanding or halting male violence. Hill (2019) noted that 'applying a pure psychopathology lens to domestic abuse has been widely discredited, but its influence is still remarkably strong' (p. 102) and had formed the basis for many US public policy and research positions. The psychopathology perspective had influenced research and policy action towards the study and diagnosis of individual pathology, using the Diagnostic and Statistical Manual (DSM), rather than the feminist focus on structural factors affecting gender relationships and violence in society (Hill, 2019).

From feminist to trauma- and violence-informed care

Contested perspectives have hampered a united stand on, and solution to, the ongoing crisis of men's violence against women. As discussed in Chapter 2, feminists had a largely sociological understanding of women's oppression at the hands of men that, for some, was socially divisive. Many saw the feminist focus on patriarchy and gender inequality as narrow and simplistic, arguing that explanations that violence against women was about men maintaining power or control did not capture the complexities of social relationships, the influence of social structures, and the traumatic effects of sexual violence. Yet, feminists were insistent that male violence stemmed from entitlement or privilege afforded to men and these values were 'formed by society, and connected to patriarchy' (Hill, 2019, p. 108). As already discussed, the beginnings of refuges and rape crisis centres stemmed from feminist community action. There was considerable conflict between community-based feminist sexual assault counsellors and the SASs, which feminist activists saw as medicalising and professionalising the care provided to women who had experienced sexual violence. The entry of government and charitable organisations into funding rape crisis and sexual assault services changed their feminist ethos. For feminist activists, this was a largely political problem. Political activism and social change gave way to 'a professionalised and depoliticised service-provider model … collaborating with, rather than agitating against, the police, medical and health systems' (Egan, 2019, p. 169). In time, what began as feminist practice gradually transformed to equally ideological trauma-informed care. Some saw the focus on the traumatic incident of sexual assault and its psychological manifestations as an attempt to reduce the 'divisive' gender-based focus (Breckenridge & Laing, 1999; Ullman, 2010). The change began with the Howard Government's rear-guard focus on men disadvantaged by feminist thinking, especially in custody decisions. The focus on the family as a whole and the development of Family Relationships Centres with an attempt to mediate marital disputes, especially around issues

relating to the custody of children was evidence of this change (Chappell, 2001; Gleeson, 2013; Sawer, 2007).

The addition of 'and violence' to trauma- and violence-informed care reflected enhanced understanding of the relationship between violence and trauma, and the long-term traumatic effects of violence (Covington, 2008; Elliot et al., 2005). Trauma and violence-informed approaches were not about *treating* trauma *per se*, for example, through counselling or therapeutic interventions. Rather, their focus was to minimise harm and retraumatisation, and enhance safety, control, and resilience for survivors. Trauma- and violence-informed approaches recognised the strong links between gender and culture and the experiences and effects of violence. Hence, the NSW Health (2020) Sexual Assault Strategy reiterated its feminist focus in its promotion of 'an explicit gender analysis and focus on changing the gendered drivers and cultural norms and values underpinning sexual assault' (p. 170), a stance compatible with trauma- and violence-informed practice. NASASV (2015), too, noted SASs employed a trauma model of recovery incorporating feminist gender awareness, and client-centred care.

However, a trauma- and violence-informed approach differed in many ways from feminist sexual assault counselling. Though creating an emotionally and physically safe environment remained the same, one change was that practitioners could acknowledge the root causes of trauma without clients needing to disclose in detail what had happened to them, thus avoiding retraumatisation. Practitioners fostered opportunities for choice, collaboration, and connection and focused on strengths and capacity building to support client coping and resilience.

Ponic et al. (2018) described a continuum of trauma- and violence-informed responses. At one end, *trauma- and violence-informed approaches* focused on minimising harm caused by triggering and retraumatising and creating supportive environments. At the other end,

trauma-specific approaches treated trauma and related health outcomes through specific healthcare modalities, such as psychotherapy, which required some understanding of a survivor's history of trauma and violence, to tailor treatment accordingly. Services could implement trauma-informed approaches widely but should complement them with a multisectoral approach involving referrals to forensic, healthcare, and housing services.

Brown (2002) highlighted that 'feminist therapists have been leaders in developing modern approaches to trauma therapy' (p. 264). Feminist therapy and trauma-informed (and trauma-specific) approaches both placed the origins or causes of trauma symptoms external to the service user. As Brown (2008) noted:

> Feminist therapy theories refer to distress (the subjective experience of ill-being) and dysfunction (behaviours and ways of being that create difficulties in life) rather than psychopathology: thus, an important origin of the problem is always located outside of the individual (p. 286).

Further, symptoms were 'evidence of resistance by the individual to those experiences of oppression and attempts to solve the problem of powerlessness via whatever means are available' (Brown, 2008, p. 286) as opposed to 'distress as pathology inherent in the medical model' (Brown, 2008, p. 287).

Ullman (2010) expressed concern that trauma responses had returned to an individual focus and thus 'effectively contributed to depoliticization of the problem' (p. 35). Breckenridge and Laing (1999) voiced similar concerns and cautioned that:

> Once the language used to describe and define sexual and domestic violence is medicalised, there is the danger of an associated shift sideways away from an analysis that incorporates power and gender as key concepts to one that focuses on diagnoses, illness and pathologies (pp. 26-27).

Further, they worried that such a stance may result in a backwards move, one that would resemble the climate before the 1970s and 1980s.

Ullman (2010), however, asserted the need to hold a theory that maintained the presence and influence of the social context in the social problem of sexual assault. She explained that 'theoretical approaches based on ecological/community psychology … hold promise for both repoliticizing women's rape disclosures and society's reactions to them' (p. 35). She further noted that the field of stress and trauma in general also emphasised the return in consideration of social analyses and stated that 'this focus is warranted because empirical research shows that social support and network responses are important buffers of the effects of trauma exposure, especially rape. Social support is actually one of the strongest protective factors associated with reduced risk of PTSD in general' (p. 35). Ullman (2010) further stated:

> Ideally, individual, personal, and collective political empowerment should go together. However, contemporary efforts still remain far too limited and underfunded. Without this level of attention to the ecological context, rape is unlikely to go away, and responses to victims are unlikely to improve (p. 36).

Risk of vicarious trauma

With the increasing trauma focus, came awareness of the hazards for practitioners, who worked with traumatised clients, to develop vicarious trauma (VT). As Trippany et al. (2004) noted, the dangers of 'developing trauma reactions secondary to exposure to clients' traumatic experiences, is not uncommon' (p. 31). McCann and Pearlman (1990) used the term 'vicarious traumatization' (p. 133) to describe 'the cumulative, pervasive, and damaging effects on the clinician that occur from chronic exposure to clients' traumatic material' (Michalopoulos & Aparicio, 2012, p. 646). Also used, sometimes interchangeably, other times as discrete concepts, were terms, such as compassion fatigue and secondary traumatic stress (Agllias,

2012; Benuto et al., 2018; Michalopoulos & Aparicio, 2012; Trippany et al., 2004). Such differences in definitions continued to be an area of debate within the literature (Dar & Iqbal, 2020). For instance, Benuto et al. (2018) defined secondary traumatic stress as developing over a shorter timeframe (e.g., among first responders) and vicarious trauma evolving over a longer period, due to gradual exposure (e.g., sexual assault advocates or counsellors); they viewed VT as more pervasive and permanent. However, Trippany et al. (2004) noted that VT symptoms might emerge suddenly, with undetectable signs leading up to onset. The effect of listening and processing traumatic material revealed by service users could affect the individual counsellor. Indeed, Trippany et al. (2004) explained that 'VT has been conceptualized as being exacerbated by, and perhaps even rooted in, the open engagement of empathy, or the connection with the client that is inherent in counselling relationships' (p. 31). Michalopoulos and Aparicio (2012) considered the importance of the counsellor's self-perceptions of power and control and safety in their lives, both personal and work related, and their ability to seek the necessary support when required. They also mentioned the relevance of a counsellor's own trauma history that could increase the risk of susceptibility to vicarious trauma, although this remained inconclusive (Agllias, 2012; Michalopoulos & Aparicio, 2012). VT could result in symptoms similar to PTSD and include intrusive thoughts and images, affect relationships, and be detrimental to work capacity and effectiveness (Agllias, 2012; Benuto et al., 2018; Trippany et al., 2004). In addition to hearing client stories, high workloads and work stress could also contribute to VT, as well as level of experience in the field (Agllias, 2012). While some had identified self-care as a protective factor to the development of VT, others suggested that workplaces needed to implement preventive strategies to support it, including balanced and appropriate workloads, clinical supervision, peer support and debriefing, and trauma training (Agllias, 2012, McCann & Pearlman, 1990). Benuto et al. (2018) stated that VT had parallel consequences for the worker and the service user: '[VT] not only negatively affects the

frontline provider's well-being, including self-esteem, intimacy, safety and trust … but transitively can impact the well-being of the client (e.g. more susceptible to making more errors, decreased motivation and decreased quality of care)' (p. 565). Trippany et al. (2004) agreed and noted that VT often resulted in decreased concern for service users and declined quality of therapeutic response. Hence, Benuto et al. (2018) highlighted the importance of awareness and assessment of VT, and subsequent care for clinicians and the service users. Further, Trippany et al. (2004) stated that VT was a normal and adaptive response to the cumulative hearing of client's trauma narratives. McCann and Pearlman (1990) noted:

> It is important that [people] … avoid pathologizing the responses of helpers. Just as PTSD is viewed as a normal reaction to an abnormal event, we view vicarious traumatization as a normal reaction to the stressful and sometimes traumatizing work with victims (p. 146).

In addition to negative impacts following a direct experience of trauma, there were positive impacts, termed posttraumatic growth (PTG), and instances where people experienced 'positive psychological changes beyond pre-trauma level' (Dar & Iqbal, 2020, p. 203). Dar and Iqbal (2020) reported that positive elements identified as PTG included 'an improvement in relating to others, greater personal strength, positive spiritual change, a greater appreciation of life, and discovering new possibilities' (p. 204). They also reported positive changes following VT, labelled vicarious posttraumatic growth (VPTG). They explained the correlation between VT and VPTG: 'Moderate levels of posttraumatic stress are more indicative of posttraumatic growth because the person remains able to cope, think clearly, and engage sufficiently in the necessary affective–cognitive processing needed to work through' (Dar & Iqbal, 2020, p. 210).

Towards greater inclusivity

Changes in policy direction over the past 15 years, such as the provision of services to include male victims of sexual assault, gave rise to several concerns and challenges. While services to all survivors, including men, were necessary, some feminists argued that these changes in service orientation and philosophical frameworks neutralised the efforts of the women who had fought long and hard to bring issues relating to violence against women to public attention and place them on the policy-making agenda. They highlighted the issue of women's unequal power status in the community at large and in the context of this type of crime particularly. They also raised concerns about the safety of women, given most perpetrators were male. Hence, historically, government SASs only employed female counsellors. However, there had been challenges to this service and employment policy in recent times, which questioned the female-only, safe-space premise that necessitated the exclusion of men. For example, Victorian sexual assault services, known as Centres Against Sexual Assault (CASAs) had employed male counsellors. Though they worked mainly with male clients, this change led, in time, to a structural shift and broadened service framework. The restructuring of government health services in NSW led to the amalgamation of previously separate sexual assault and domestic violence services in the Wollongong area, approximately a decade ago. Consequently, a male counsellor, who had been working in the domestic violence service, then worked in sexual assault with adult survivors of childhood sexual abuse.

Although other services had employed men as counsellors and some SASs had arrangements that would facilitate referral to a male worker, if necessary, the employment of male counsellors in NSW SASs heralded a trend toward greater inclusivity with other groups to consider with this shift. Though beyond the purview of this study, due to her awareness of growing understanding and acknowledgement of trans issues, the researcher questioned whether having male counsellors would lead to trans women feeling more comfortable entering

the historically ‘women-only’ domain of NSW SASs. As the employment of male counsellors challenged the established feminist mindset, she wondered whether this would enhance the welcoming and acceptance of transgender people, and people who might also identify as lesbian, gay, and bisexual, into this space. Love et al. (2017) argued that, as society evolved and progressed, trans counsellors also would become more accepted, which would promote the inclusion of trans people in this counselling space. Hence, the researcher questioned whether the inclusion of male counsellors reflected a move towards a non-binary world, where services would not be female only or cater for male and female survivors separately. Inclusivity embraced varying gender identities, including cis female, cis male, trans, and queer. Transgender people experienced much higher rates of domestic and community violence, and human rights violations, than the general population and faced extensive barriers to service. (Maguire, 2019). Hence, Love et al. (2017) envisioned a world where services welcomed and accepted all survivors, regardless of gender identity, and service users understood that counsellors, too, could be non-binary.

Multisectoral approach

NSW Health (2020) noted ‘to be effective, SASs need to be located within a supportive, collaborative and person-centred, whole-of-health-system and multi-sectoral approach’ (p. 28). Given the multidimensional nature of sexual assault, the provision of comprehensive, seamless, integrated, multisectoral services presented ongoing challenges. It required a sound knowledge of the services available within Health and in the community to address the unique and varied needs of victims and survivors and an informed network that respected each other’s roles and capacity for intervention. According to NASASV (2015), these systems included:

- Justice agencies, such as police, prosecutions, corrections, and juvenile justice.
- Victims of crime services, and criminal and family courts.

- Health services, such as emergency services and forensic medical examiners.
- Sexual health services, general practitioners, mental health, and addiction services.
- Child protection services, including caseworkers, foster carers, education, and support services.
- Family violence services.
- Community legal services
- Private professionals, including social workers, counsellors, psychologists, psychiatrists, health professionals, and legal practitioners.
- Welfare and family support services, as shown in Table 6.1.

Referring to comprehensive (integrated) service provision as tertiary prevention, and again demonstrating the necessity and complexity of this undertaking, Chamberlain (2008) noted it included services to address:

- Immediate needs, such as medical care for physical injuries, restraining orders, safety planning, and shelter services.
- Long-term needs, such as trauma counseling, support groups, employment assistance, transitional housing, children's services, and parenting after domestic violence initiatives.
- Strategies to enhance the quality, coordination, and access to victims' and batterers' intervention programs.
- Legal advocacy programs to help victims navigate the legal system (p. 4).

Medical, forensic, and legal focus

Forensics relates to or denotes the application of scientific methods and techniques to, the investigation of crime and court matters (Lincoln, 2018). Forensic medical examinations and the medical needs of victims of sexual assault have been a priority since SASs were first formed

(Boxall et al., 2014; Carmody, 1990). They have always been an important area of care, as long as this was the victim's or survivor's choice. The unjust prosecution of a man in a sexual assault case in Victoria in 2008 heightened attention to this part of service delivery, specifically in relation to DNA collection. In this case, an error in the examination room led to the contamination of the DNA collection, whereby the DNA of an innocent man was gathered with that of a sexual assault case. This, subsequently, led to a wrongful conviction and six-year prison sentence.

Table 6.1: Social sectors relating to sexual assault

Social structure	Service sector	Expertise
Criminal justice: Police, forensic, and legal services	Law enforcement	Police officers, lawyers, and judges
	Legal system	Lawyers, advocates, and judges; forensic social workers; and psychologists
Health	Hospitals and allied services	SASs mainly employed social workers and psychologists
Medical	Private and hospital based	GPs and medical specialists, nurses, medical social workers, and allied health workers
Mental health	Mental health	Psychologists, psychiatrists, and social workers, mental health nurses, allied health workers
Social	Family and community services, including DV and child protection, family support	Child protection workers, social workers, family support workers, and childcare workers
	Shelters, transitional housing, and women's refuges	Welfare workers, advocates
	Addiction services	Psychologists, psychiatrists, and social workers, nurses and allied health workers

Farah Abdulkadir Jama had DNA collected, in unrelated circumstances, the day before a 48-year old female presented to a local Melbourne hospital for a forensic examination. A member of the public had found the woman semi-conscious in a toilet cubicle of a Melbourne nightclub; she had no recollection of the events that had taken place. The forensic evidence

revealed that DNA from a semen specimen collected as part of the examination matched Jama's DNA and a court hearing on July 21, 2008 found him guilty of rape on DNA evidence alone. Fourteen months later, the forensic examiner acknowledged the error and, on December 7, 2009, the prosecutor admitted to a 'miscarriage of justice', immediately acquitting Jama of all charges and awarding him an ex-gratia payment of AUD525000. Former Supreme Court Justice, the Honourable Frank Vincent conducted, with the subsequent report, the *Inquiry into the Circumstances that Led to the Conviction of Mr Farah Abdulkadir Jama* on March 31, 2010. In his report, known as 'the Vincent report', he noted that a lack of adequate cleaning in the examination room had led to this wrongful conviction. Though satisfactory for the prevention of infections, the cleaning had been insufficient to avoid DNA contamination, given the nature of the examination and high stakes involved. Further, the Vincent report called for DNA collection in a DNA-free space. Subsequently, forensic examiners and counsellors supporting sexual assault victims underwent specialist training and education, and the report recommended similar training for prosecution teams and police officers on the centrality of forensics in contemporary police investigations and court matters, and their role in the preservation of non-contaminated zones for forensic examinations (Rayment, 2010).

Through forensics, the sectors of criminal, legal, medical, and victim care and support coalesced in comprehensive, integrated SAS provision. This could prove problematic when the focus on forensic matters minimised the value and focus of victim care and support or disregarded it entirely. The determined actions of the police and legal profession for the pursuit of justice did not always align with the values of the sexual assault counsellors for whom the victim's wellbeing was always the primary focus.

The NSW Sexual Assault Strategy has as one of its goals the reshaping of services portending further changes afoot. A further rebranding of predominantly feminist SASs with safety a primary consideration into trauma-specific and trauma-informed services is anticipated

(AIFS, n.d.). Also anticipated are further changes following the NSW Government's acceptance of the recommendations of the Royal Commission, discussed in Chapter 4, and further inclusions of male interests. Thus, this study coincided with major changes to SASs. As the findings show, practitioners carried with them reminiscences and regrets about past changes, though remained optimistic about future developments.

Multilevel interventions

Though many have written about sexual violence from the 1970s onwards, most studied rape and sexual assault from a feminist, social, and political perspective, with less attention to effective clinical interventions and service approaches (Petrak & Hedge, 2002). While there was a wide range of trauma-informed therapeutic approaches, as discussed in Chapter 3, there was little empirical research on their effectiveness with female survivors of sexual assault (Regehr et al., 2013). Carlson (2005) noted that standard short-term interventions, such as counselling, education, advocacy, and support, though sufficient for many, were limited and ineffective for women with a longstanding history of exposure, who suffered from PTSD, depression, and substance abuse, and required longer-term evidence-based trauma-specific treatment from highly trained mental health professionals, such as specialist social workers.

From an ecological perspective, microlevel theories sought to explain violence against women in terms of psychosocial or individual characteristics, mesosystems theories examined organisational and service responses, while macrolevel, sociocultural or structural theories examined the broader conditions that made violence likely (Allen, 2013; Campbell et al., 2009). Yodanis (2004) explained the value of a multisystem analysis:

> We need to look behind individual level variables to understand and develop strategies for reducing violence against and fear among women. Violence is not solely explained

> by men's individual characteristics, attitudes, and experiences. Rather, violence against women is linked to structures of male dominance (pp. 672-673).

This pointed to policy interventions to ensure functional criminal and legislative justice structures that treated survivors empathically and brought perpetrators to justice. Also important were effective services working in tandem with one another to ensure interventions at all levels to 'minimize the impact and restore health, wellness, and/or safety as soon as possible … [as] a rapid, coordinated response and follow-up can reduce the impact of victimization, and prevent predictable, long-term consequences and revictimization' (Chamberlain, 2008, pp. 3-4). Multilevel interventions included crisis care, counselling, advocacy, therapy, education, prevention, and perpetrator programs aimed at rehabilitation and the prevention of further violent behaviour. Such multilevel interventions were essential for prevention at the individual, service, community, and systems levels, as already discussed. This was also true for therapeutic responses. Service delivery through SASs, as shown, involved such multiple levels of intervention.

Focus on prevention

Extremely important within the primary healthcare approach (WHO, 2002, 2014) modelled on an ecological framework was prevention (Banyard et al., 2010; Carlson, 2005; Carmody & Carrington, 2000; DeGue et al., 2012; NSW Health, 2020). However, Carmody and Carrington (2000) noted that prevention of sexual violence, as a policy target, has been notoriously difficult to achieve. Despite this, they acknowledged the important impact that public education has played as a key feminist activity. They noted:

> This approach, while limited … nevertheless was historically appropriate in the 1970s, a time when there was an almost complete communal and governmental denial of the reality of sexual violence experienced by women. Feminist campaigns over the last two

> decades have placed violence against women as part of the policy landscape and in the minds of community members (Carmody & Carrington, 2000, p. 352).

Carmody et al. (2009) highlighted that the WHO (2002) approach 'to preventing interpersonal violence has significantly shaped Australian health and social policy … [instilling] optimism … that the violence can be stopped; violence is no longer considered as random, but … can be predicted and therefore prevented' (p. 15). Public education programs, as prevention initiatives, remained relevant although they required specific and appropriate targeting in the broader community. Carmody and Carrington (2000) argued for a well-considered approach, due to the large proportion of sexual violence still hidden from public awareness, given under-reporting to the police, as discussed in Chapter 2. Statistics over the years continued to show the reticence of victims to report the crime of sexual violence to the police. This resulted in a limited awareness and recognition of the crime in the community and hence social policy responses were not able to counteract the true nature and extent of the social problem (Carmody & Carrington, 2000). Such campaigns that continued to focus on stranger danger, i.e., the atypical scenario of sexual assault, deflected the focus of crime prevention to these circumstances, thus weakening efforts to address the complex nature of sexual assault in the community and obstructing the comprehensive and multifaceted response required. Stubbs (2008) agreed and referred to the limited ability of the criminal justice system in preventing violence against women. She argued: 'deterrence, at least as a key strategy, has poor prospects for an offence like sexual assault, with low reporting rates, low clear up rates, and low conviction rates' (Stubbs, 2008, p. 11). Further, Stubbs (2008) highlighted that most men would not conduct themselves in such harmful and oppressive ways as this did not accord with their values and morals about acceptable behaviour between men and women, and it was these beliefs that would deter them rather than legal consequences. Rather, Stubbs (2008) argued that a prevention approach required an understanding of women as sexually autonomous and, in

parallel, the promotion of ethical and respectful sexual practices. Hence, Stubbs (2008) argued for change at the broader, community level to target social values and attitudes towards gender and sexuality: 'While most men engage in sexual relations in an ethical and non-violent fashion, the problem of sexual assault is sufficiently widespread and resilient to suggest that explanations at the individual level will not be adequate' (p. 9). Carmody and Carrington (2000) also emphasised this element of social change noting the importance of:

> Promoting a cultural intolerance for unethical sexual practices … an ethical culture in which negotiating consent is commensurate with sexual desire. This requires policy and community responses which avoid universalising frameworks (i.e. all men are potential rapists), and actively inculcates ethical sexual practices which no longer tolerate intimate sexual violence as the expression of normal male sexuality. Developing ethical sexual practice will mean that both women and men are required to re-evaluate their cultural expectations of each other in relation to intimate relations and to take explicit responsibility for their sexual desires and practices (p. 361).

Carmody and Carrington (2000) also emphasised the need to include social responses and public education campaigns that alleviated the fear and ambivalence many victims experience in reporting to police. Carlson (2005) observed that effective prevention programs depended 'on a better understanding of the risk factors and processes involved in [the] development of offending behavior so that interventive efforts can begin earlier' (p. 123). Given the importance of public education, accurate information is essential to counteract widespread ignorance about sexual violence (Carmody, 2009; Carmody et al., 2009). Carmody et al. (2009) listed NASASV's (2009) principles, which held that:

1. A clear gender analysis and feminist understanding of why sexual assault occurred must underpin primary prevention work.

2. The goal of primary prevention was to achieve behaviour change.
3. Primary prevention work must target men and women and include the broader community, including strategies to engage parents and caregivers.
4. Projects based on risk management and stranger danger were not primary prevention.
5. Primary prevention programs targeted a range of delivery locations, including schools.
6. Primary prevention used a range of practices to respond to geographical and cultural differences across Australia.

The NSW Health (2020) Sexual Assault Strategy highlighted the role of primary prevention in tackling 'the underlying social conditions that allow sexual assault to occur in the first place, primarily gender inequality, but also including: norms, practices and structures that are in place in current society' (p. 169). This contrasted with the 1990s' neoliberal-informed policies that promoted women as responsible for prevention of sexual violence (as discussed above). Contemporary feminist notions remained firmly attached to the premise that victims were never responsible for the crime of sexual violence against them, as reinforced by the NSW Health policy and procedures (NSW Health, 2020). While there could be some room to argue for women's autonomy and agency within the context of sexual assault by a stranger, women were still not responsible for the offender's actions. This remit also did not work where the victim knew the perpetrator, particularly in intimate relationships. Hence, the need for prevention policies to promote a different understanding of the nature of this crime and social problem (Carmody & Carrington, 2000).

To address the backlash and halt of progress seen from the latter half of the 1990s, Breckenridge and Laing (1999) also recommended a revision of the actions of feminists in the 1970s and 1980s. They promoted the raising of victims' voices again, through acts such as

research and feedback about service provision and their needs; community action, workshops, and groups to encourage input and responses to political comments and policies. In addition, they encouraged workers and professionals in the field to return to the days of dialogue, communication, debate, and advocacy. They asserted that 'such comprehensive dialogue would allow us to develop further creative therapeutic and political responses and would provide a crucial sense of collective action that has been diminished by the attacks of backlash over recent years' (p. 29). These authors argued for the inclusion in this of marginalised groups, e.g., Indigenous women and women with disabilities, 'whose voices are very often absent from mainstream research' (pp. 29-30). Although they stated this 20 years ago, such actions remained necessary in contemporary responses and prevention approaches to sexual abuse and sexual assault. Further, they stated that 'without extending our understanding to incorporate possible difference experienced by individuals we will be unable to tease out the complexity of the issues and our analyses will lack sophistication' (p. 30). They noted that 'qualitative research methodologies … will necessarily assist victims to speak of their experiences publicly and ensure that the development of knowledge occurs from the ground up, rather than being imposed from above by the 'experts' (p. 30).

Essential to prevention, Carmody and Carrington (2000) argued for a 'framework that acknowledges the power of cultural constructions of femininity and masculinity and develop multilevel prevention strategies, which promote an alternative cultural landscape of sexual practices and gender norms' (p. 360).

Contemporary SASs

Egan (2019) described SASs as specialised and professionalised, since they employed trained professional counsellors, with a formal tertiary qualification, prior counselling experience, and specialised NSW Health training in sexual assault counselling. As such, they were subject to

governmental review, evaluation, and monitoring to ensure they met standards of service delivery (NSW Health, 2020). The scope of the services rendered depended on federal and state government funding priorities, service coordination within a state or region, local community needs, and the organisation's purpose. Service-users included:

- Adults who had experienced recent or past sexual assault as adults.
- Adults who had experienced sexual abuse in childhood.
- Children and young people who had experienced or were believed to have experienced sexual abuse.
- Non-offending family members or supporters of those who had experienced sexual assault or abuse.
- Children (under 10 years of age) with problematic sexualised behaviours (NSW Health, 2020).

Service users of SASs did not include adult perpetrators of sexual harm, or young people (aged 10-17 years) who had caused sexual harm. As stated in the most recent policy and procedures, these groups required a specialised service response and, in light of their trauma-specific focus, 'their presence in SASs may compromise the safety of the SAS client group' (NSW Health, 2020, p. 23). NSW Health (2020) offered a range of services:

- 24/7 telephone and online crisis counselling service to anyone affected by sexual violence through the NSW Rape Crisis Centre.
- State-wide specialised training, consultancy, and resource development for NSW Health and interagency workers providing services to children and adults who have experienced sexual assault, domestic or Aboriginal family violence, and physical and emotional abuse and neglect through the Education Centre Against Violence (ECAV). The Centre:

Holds accredited training for mental health [and other health] service providers and sexual assault service providers to encourage cross-sectorial professional development and to reduce the silo approach to managing issues of mental health with experiences of sexual violence. Although located in NSW, the training is open to service providers across Australia (Keel, 2005, p. 19).

- Domestic Violence Routine Screening for women presenting to antenatal and early childhood health services, and women aged 16 years or over presenting to mental health and alcohol and other drugs services to improve identification of, and responses to, victims of domestic violence. This early intervention strategy also played a role in the prevention of domestic violence by providing information to at-risk populations (NSW Health, 2006).

SASs provided to the wider community: professional consultation and training; systems advocacy; and community engagement, development, education, awareness raising, and prevention (NSW Health, 2020). Services provided to adult and child victims of sexual assault and non-offending family members included free crisis and ongoing counselling and court preparation and support (NSW Health, 2020). Counselling services included:

- Safety assessments, immediate and ongoing support, health care needs, and psychosocial services, including crisis and longer-term counselling and other therapeutic interventions, provision of information, casework and client advocacy (including support with Victims Recognition Payments (formerly compensation) applications).
- Medical and forensic services, including examination, follow-up medical treatment for injuries or health concerns related to the assault and collection of forensic evidence from victims.

- Court preparation, court support and reports, including Victim Impact Statements.

Sexual assault counselling

Sexual assault counselling in multidisciplinary SASs was a generalist approach that addressed the multidimensional impacts of sexual assault framed within an ecosystems perspective. It formed part of an integrated post-assault professional multisectoral response comprising medical, forensic, and psychological services. The NSW Health (2020) policy and procedures explicitly referred to sexual assault counselling as a form of practice conceptualised within a socio-ecological framework that combined the structural-feminist and ecological (ecosystems) perspectives:

> [SASs] provide an integrated holistic and multi-disciplinary response to sexual assault informed by socio-ecological, victim-centred and feminist perspectives that acknowledge the social pattern of inequality in which sexual assault is perpetrated, and underpin a social justice framework for practice. This includes consideration of gender, culture, ethnicity, age, sexuality, religion, ability/disability and socio-economic status (p. 38).

It did this still within the feminist discourse of choice and respect for service users, as outlined in the principles of intervention:

> 5. Interventions recognise that abuse of power and loss of control are inherent in sexual assault and so therapeutic interventions must be respectful, supporting the client's control and choice, and building their resilience.
>
> 6. Interventions will: validate the person's experience; be non-judgemental; not make assumptions about what the person needs; offer choices and alternatives; seek informed

> consent; be open, honest and respectful; and be guided by the person, including in addressing their stated priorities (NSW Health, 2020, p. 40).

In her review of NSW SASs, Egan (2019) found individual sexual assault counselling was the dominant intervention. She identified three core feminist counselling techniques: 'techniques that work with the concept of power, techniques that focus on self-blame and techniques that focus on the relationship between the individual and the structures that support sexual assault' (p. 175). She saw this as evidence that sexual assault counselling remained feminist informed. She described the role of the sexual assault worker as:

> An advocate who supports the victim as she comes to her own decision about whether to make a police report, whether to have the forensic medical examination or, further down the track, whether to continue with a court case (Egan, 2019, p. 174).

Egan (2019) noted that most survivors who accessed SASs chose not to make a police report or have a medical examination; some would be in the process of considering this option, while others would have decided not to pursue legal intervention. Some survivors decided while in therapy that they wished to make a police report and seek legal redress. Most who engaged in ongoing counselling had also not had a medical examination or sought hospital-based care following the sexual assault. Draucker (1999) observed that:

> Despite the emotional sequelae of sexual assault, relatively few survivors either seek formal mental health services soon after the assault, return after an initial visit to a mental health professional or complete brief post-rape treatment programs … Research indicates, however, that almost half the women who are sexually assaulted will seek counselling eventually (p. 18).

Counsellors understood survivors' legal rights and options and the processes involved if cases were to make their way to trial. They prepared survivors for court and supported them through the trial. They arranged debriefing sessions after the trial to process the outcome. They provided assistance and support with the development of Victim Impact Statements for those who wanted to do this as part of the sentencing process. They wrote summary reports of therapeutic intervention and outlined the impacts of the sexual violence, for those seeking victim recognition payments.

In the acute phase, counsellors assessed the survivor's safety needs by exploring whether they felt safe returning home, had somewhere else to go to or needed emergency accommodation, required police intervention to assist with safety, and had child protection or mental health concerns. Assessment, at this acute stage, involved determining child protection and mental health needs, mindful of their duty of care, legal obligations, and mandatory reporting responsibilities (Astbury, 2006; Eogan et al., 2013). Counsellors also assessed the survivor's need for ongoing support and counselling, and referral to other services. They explored the survivor's family and community support network in determining the need for informal services. Where necessary, counsellors referred clients to community support services, including allied health agencies offering mental health, drug and alcohol, and family support services, volunteer groups, medical and legal professionals, private counsellors, and rape crisis and women's centres and shelters. Some service users continued with ongoing counselling. This formed the bulk of counsellors' work in SASs. The following case study shows the work of a sexual assault counsellor.

Case study

The following case study describes the ongoing impacts of sexual assault and childhood abuse. It highlights survivors' intermittent engagement with counselling, due to the tendency to commit to, withdraw from, and then recommit to services to meet their complex trauma-related

needs. It demonstrates survivors' persistence with their healing journey, despite occasions where they might receive sub-optimal therapeutic experiences.

Stephanie (not her real name) was a young woman in her early 20s who referred herself to the local SAS. She contacted the service following a recent sighting of the man who had sexually assaulted her two years previously. She presented with issues of hypervigilance, fear, increased anxiety, re-emergence of nightmares, self-harm behaviours, and a decline in her general mental health that was affecting her ability to work and her relationships. A counsellor met with Stephanie to assess her needs and ensure a timely response. In the ensuing three sessions, the counsellor validated Stephanie's feelings, assuring her they were a 'normal' response, triggered by seeing the perpetrator again. She explained this in relation to knowledge on trauma, the brain's response, and strategies to assist in dealing with her symptoms, while exploring her ongoing counselling needs.

During the assessment, Stephanie told the counsellor she had not sought counselling following the sexual assault two years ago. She had reported the assault but had not had a satisfactory experience with the police and had encountered distressing obstacles. She said the police had advised her not to proceed as no one could support her version of events and the timing was not right, as she was pregnant. When she approached them after she had given birth, the police said they could not take the matter further, as there was no new information to go on. The counsellor discussed the reporting and legal process with her and the difficulties she had encountered, suggesting she might want to revisit the matter with the local detective. Stephanie said she did not want to do this, at which point the counsellor highlighted her right to justice but also to self-determination.

Stephanie also mentioned relationship issues with her partner, including nonconsensual sexual intercourse and controlling behaviours, e.g., he discouraged friendships and family contact, always needed to know her whereabouts and how she was spending her money, and

complained that Stephanie was having affairs. The counsellor voiced her concerns about this, named it as domestic abuse, and reminded Stephanie of her reporting obligations. The counsellor informed Stephanie of how the service could currently assist and support, however, there was a waiting list for ongoing counselling. She advised Stephanie that, in the meantime, she might want to consider other options. She could see her GP and request that they place her on a mental health care plan, or she could see a private counsellor through Victims Services or privately if she could afford the fees. Stephanie said she would approach Victims Services. The counsellor provided information on the application process and encouraged Stephanie to recontact the service as needed. Following the session, the counsellor made a child protection report to the NSW Child Protection Helpline, highlighting her concerns about a young child living in a household where there was domestic abuse, in keeping with her mandatory reporting obligations.

Three months later, Stephanie had contacted the police after a sexual assault by her partner. The police had transported her to the local hospital for a forensic sexual assault medical examination. The local SAS (counsellor and forensic examiner) provided support and information about her legal options following the medical examination and had assessed Stephanie's safety needs. Stephanie felt safe enough to return home and decided she would proceed with legal proceedings and receive ongoing counselling support from the local SAS. She told the counsellor she had seen a private counsellor but had not continued with this, as it had not met her expectations. Stephanie was able to meet again with the counsellor, who had conducted the initial assessment, for ongoing counselling. The counsellor was able to provide ongoing counselling at that time, due to Stephanie's experience meeting one of the high priorities of the service, namely, a very recent assault.

At this stage, Stephanie talked about her childhood trauma, which had affected her sense of self, capacity for work, and relationships and interactions, with her family of origin,

friends, and partner. She had dropped charges against her former partner (who was also the father of her child), due to family pressure and the stress this had placed on their co-parenting arrangements. Her family were not supportive and did not believe her partner had sexually assaulted her. They saw her behaviour as dramatic, unnecessary, and unfair on her former partner. Nevertheless, Stephanie continued with counselling and working on achieving her goals. The counsellor affirmed her decisions and validated her experience noting any nonconsensual sexual activity in a relationship constituted sexual assault. The counsellor worked with Stephanie to enhance and reinforce her view of herself and her personal strengths, skills, and abilities. Together they developed strategies to assist Stephanie to monitor and manage her trauma responses, e.g., by practising mindfulness (breathing exercises, visualisation, and meditation) as a self-care strategy. Stephanie found drawing, gardening, and playing with her child helped reduce her distress and anxiety. These strategies formed a secure foundation for EMDR therapy (discussed previously). Stephanie also explored other avenues to strengthen her social connections. She joined a single parents' group, yoga class, and gym. She also explored parenting groups and support services and, in collaboration with the counsellor, engaged with a family support service to help her develop parenting skills and manage the co-parenting. The counsellor referred Stephanie to an advocacy group to support her with the legal (police) process.

Conclusion

This chapter examined the service context. It discussed the feminist origin of SASs and trends in their development, and provided a detailed account of the services offered and the processes followed by sexual assault counsellors, ending with a case study to demonstrate these. This and the preceding chapters provided the context of the study in which to consider its findings and conclusions. The following chapter describes the study's methodology.

CHAPTER 7

Methodology

Everyone has their own path of how they respond and that's something you'd want to look into (Toni)

It might have been a nice experience for us but I'm not sure it's been a nice experience for the clients (C9 talking about male clinicians in the multidisciplinary team)

This chapter describes the methodology used in this study of the experiences of adult female sexual assault survivors and female counsellors working with this client group to establish their perspectives on the employment of male counsellors in NSW SASs. It begins with a description of the literature review methodology before discussing the qualitative, feminist research approach taken. It then describes the study's location, sampling methods, recruitment procedures, and participants. Thereafter, it discusses the process of data collection and analysis, and the ethical considerations in conducting the study. It ends with a discussion of the study's limitations.

Literature review methodology

The criteria used in the literature search were as follows: Peer-reviewed journal articles published in the last 30 years, from 1990-2020. Only seminal articles published outside this period were included (e.g., Bronfenbrenner, 1979). Books were found via NEWCAT – the

University of Newcastle's library catalogue. The researcher continued searching the literature over the course of the thesis, considering and reviewing numerous articles and books. She included journal articles and books that included reference to the issue of sexual violence against women, therapy or counselling with female survivors of male violence, feminism and feminist theory, sexual assault services and their history, and policy concerning, or political responses to, violence against women. Databases searched included CINAHL Complete, Sage Journals Online, Informit Health Collection, EBSCO, ScienceDirect, Master FILE Premier, SocINDEX, Scopus, Index to Legal Periodicals and Books Full Text, Art Full Text, Wiley Online Library, SocINDEX with Full Text, and Google Scholar. Key search terms included feminist philosophy and sexual assault services; sexual assault statistics Australia; sexual assault services; counselling sexual assault; male counsellors; male counsellors and sexual assault services; sexual assault services international; male counsellors and rape; gender preferences for counsel*, and international sexual assault services. These yielded a broad range of literature. Thus, the researcher conducted a more focused search using the terms trauma and women; women and rape; and sexual violence. As discussed in Chapter 1, the terminology for sexual assault varied widely within Australia and internationally. Thus, it was difficult to determine the best descriptor or search term to use. This resulted in further searches for sexual violence, rape, nonconsensual sex, nonconsensual intercourse, and penetration without consent.

The researcher searched the feminist literature using the terms feminist practice, feminism, feminist theory, history of feminism, first-wave feminism, second-wave feminism, third-wave feminism, and the women's movement. Relevant articles and books published before 1999 were included if they provided a sound history of the origins and development of feminism and explanations of the internal conflicts on different thoughts on women's issues.

Where suggested (by supervisors or participants), the researcher sought the work of specific authors, such as Bob Pease and John Briere.

The researcher also examined the reference lists of articles to identify further sources for review. She also reviewed print newspapers, online news, magazine articles, and social media published over the five-year duration of the thesis to identify material relating to issues of sexual abuse, assault, and harassment, and community and political responses to them. These included the #Me Too movement, the reporting of legal matters, particularly in relation to high-profile defendants, and the Royal Commission into Institutional Responses to Child Sexual Abuse in Australia.

The researcher excluded articles exclusively discussing theoretical approaches and counselling interventions related to children and sexual violence, women and domestic violence, and male victims of sexual assault or sexual abuse. The reason for this was the study's focus on adult women survivors of sexual assault and sexual abuse. While the domestic violence and sexual assault literature contained similar feminist analyses of male power and privilege underlying these crimes of violence and the societal ideas and norms that sustained them, there were also important differences. For example, sexual assault might not necessarily occur within a controlling and abusive relationship, while sexual abuse might include acts of violence in childhood involving the betrayal and abuse of trust of adults or people in authority that should protect, not harm, children. Thus, the researcher included books that explored and discussed issues of adult sexual abuse and assault, as well as domestic and family violence. Over the course of the thesis, there was increased community awareness and academic understanding of violence against women in Australia and internationally. This led to the enhanced understanding that sexual violence might be part of domestic abuse and, indeed, sexual violence against a woman in an intimate relationship might be an indicator of the increasing severity of the violence perpetrated against her (NSW Health, 2020).

The research excluded material focused solely on immediate care and health needs following a sexual assault, such as the conduct of acute health, and medical, forensic, and therapeutic assessments. This was because the study's focus was not immediate or crisis medical or therapeutic needs following a sexual assault, but rather the short- and long-term counselling and support received in the aftermath of sexual assault or sexual abuse. However, such content was included where it gave a clear description of procedures or allowed for understanding of the holistic SAS response to sexual assault survivors (discussed in Chapters 3 and 5).

The area of sexual violence against women is a very well researched area. For example, a search for peer-reviewed published articles and books between 1990 and 2019 with the search term 'sexual violence against women' located over 442,000 articles. A similar search for the term 'sexual assault counselling with women' located 14,958 books and journals. Given this extensive literature, the researcher favoured journal articles, because they were easier to access, download, and print from the library system. In contrast, she requested books through the university library network only if the content was directly relevant to the study (e.g., Thompson & Armato, 2012). Despite the extensive literature, it was difficult to find articles specifically on:

- Counselling services for adult women survivors of sexual abuse and sexual assault and their modes of operation.
- The views or experiences of adult women consulting male counsellors in sexual assault or related therapeutic fields.
- International literature for comparison of adult women in other countries consulting male counsellors in private or government services, where the focus was sexual assault or sexual abuse.

The literature review for Chapters 4-6 on policy and services, involved a similar process as that described above. It produced a substantial literature on services and Australian policies. Further, the researcher was able to use books already in her possession that provided a history of the development of Australian policy in this field, e.g., *Sisters in Suits* (Sawer, 1990) and *Challenging Silence* (Breckenridge & Laing, 1999).

The researcher also searched Australian federal and state government and international policy, such as the *Family Law Act 1975* (Cth) and WHO (2002) and literature discussing Australian and international policy and services. She followed up on relevant programs and inquiries mentioned in the articles by searching for these, e.g., Inquiry into Human Relationships (1977a), Workplace Gender Equality Agency (WGEA), and 2019 Family Law review.

As part of the researcher's employment as a sexual assault counsellor, articles, documents, reviews, and grey literature came to her attention. She included material received during the course of the study, such as the NSW Health Policy and Procedures (2020), Integrated Prevention and Response to Violence, Abuse and Neglect Framework (2019), Practice Guidelines for Clinical Treatment for Complex Clients (2019), Royal Commission into Institutional Responses to Child Sexual Assault, and review of consent in sexual assault legislation.

She purchased books exploring sexual assault and feminism, including *The F Generation* (Trioli, 1996, 2019), *See What You Made Me Do?* (Hill, 2019), *Women, Men and the Whole Damned Thing* (Leser, 2019), and *This is what a Feminist Looks Like* (Maguire, 2019). Finally, she sought articles or authors her supervisors recommended, such as Brown, Ullman, and Egan.

In addition, she conducted a search of Wiley, EBSCO, and CINAHL using the terms 'vicarious trauma', 'vicarious trauma in sexual assault work', 'vicarious trauma in sexual

assault counselling', and 'risk of vicarious trauma' and located over 21,000 matches. She then searched for articles published in the last 10 years that provided a sound explanation of vicarious trauma. Finally, she included pioneers in their field discussed in related sources, such as McCann and Pearlman (1990).

Theoretical framework, research approach, and methods

Hesse-Biber (2012) explained the difference between epistemology (theoretical framework), methodology (research approach), and method. An *epistemology* is a theory of knowledge that delineates a set of assumptions about how we come to know the world and ourselves. Different epistemologies had different sets of assumptions about the social world that influenced a researcher's decision about what to study and how to conduct a study. A *methodology* describes how the researcher conducted the research, the process he or she followed, informed by the guiding epistemology. It included explanations and justifications for the approach the researcher chose to take and the *methods* the researcher chose to use to collect and analyse the data. Social science methodologies generally had a strong concern with reflexivity, research relationships, 'the protection of the researched … [and an emphasis] on the consideration of power within research relationships, and on the potential for researchers to harm participants' (Sampson et al., 2008, p. 921). However, the feminist agenda has largely 'driven a concern for participants, for power relations, and for an examination of subjectivities in research practice. In doing this, feminists have influenced modern research techniques considerably and have had a particularly strong influence on qualitative research approaches' (Sampson et al., 2008, pp. 921-922). Given the nature and context of the study, the researcher chose a qualitative, narrative-based, phenomenological feminist research approach in keeping with a 'feminist standpoint epistemology' (Allen, 2011, p. 25). A feminist standpoint valued women's experience, needs, interests, and ideas about the social world.

Feminist research brought a uniquely feminist understanding of violence against women to the research process. Langan and Morton (2009) explained that 'a critical feminist theory of violence against women understands violence to be one facet of women's subordination in a patriarchal society that endorses men's power and control of women' (p. 166). It viewed women as victims of violence arising from dangerous situations that put their safety in jeopardy continually, even if they were able to leave an abusive partner. The motives, concerns, and knowledge feminists brought to the research process characterised uniquely feminist research.

Qualitative, feminist approach

Campbell and Wasco (2005) noted that sexual assault research had often been quantitative in nature. Although this had been useful in analysing and making sense of this complex problem, qualitative research enabled deep exploration into areas often not covered in quantitative studies. It sought to answer how-and-why process questions and often drew on the diverse insights and expertise of researchers, academics, counsellors, advocates, *and service users*. Brown et al. (2013) noted the compatibility of feminist epistemology with qualitative methodologies, including narrative and phenomenological approaches. Many feminists had adopted the postmodern and many ways of knowing assertion that there were 'multiple pathways to scientific knowledge and multiple perceptions of what is '"true"' (Beckman, 2014, p. 165). Thus, women's perspectives represented one truth, among many, but one that research had often neglected (Alston & Bowles, 1998; Sampson et al., 2013). As Bierema (2002) explained, feminist researchers premised their research on the assumption that 'the knowledge of women is marginalized, devalued, and invisible in large part because women have been traditionally excluded from the knowledge creation process' (pp. 448-449). Gates (2019) noted there would never be an all-encompassing system, so there would 'never be a substitute for

hearing women's stories. But we have to keep working to get better data so we can understand the lives of the people we serve' (p. 77).

Beckman (2014) saw feminist research as distinguishable by its methodology, noting 'what makes research feminist is the application of feminist principles' (p. 165). Kirsch (1999) added that:

> Many feminist principles of research overlap, to some extent, principles central to new ethnographic, critical, and hermeneutic approaches to research … What distinguishes feminist research from other traditions of inquiry, then, is its deliberate focus on gender combined with an emphasis on emancipatory goals (pp. 6-7).

However, there were multiple feminisms and no 'single feminist epistemology or methodology. Instead, multiple feminist lenses wake us up to layers of sexist, racist, homophobic, and colonialist points of view' (Hesse-Biber, 2012, p. 4). Generally, however, feminist epistemologies argued that:

- Knowledge was incomplete, situated in time and place, and embodied by social and cultural constructions. The idea of situated or embedded knowledge implied that the sociocultural context shaped the knower's perspective and understanding with knowledge viewed as a social construction.
- Identified the way in which dominant ways of knowing might disadvantage women and other oppressed groups to bring that knowledge to the surface, challenge power constructions, reshape understandings and practices, and improve the situation for the oppressed group.
- Contended that gender affected understanding, informed approaches to the central issue under study, influenced the social and political roles of people in the study,

> and affected the values underpinning the inquiry and understanding of objectivity, consistency, and authority (Kralik & van Loon, 2008).

Feminist epistemology acknowledged 'the incredible diversity of individual people's lives and personal experience necessitate the need for multiple and flexible approaches to research' (Kralik & van Loon, 2008, p. 36). In this study, the researcher explored female counsellors' views and experiences to add to anecdotal information on the consultation experience of women service users with male counsellors. In addition, she sought female counsellors' views on the relevance and currency of feminism in NSW SASs, particularly whether male counsellors would undermine this. She sought to hear the women's narratives to provide an understanding of their experience, as they understood them. Feminist methodology gave women the space to voice their realities from their experience (Andrews, 2002). Hence, 'the narrative interview is constructed as a natural communication process which encourages the interviewee to tell her story, and the interviewer to listen without interrupting or distracting her' (Allen, 2011, p. 31). As Beckman (2014) noted, by listening to women's voices, the researcher uncovered 'an alternative and richer knowledge' (p. 167), based on direct experience. These experiential insights countered the 'inheritance of living under the male gaze' and tendency of heterosexual women to 'look at other women the way a man would' (Taddeo, 2019, p. 2). This meant:

> Existing research on responding to male-to-female sexual assault does support the notion that people can interpret events in a way that shows bias toward the perspective of the ingroup male perpetrator and that this can have negative implications for their attitudes and behaviors toward female victims (Bongiorno et al., 2020, p. 14).

Feminist research sought to change this dominant narrative by telling the stories of women directly affected by sexual assault.

Secondly, the researcher sought to develop a non-exploitative, collaborative research relationship by equalising the power between the 'researcher and researched … a central concern for feminist researchers' (Sampson et al., 2013, p. 927). As Beckman (2014) explained, 'the idea of giving "voice" to women participants implies that the participants are active collaborators rather than passive "subjects"' (p. 169). Aware of the power inherent in her role as researcher, the researcher gave special attention to power issues in the process of gathering and analysing data, reporting on the outcomes, and distributing the findings and recommendations of the study. The researcher sought to minimise power imbalances through collaborative, respectful, and empathic engagement that encouraged a sense of empowerment for the service-user participants and female counsellors.

Thirdly, feminist research was relational in that it used methods, like in-depth interviews and focus group discussions, involving an interactive process: It was based 'on the premise that the relationships between knower and what is to be known are subjective and interactive' (Messias & DeJoseph, 2004, p. 45). Like the relationships social workers strove to develop with their clients, feminist methodologies saw researcher-respondent encounters taking place within 'interpersonal and reciprocal relationships' (Messias & DeJoseph, 2004, p. 42). Thus, feminist researchers acknowledged the intersubjective nature of the data generated and recognised that:

> Our values, as well as those of the women we interviewed, inevitably influence the inquiry. Therefore, the resultant knowledge … is mediated by and inextricably intertwined with the interactions between and among the investigators and the women who participate in the study (Messias & DeJoseph, 2004, p. 45).

It shared 'with other qualitative and interpretative research the assumption of intersubjectivity between researcher and participant and the mutual creation of data' (Messias & DeJoseph, 2004, p. 45).

Fourthly, feminist research incorporated reflexivity at its core. Finlay and Gough (2003) defined reflexivity as 'thoughtful self aware analysis of the intersubjective dynamics between researcher and the researched' (p. ix). As Beckman (2014) explained, it referred to process where researchers used self-reflection on 'themselves and their reactions to others to uncover different types of knowledge' (p. 169). She continued: 'Through critical self-reflection about one's own thoughts, feelings, values, biases, experiences, and theoretical models, the researcher can reveal hidden privilege, identify power differentials that limit participant involvement, illuminate ethical concerns, heighten understanding and create more egalitarian relationships' (Beckman, 2014, p. 169). Thus, reflexivity involved examining the impact of the researcher's position, perspective, and presence on the research process; promoting rich insight by reflecting on personal responses and interpersonal dynamics; uncovering unconscious motivations and implicit biases in the researcher's approach; empowering others by opening up a more radical consciousness; and evaluating the research process, method, and outcomes (Finlay, 2003; Hesse-Bieber, 2012). Brown et al. (2013) believed that 'this reflexive stance in combination with everyday experience, women's subjective and shared knowledge, and the presence and influence of emotion, results in rich and diverse research processes and outcomes' (p. 144).

In keeping with these feminist research principles, this qualitative approach to exploring these women's subjective views of their experiences sought to:

- Capture women's experience of consulting with male counsellors regarding sexual assault or sexual abuse.
- Empower women by equalising power relations between the researcher and research participants and privileging women's experiences and perspectives.
- Improve women's lives through action and advocacy aimed at service improvement and policy change contingent on the study's findings.

Capture women's experience

The feminist framework promoted a sensitive approach to capturing women's experiences, grounded in an acute awareness of the impact of sexual violence on their lives and, therefore, of the sensitivities surrounding their participation in the study. This unique approach in capturing women's experience used in feminist research arises from its feminist epistemology. The narrative-based feminist methodology used in this study sought to capture, document, analyse, and disseminate women's *stories* (Carter & Little, 2007; Woodiwiss et al., 2017). Feminist researchers sought to hear women's voices cognisant that, in the past, research had excluded women from conversations on issues concerning them (Alston & Bowles, 1998; Breckenridge & Laing, 1999; Carmody, 1997). Sampson et al. (2013) noted, 'the notion of "giving voice" to the "voiceless" … strongly drives the feminist research agenda and has impacted more generally on the motivation of many researchers undertaking qualitative studies' (p. 922) from a woman's subjective perspective. Thus, this study explored the:

1. Views of a group of women service users to hear their voices on their experiences of male counsellors. The researcher explored their experiences of, and reflections on, therapy, especially the development of rapport, trust, and safety within the counselling relationship; the impact of the counsellor's gender on this counselling relationship; and the negatives and positives of this experience for them. In reflecting on elements of counselling practice, the researcher invited female service users to consider its feminist aspects, including feminist principles of listening and feeling heard, respected, and safe and having a sense of control over the situation and process, i.e., feeling a sense of 'power with' the counsellor rather than a sense of the counsellor having 'power over' her.

2. Female counsellors' views on the inclusion of male counsellors in SASs and their thoughts on whether these services still embraced feminist philosophy and practice.

The study was phenomenological in the sense that it aimed to understand the participants' subjective experiences and the meanings they attributed to them (Hesse-Biber, 2012; Hoover & Morrow, 2015). As Deutsch (2004) explained, 'the importance of individual experience to feminist researchers comes out of the interpretivist paradigm, grounding research in the everyday lives of women' (p. 890). Feminist phenomenological research used methods of data collection that yielded rich and thick descriptions and stories and their unique meaning for female participants, mindful of the 'multiple, subjective and partial truths' (O'Leary, 2004, p. 127) that existed in individual and collective experiences and recollections (Silverman, 2010). It acknowledged differences and sought to capture the diversity of women's perspectives and experiences (O'Leary, 2004). It also sought to stay true to respondents' accounts of events and experiences. Therefore, feminist researchers preserved women's voices by staying true to their narratives and 'the saliency of women's own words' (Messias & DeJoseph, 2004, p. 47) in generating codes and categories for data analysis and reporting on findings. In this way, in building knowledge, feminist researchers conveyed an understanding of the meanings women attributed to their experiences and the wisdom they had gained through them (Hesse-Biber, 2012).

Empower women

Feminist research sought to empower women by providing them an opportunity to express their views and have their voices heard (Beckman, 2014; O'Leary, 2004; Wadsworth, 2001). As Gates (2019) observed, most of the time, the women feminist researchers interviewed were eager to answer their questions. There was something 'empowering about being asked. It sends

a message that your life matters' (p. 75). By using interview and focus group methods of data collection, with an open-ended, semi-structured format, the study encouraged freedom of expression within a safe trusting researcher-respondent relationship, as already discussed (Hoover & Morrow, 2015). Flexibility and safety were key to respondents feeling comfortable and in control of what they chose to share. Though the researcher asked predetermined questions following a semi-structured interview or focus-group guide, a conversational, dialogical interchange encouraged the participant to volunteer other interesting information. O'Leary (2004) noted that in this 'flexible structure, interviews can start with a defined questioning plan, but will shift in order to follow the natural flow of conversation … [and] may also deviate from the plan to pursue interesting tangents' (p. 195). Further, the approach should be 'flexible enough to allow you to explore tangents, structured enough to generate standardized, quantifiable data' (O'Leary, 2004, p. 196). The advantage of this data-collection method was that, not only would the researcher gain the data she was seeking, but also other interesting information along with it (O'Leary, 2004).

A feminist approach also sought to remain aware of, and, where possible, minimise, potential power imbalances, undue privileges, and respondent exploitation in undertaking research (Beckman, 2014; O'Leary, 2004; Wadsworth, 2001). As Beckman (2014) explained:

> Feminist researchers recognize that power and privilege are part of the social structure of our society, social institutions and policies, and recognize the need to impact these social structures and policies in order to secure equality on the individual level (p. 166).

This was part of feminist epistemology. To achieve equality in the research relationship, feminist researchers ensured women had a choice in how, when, and where they told their story (Hoover & Morrow, 2015). Further, they sought to:

> Empower participants through techniques such as having them read and comment on the researchers' interpretation of their information, enlisting them as co-researchers or co-analysts in interpretation of data, and explicitly recognizing them as experts and partners in the research endeavor (Beckman, 2014, pp. 169-170).

Improve women's lives

The primary goal of feminist qualitative research was to gain 'knowledge explicitly dedicated to bringing about change and improvement in our situation as women' (Wadsworth, 2001, p. 2), through deepened understanding of issues that affect us. Hesse-Biber (2012) emphasised that feminists undertook research 'often with the intent to change the basic structures of oppression' (p 4). Hence, activism and advocacy were core to feminist research (Beckman, 2014) as feminist researchers used research findings to improve women's lives through, for example, better services or improved policies or both. As Beckman (2014) explained, 'the involvement of research participants as collaborators and co-researchers may increase their knowledge, competencies and feelings of empowerment, leading to increased motivation, resilience, advocacy and social action' (p. 170). Further, Brown et al. (2013) noted that feminist research might 'bring about change for women in the ways they understand in their everyday lives' (p. 441), especially if they 'come away from the research process feeling educated, encouraged, and inspired to take action' (p. 441).

Ethical considerations

The researcher placed the following ethical considerations within a feminist framework. As Hesse-Biber (2012) explained:

> A feminist ethical perspective provides insights into how ethical issues enter into the selection of a research problem, how one conducts research, the design of one's study,

> one's sampling procedure, and the responsibility toward research participants. Feminist ethical issues also come into play in deciding what research findings get published (p. 17).

Hence, the overarching premise of hearing, recording, and sharing women's voices in a safe, collaborative, as equal as possible, and respectful manner influenced the ethical considerations described below.

Positionality

Davies and Dodd (2002) suggested that meeting ethical practice in qualitative research involved acknowledging and locating 'the researcher in the research process' (p. 281). Feminist researchers highlighted the importance of context, including the researcher's standpoint, positionality, and the way they shaped and influenced the choice of research questions, methods, and processes (Brayton, n.d.; Carmody, 1997). Thus it was necessary to reflect on, and make explicit, the manner in which the researcher's positionality determined the decisions taken in the research enterprise, as 'the process of documenting, analysing and (re)presenting the lives of others involves acknowledging our own social location as researchers and how this affects the kind of knowledge we produce' (DeShong, 2013, p. 3). The researcher's knowledge that women's voices in the past had not been equal to those of men (Alston & Bowles, 1998; Hesse-Biber, 2012) resulted in the research emphasis on the participants' words in the data collected and how this was carried through in reporting on the findings. Because she understood sexual assault and abuse, she assumed a position of supportive inquiry and created a nonjudgmental space for the free expression of participants' experiences. In addition, the researcher's understanding of the complexities faced by counsellors in their roles (with requests by management that were, at times, difficult to meet in a busy and high demand field) allowed a conversation to flow unhindered by prompted explanations or rationales. Such positioning

was apt within the qualitative feminist approach used, where 'the researcher should acknowledge their own values, biases and position in relation to the researched' (Alston & Bowles, 1998, p. 10). Further, Hesse-Biber (2012) emphasised that such reflection and acknowledgement of the researcher's own values and biases, and possible influence therefore on the research process, promoted more objective study outcomes. Hesse-Biber (2012) stated that 'to practice strong objectivity requires all researchers to self-reflect on what values, attitudes, and agenda they bring to the research process' (p. 10). The researcher acknowledged that her 'values, biases and position' might have influenced the way in which she questioned the participants and their interpretation of, and responses to, her questions. In addition, the researcher remained aware of this within the data analysis process and subsequent discussion and recommendations.

Safety issues

Hjort Nielsen et al. (2016) argued that 'one of the main reasons for doing research on sexual assault is to shed light on issues that might lead to changes and improvements for survivors of sexual crimes' (p. 412). They continued: 'Researchers must be aware of the fact that research participation may affect some individuals negatively and it is recommended that researchers ensure that mental health services and support networks are readily available to victims who choose to participate in research' (p. 416). Thus, the researcher discussed the availability and accessibility of support services and networks prior to the commencement and at the end of the interviews to minimise risk of harm, as outlined below. However, research showed that most participants in studies of sexual assault were not retraumatised by the process: 'Only a minority of participants become distressed immediately after participation in trauma-focused research, and there is currently no solid evidence to suggest long-term adverse impact on research participants' (Hjort Nielsen et al., 2016, p. 412). These studies also showed that most participants had had a positive experience, with Campbell et al. (2010, in Hjort Nielsen et al.,

2016) claiming this was true for most interview research where 'benefit ratings are substantially higher' (p. 416). To the best of the researcher's knowledge, this was also true for the participants in this study.

Minimising risk

Due to the sensitive nature of the subject of the interviews, the researcher was mindful that female counsellors could become defensive about their positions on, and beliefs about, male counsellors in SASs, especially if there were different or conflicting points of view. She was also aware that service users could become distressed through the interview process, should troubling memories and disturbing thoughts surface. Anticipating this, the researcher discussed supports and resources at the beginning of the interview. At the end of each interview, she checked in and assessed the status of the service-users' level of stability, and reconfirmed the supports available to them, as needed. Further, mindful of her duty of care, she monitored the interviews carefully, observing body language to determine participants' level of comfort with the material they were discussing. She attempted to minimise and address anxiety about sensitive questions, as it arose, and used humour and friendly engagement to enhance rapport with the participants. She paid particular attention to language, avoiding judgemental responses and respecting participants' views. She emphasised the value of the participants' involvement as a way of being heard, respected, empowered, and acknowledged as experts of their own experiences. She reiterated that participation was voluntary, and participants could cease their involvement at any time without undue consequences.

The researcher engaged in a collaborative manner with service users and counsellors, with relationship building a focus of the research interaction, in keeping with her expressed aim of collecting important and valued perspectives to assist with promoting effective and optimum service delivery. She explained the aim of the research and its potential benefit to service delivery and management. Therefore, she emphasised that participants (service users

and counsellors) were assisting in the development of appropriate services that were responsive to service-user needs.

The researcher discussed possible risks in supervision and planning sessions. Had any harm come to participants, the researcher would have reported this to her supervisors immediately. She emphasised her legal obligations and duty of care for the participants' safety in the Information Statement and Consent Form, noting the Child Protection Helpline in relation to concerns about children's safety or wellbeing, and consideration of services that could provide mental health assistance if required. At the outset, the researcher acknowledged that service users might become distressed, due to the nature of the topic, and discussed supports and resources at the beginning and end of the interviews. At the end of each interview, the researcher checked in and assessed the status of service-user's level of stability, and reconfirmed supports available to them as needed. However, this need did not eventuate. The researcher also assured the female counsellors and service-user participants that she would maintain confidentiality and had no bias for any particular results or outcomes. To obviate possible risks for counsellors, the researcher conducted the focus groups and interviews in a planned and consistent manner. Resultantly, the research participants did not experience any untoward consequences from the study.

Reducing power imbalances

As already discussed, a feminist perspective highlights the relationship between individual and structural inequalities and feminist services seek organisational practices and policies that promote social justice, challenge oppression, and improve the wellbeing of women in society. As Wall (2014) highlighted: 'At the service provision level, recognising and acknowledging the impacts that entrenched inequality based on gender and other intersecting disadvantage have is important in order to move forward' (p. 13). Therefore, a central question surrounding the employment of male counsellors in sexual assault services relates to whether this would

lead to improvements for women, especially given sexual assault is a gendered crime of violence, perpetrated mainly by men, who abuse their power (Theobald, 2011).

The issue of power and the abuse of power was a strong and crucial element in the crime of sexual violence against women. Disrespect and disregard of others' humanity and a sense of entitlement and privilege was also evident. With these understandings in mind, it was extremely important that the researcher did not model or condone such attitudes or practices.

The principle of equalising power relations between the researcher and research participants was an important principle of feminist research (Hesse-Biber, 2012). Thus, feminist researchers used a collaborative approach, viewed interviews as conversational dialogues, and research participants as experts of their own experience. They endeavoured to stay as closely as possible to the women's accounts of their experience, ensuring accuracy in data collection and analysis.

The researcher used techniques that minimised the distance between herself and her participants, such as ensuring they were comfortable with the interview process, they felt safe talking to the researcher, and felt free to ask questions about the research. The participants asked questions about the reasons for the study, its aims, and duration. They also asked the researcher about her role in sexual assault counselling. By listening to their stories and being sensitive and respectful, the researcher sought to equalise the research relationship in keeping with feminist research principles.

Confidentiality and informed consent

The interviews and focus groups only proceeded once participants had signed the consent forms (or provided consent verbally for the telephone interview). At the beginning of the interview, the researcher assured participants she would maintain confidentiality, thus reiterating the Information Statement. She also ensured that they understood the purpose of the research and knew what to expect from the interview process. The researcher discussed issues of consent

with each participant to ensure they understood what they were agreeing to. She was clear, at the outset, that the research was separate from the counselling services, especially where counsellors had recruited service users. Thus, they would not experience any undue consequences to the services they received and, as per the Information Statement, the counsellors would not know who had agreed to participate in the research, unless the service user chose to reveal this information or gave their permission for such disclosure. This occurred in one case, where a counsellor had facilitated a meeting between the researcher and a service user they had introduced to the study. The researcher also reminded the counsellors about the confidentiality of their involvement in the research and urged those who participated in the focus groups together to be respectful of one another and value one another's viewpoints and experiences and protect group confidentiality, as per the discussions around consent and safety developed at the start of the focus groups. Finally, the researcher preserved confidentiality by using pseudonyms in coding and reporting on the findings. The transcripts were stored on a password-protected computer and the USB stick was stored in a secure filing cabinet, along with other confidential information pertaining to the research.

Ethics approval

The ethics process with HNE LHD for approval to access multiple Health sites across NSW and the UON occurred simultaneously. Following its review of the ethics application, the HNE HREC requested fuller details on how the researcher would respond to participant distress should this eventuate during the course of the interviews. It raised questions about how the researcher aimed to address participants' cultural safety needs in the interview process, particularly those of Aboriginal women. It also raised concerns about potential participant coercion given the researcher's employment in a SAS and sought further information on how she would manage the participant recruitment process. Following the researcher's satisfactory

response to these issues, the committee provided ethics approval in May 2017 (as shown in Appendix II). Three months later, the researcher submitted an application for variation to the approval once it became apparent that the approval documentation did not include all the relevant sites she wished to approach. The committee approved the variation in August 2017 (as shown in Appendix IV).

The UON Research Integrity Unit registered the ethics application and noted the external HNE HREC's approval H-2017-0172 for the study in June 2017 (as shown in Appendix III). However, once the researcher realised that the HNE HREC approval only covered Health sites for service-user recruitment, she lodged an additional UON ethics application to seek approval to recruit service users from non-Health sites. In its response to this application, the UON HREC raised concerns about service-user confidentiality and privacy, informed consent, and participation for women from non-English speaking backgrounds with language issues or those with an intellectual disability. Satisfied that the researcher had addressed these concerns, the UON HREC approved the application to recruit service users from non-Health sites in December 2018 (as shown in Appendix V).

Location of the study

The researcher conducted focus groups and interviews with female counsellors of SASs in NSW across regional and rural Local Health Districts (LHDs). Her aim was to contact SASs in different parts of NSW to ascertain whether perspectives and experiences varied across rural, regional, and urban parts of the state. However, only SASs in regional and rural LHDs (n=45 SASs) agreed to participate in the study. The female service users interviewed worked in regional areas, with only one based in a rural location.

Sampling methods

As an experienced sexual assault counsellor and long-time employee of NSW Health, the researcher had 'a good understanding of the most appropriate way of drawing a sample' (p. Gibbs et al., 2007, p. 543) for this study. Rubin and Babbie (2009) noted that purposive, non-probability sampling involved the selection of a sample 'the researcher believes will yield the most comprehensive understanding of the subject of study, based on the researcher's intuitive feel for the subject that comes from extended observation and reflection' (p. 627). In non-random sampling of this nature, factors other than chance determined sample selection, such as convenience, prior experience, or the judgement of the researcher. Thus, the researcher *purposively* selected two respondent samples based on her knowledge of the field of study using the following selection criteria:

1. Female sexual assault counsellors employed in SASs.
2. Female service users, aged 18 years and over, who had experienced sexual assault or abuse at any time in their life and had consulted a male counsellor or therapist about the sexual assault or abuse.

There were 54 SASs (shown in Appendix I) in 15 LHDs. As shown in Figure 7.1, there seven rural and regional LHDs: Far West, Hunter New England (HNE), Mid North Coast, Murrumbidgee, Northern NSW, Western NSW, and Southern NSW, where 45 SASs were located (NSW Health, 2017). There were eight LHDs in the Sydney metropolitan region, where nine SASs were located: Central Coast, Illawarra Shoalhaven, Nepean Blue Mountains, Northern Sydney, South Eastern Sydney, South Western Sydney, Western Sydney, and Sydney (NSW Health, 2017), shown in Figure 7.2.

Figure 7.1: NSW LHDs

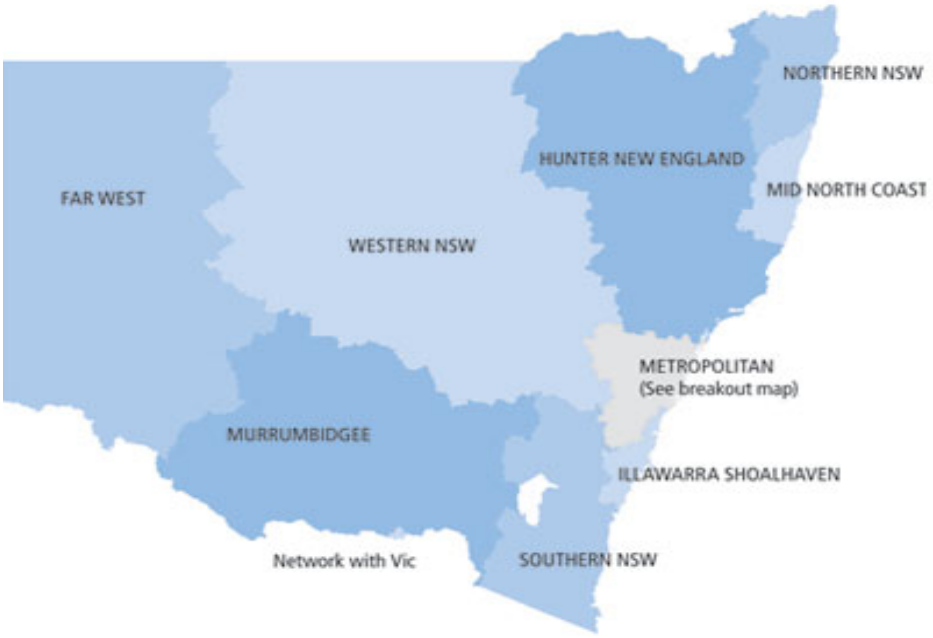
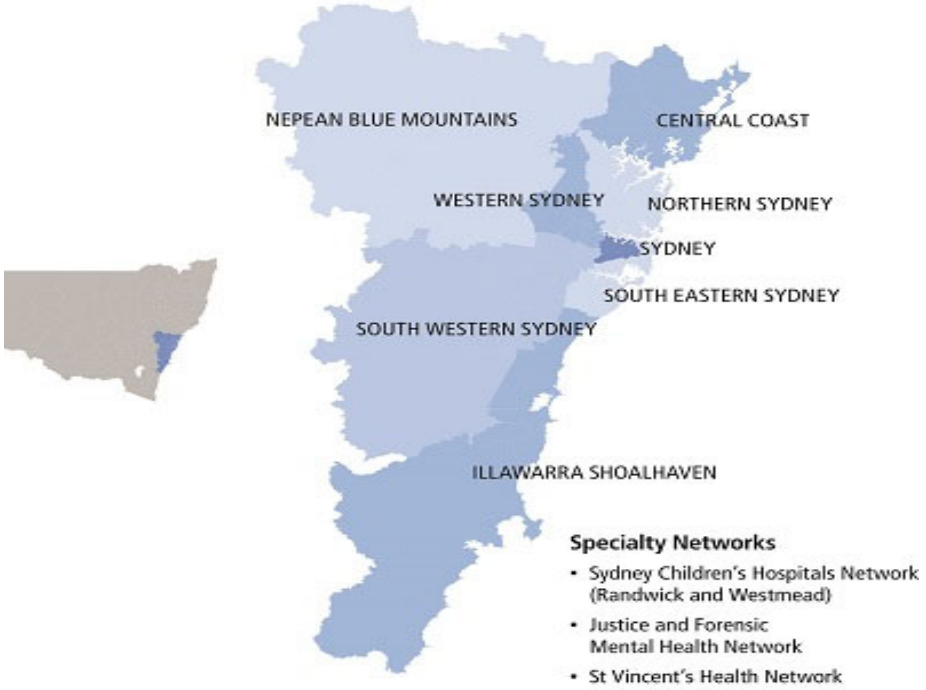


Figure 7.2: NSW metropolitan LHDs



Source: NSW Health (2017)

The researcher selected SASs throughout the state hoping to recruit female counsellors from metropolitan, regional, and rural regions. Thus, she selected SASs in four metropolitan LHDs (Sydney, Western Sydney, Illawarra Shoalhaven, and Central Coast), four regional LHDs (Port Macquarie in the mid-North Coast LHD and Newcastle, Taree, and Lower Hunter in the HNE LHD), and two rural LHDs (Western NSW LHD and the Upper Hunter in the HNE LHD) for inclusion in the study, due to their accessibility. Most of the services to which she successfully gained access were in rural and regional areas, as no metropolitan services completed the Single Site Access (SSA) process.

The researcher also used non-probability purposive sampling to recruit service users through Health SASs that had agreed to participate and SAS counsellors informing eligible female service users. As well as this, she used *snowball sampling* through male counsellors in the private sphere. The purposive snowball sampling method involved identified sources or recruited participants that could direct the researcher to others who were knowledgeable about the topic (Bryman, 2016; Marlow, 2011). One of her research supervisors recommended that she contact three male counsellors in private practice, who she knew consulted sexual assault survivors and could inform them about the study. The researcher then contacted the male counsellors to confirm their willingness to assist in informing their clients, who had consulted them on a sexual assault experience, about the study and she provided them with flyers (shown in Appendix XI) to place in their consultation rooms. Two agreed to assist and the researcher recruited one service user through this process. She could not contact the third.

Finally, the researcher used *self-selection* through flyers posted around the University of Newcastle (UON) Callaghan campus, as discussed below. Through these various methods, the researcher recruited 10 service-user participants in all. A female counsellor informed one service user about the study; a male counsellor informed another; one was both a counsellor and service user; and seven responded to the flyers on the UON Callaghan Campus.

Gaining access to, and recruitment of, participants

Gaining access to research sites

Following approval from the HNE Human Research Ethics Committee (HREC) obtained in May and August 2017 (shown in Appendices II and IV respectively), the researcher approached SASs in each selected LHD. She completed SSA forms for 10 SASs, as already discussed. Then, as required, she gained further approval to conduct the study at each location from the corresponding head of department, who needed to authorise on-site access. The researcher also contacted the coordinators of the SASs, because they were on-site with the team, to initiate completion and approval of the SSA forms. These had to go through the Research Governance Officer (RGO). At times, this meant acquiring several signatures for a LHD with multiple SASs. Identifying the delegated person to sign the forms proved difficult, especially when the RGO of the LHD failed to identify the correct contact person. Thus, on occasion, it took several attempts to locate the appropriate person. This process was challenging and time consuming, due to diverse LHD service requirements and a lack of understanding of the approval processes and systems at many sites. The researcher persevered, despite these obstacles and challenges, at times seeking the support and assistance of the RGO to liaise with the heads of department and explain the research process and requirements. This confusion and lack of understanding led to hesitation, or even reluctance, to participate from some sites and, in some instances, the approval process took six months. Ultimately, it took almost a year of the study to obtain SSA approval to proceed in 10 SASs and the counsellors, who agreed to participate, came from eight of these.

The researcher decided to discontinue the SSA form process for one LHD, as it was cumbersome, onerous, and unreasonable, with the service requiring that she become an employee and complete the workplace orientation and health checks. No other LHD had

expected this though each had its own processes and requirements, with some time consuming and costly; for example, one LHD required payment to the RGO prior to approval and, subsequent to this, the SAS team did not participate in the study.

Three SASs in separate LHDs failed to respond to subsequent emails and phone calls, despite interest expressed in the initial discussions; two of these had (currently or in the past) male counsellors connected to their sexual assault and violence prevention services. While the study was voluntary, none provided an explanation for not proceeding. The researcher believed that some teams with a male counsellor connected to the service might have been uncomfortable with participating, because the female counsellors might have felt this would compromise their loyalty to the male counsellor or thought they could not share their views and experiences truthfully in the circumstances. These difficulties might have affected access to some teams and limited the study's access to potentially valuable data.

Recruiting the female counsellors

The researcher contacted the SASs via phone or email and provided the coordinators and or heads of department with documentation on the research, including ethics approval and information statements, consent forms, and flyer (shown in Appendices II, VIII, IX, and X respectively). Once the researcher had received initial approval from the head of department, she then sought final approval from the CEO, via the RGO for each LHD. Upon receipt of CEO approval, on some occasions, the head of department facilitated access to the female counsellors or coordinators in their region; at other times, the researcher approached them independently. She asked her contacts in each of the services to which she had gained access to disseminate information about the research to their teams and ascertain their willingness to participate in focus groups. She then recontacted them to determine whether any had agreed to participate and, if so, to arrange a time and place for the focus group. For some services, especially those in remote LHDs, where there were sole counsellors, the researcher conducted

interviews with them. In one instance, due to the vast distance, the researcher interviewed the female counsellor via messenger. She conducted face-to-face interviews and focus group discussions with all the other participants.

Recruiting the female service users

The researcher sought to recruit female service users, aged 18 years and over, who had experienced 'an unwanted sexual experience or … been sexually assaulted or raped' (Hoover & Morrow, 2015, p. 1478), and had consulted a male counsellor or therapist about the sexual assault or abuse. The researcher used several methods to recruit the female services users. The first involved SAS counsellors identifying eligible participants, informing them about the study, and providing them with an information package (shown in Appendices VI and VII) to review at their leisure. The second involved the researcher inviting SAS counsellors to post flyers (shown in Appendix X) in waiting areas, with information packs immediately available or obtainable on request from reception staff. The researcher asked the counsellors to facilitate communication about the study and collect the consent form if the service user requested this. To ensure confidentiality, privacy, and service-user discretion in the decision to participate, the researcher requested that counsellors emphasise that they, and their service, were independent of the study. The third, already discussed, involved contacting male counsellors, and, the fourth, posting flyers (shown in Appendix XI) around the UON Callaghan campus. Following the success of the recruitment process on this campus, the researcher did not need to extend the invitation to the Newcastle and Central Coast campuses, local community, or organisations external to NSW Health, such as Rape and Domestic Violence Services Australia and Victims Services, as originally intended.

The researcher then contacted the service users, who had indicated an interest in the study. One service user gave permission to the counsellor to pass on her name and contact details, the others contacted the researcher directly on receipt of the information pack or reading

of the flyer. The researcher contacted the service users by the preferred method they had indicated (e.g., phone, reply email, liaison with counsellor, or SMS). During this initial contact, the researcher established a location for the interview that was comfortable for the participant or discussed alternative ways of participating, e.g., via email, Skype, face-time, and phone, as appropriate. She also answered questions as they arose and confirmed eligibility requirements. The researcher noted the preferred method of communication on the consent form to enable further contact, if needed, e.g., for distribution of the final report summary once she had completed the research (Beckman, 2014; Wadsworth, 2001).

Data collection

Data collection involved in-depth interviews with service users (n=10) using an interview guide (shown in Appendix XII). The researcher conducted focus groups (n=3) for counselling teams (n=12 focus group participants in three focus groups, n=7, 2, and 3 respectively) and interviews with sole counsellors in a service (n=5) using an interview guide (shown in Appendix XIII). The total number of interviews and focus groups with counsellors was eight, with 17 counsellors participating in all, as shown in Table 7.2.

The researcher sought the informed consent of participants prior to commencing data collection. She emphasised the voluntary nature of participation, which could cease at any time of the study without undue consequence should the participant desire this. She used a semi-structured interview and focus group guide to allow for unique lines of inquiry, as already discussed. This provided an opportunity to collect rich and thick descriptions and understandings of each persons' experiences. Data was audio-recorded with participants' consent (Marshall & Rossman, 2011) and stored securely in password-protected files (Hoover & Morrow, 2015). Three interviews were not audio-recorded: A telephone interview with a service user and an interview with a sole counsellor and a service user via messenger, due to

technical difficulties. The researcher asked the participants for permission to contact them again, should further clarification and exploration prove necessary. This would 'allow opportunity to discuss uncertainties and clarify participants' thoughts' (Hoover & Morrow, 2015, p. 1480). All agreed to further contact, however, the need for this did not eventuate.

Interviews with service users

Ten service users agreed to an interview. For the eight service users recruited through the male counsellor and UON campus, the researcher provided the information statement and consent form (shown in Appendix VI and VII) upon meeting. She read the documentation with all 10 participants prior to commencing the interview to answer questions and gain informed consent.

The researcher used a conversational, informal, semi-structured interview method (shown in Appendix XII) to explore the service-users' views and reflections (n=10). This interview format allowed the opportunity for these women to tell their stories about their experiences of, and the wisdom they had gained through, counselling. Further, the conversational interview style allowed for questions on areas of particular interest and clarification of meaning, where appropriate. It also meant that participants could correct the researcher's incorrect assumptions or interpretations immediately to support the collection of valid and reliable data. The focus was on valuing and promoting women's voices that to date had been missing from the literature in this therapeutic field. Further, anecdotal discussions had revealed the need for more systematic research that included women's direct accounts of their experiences.

In keeping with the empowering feminist approach taken in this study, the researcher provided a choice in how, when, and where the women told their story (Hoover & Morrow, 2015). These included choices relating to how she conducted the interview, whether by phone, email, skype, or face-to-face, and when and where. For example, the researcher conducted one

interview in a counselling room at a SAS prior to the service-user's counselling session (Em), one at the participants' home (Becky), and another at a library (Jackie).

The researcher endeavoured to establish rapport before commencing and during the conversational interview seeking to reduce power imbalances and improve the quality of the data collected (Hoover & Morrow, 2015; O'Leary, 2004). She asked the women to choose a pseudonym to ensure confidentiality. Some service users decided to choose their own pseudonym, others requested that the researcher do this. The researcher reminded the participants that they had control over when the interview ended. Campbell et al. (2010, in Love et al., 2017) recommended these interview techniques for sexual violence survivors, while the researcher followed O'Leary's (2004) ethical guidelines on approaching research participants. They included arranging a time and location convenient for the participant, arriving on time, setting up and checking equipment, discussing and gaining consent, establishing rapport, introducing the study, and explaining the ethical considerations, as discussed below.

Silverman (2010) referred to 'process consent' as the participants' ability to withdraw their consent at any time in the study. The researcher sought informed and process consent, thereby giving the women a sense of control over their participation from the outset. The researcher assured the participants (women service users and counsellors) of the confidentiality of the information they provided. As well as exploring their experiences of consulting a male counsellor, the researcher asked the service users what advice they would give other women. She sought to validate their experiences and insights through the research relationship by:

- Being collaborative and supportive.
- Encouraging partnership in, and ownership of, the interview process.
- Assuring them they were the experts in the inquiry.
- Assuring them they were not alone and other women had had similar experiences.

- Thanking them for contributing to the research aimed to make a difference to women's lives.

During the interview, she asked the service-user participants to:

- Give their age range and cultural background.
- Provide a general background to their story of consulting a male counsellor.
- Briefly describe their experience of sexual assault or abuse to determine whether it was familial or nonfamilial and whether it had occurred in child or adulthood.
- Discuss their reasons for consulting a male counsellor, whether this was voluntary, what this experience was like for them, and their views on adult females consulting male counsellors about the issue of sexual assault and abuse.

The researcher debriefed the participants at the end of the interview, discussed resources and referral, as needed, and provision of a summary of the study's findings. None of the service users appeared distressed in any of the interviews or indicated a need to connect with their support network at the conclusion of the interview.

Following Silverman's (2010) suggestion, the researcher took hand-written notes even though she audiotaped the interviews. She recorded her observations to assist with subsequent transcription and analysis. This proved useful when audiotaping failed (two interviews) and was not available (one interview). The researcher ensured the information was stored securely, de-identified participants, and used pseudonyms, as already mentioned, to protect privacy and maintain confidentiality (Marshall & Rossman, 2011).

The interviews with service users lasted from 35 to 59 minutes. All were responsive to the questions posed. Several had had a number of years of therapy, were aware of strategies to assist them, if required, had supports in place, and felt prepared to engage in the proposed

discussion. Even so, at the completion of each interview, the researcher enquired again about the participants' wellbeing. None expressed concerns, worries, or upsets.

Characteristics of service users

Table 7.1 shows the characteristics of the adult women service users (n=10), who participated in the study via in-depth interviews.

Table 7.1: Characteristics of the service-user participants (n=10)

Interview	Age bracket	Culture	Type of sexual abuse	History of counselling type	Type of current support	Pseudonym
1	51-60	Australian	Childhood: familial	Government and private	Informal	Patricia
2	41-50	Thai	Adult: nonfamilial	Government and private	Formal and informal	Em
3	31-40	Australian	Childhood: familial	Government and private	Formal and informal	Jackie
4	31-40	Australian	Childhood: familial	Government	Formal and informal	Becky
5	18-25	Australian	Childhood: familial	Government	Formal and informal	Gwynneth
6	31-40	Australian	Childhood and adult: nonfamilial	Private	Formal and informal	Victoria
7	31-40	Australian	Childhood and adult: familial and nonfamilial	Private	Formal and informal	Shirley
8	31-40	Australian	Adult: nonfamilial	Government and private	Formal	Tanya
9	26-30	Australian	Childhood and adult; familial and nonfamilial	Nongovernment and government	Formal	Toni
10	18-25	Australian	Adult: familial	Nongovernment	Informal	Helen

Nine of the participants identified as Australian with only one stating they were from a Non-English-Speaking Background. No service users identified as being First Nations people. Two of the 10 participants were under 25 years of age; one fell in the 26-30-year age group, five in the 31-40-year group, one in the 41-50-year age band, and one in the 51-60-year age range.

Of the 10 participants, seven had consulted a male counsellor about childhood sexual abuse; of these, six involved familial abuse and only one, nonfamilial abuse. Six service users had consulted a male counsellor about an experience(s) of adult sexual assault. Five of these involved nonfamilial assault and one familial assault. Three participants reported childhood and adult experiences of sexual violence. Seven had sought counselling support from government, two from nongovernment, and six from private counselling services. Some had engaged with more than one type of support service. All stated they had support, two informal, two formal, and six both types of support in place.

Interviews and focus groups with counsellors

The researcher conducted semi-structured interviews (n=5), where there was only one counsellor, or focus groups (n=3), where there were several counsellors in a service (shown in Appendix XIII). As well as their perspectives on male counsellors working with adult female service users, the researcher explored the counsellors' (n=17) views on the impact of different genders on team dynamics and organisational culture. She also explored their views on the currency of a feminist framework to the practice of sexual assault counselling in the service, i.e., whether a feminist philosophy informed contemporary sexual assault service delivery and practice. At the commencement of the focus group or interview, the researcher gathered general details on age, work experience, and culture, shown in Table 7.2.

The researcher used an open and collaborative approach, actively consulting counsellors on their views and ideas in the belief that positive benefits might emerge from 'the

involvement of research participants as collaborators … [to] increase their knowledge, competencies and feelings of empowerment, leading to increased motivation, resilience, advocacy and social action' (Beckman, 2014, p. 170). Sole interviews and focus group discussions with counsellors lasted from 42 to 85 minutes. Generally, the interviews with the sole counsellors were shorter than the focus group discussions with counselling teams.

Characteristics of counsellors

Table 7.2 shows the characteristics of the counsellors (n=17) from eight of the 10 SASs to which she had gained access that participated in the study.

Table 7.2: Characteristics of counsellor participants (n=17)

Counsellor	Data collection method	Location	Organisation	Practice experience as SAS counsellor
C1	Interview	Rural	Sole counsellor	13 years
C2	Interview	Rural	Sole counsellor	4 years
C3	Interview	Rural	Sole counsellor	3 years
C4	Telephone interview	Rural	Sole counsellor	15 years
C5	Focus group 1 (n=7)	Regional	Team	10 years
C6				8 years
C7				12 months
C8				10 years
C9				3 years
C10				10 years
C11				7 years
C12	Focus group 2 (n=2)	Regional	Team	8 months
C13				5 years
C14	Interview	Rural	Sole counsellor	2 years
C15	Focus group 3 (n=3)	Regional	Team	3 years
C16				21 years
C17				Nearly one year

Five participants were sole counsellors in rural services (C1, C2, C3, C4, and C14) and the remaining 12 were from regional services. They participated in three focus group discussions (FG1 n=7; FG2 n=2; FG3 n=3). The female counsellor participants comprised two psychologists and 15 social workers. Only one identified as an Aboriginal woman.

The participants' time spent in sexual assault counselling varied from less than a year (n=2), one to five years (n=7), six to 10 years (n=5), 11 to 15 years (n=2), with one having 21 years counselling experience. Hence, nine counsellors had between one-and-five years and seven between 11-and-15 years' experience in sexual assault counselling. Cumulatively, the female counsellors had between six- and 30-years' clinical working experience; five had 10 or less and four had over 15 years clinical experience overall.

Data analysis

The researcher followed O'Leary's (2004) organic process of reflective qualitative analysis involving several interrelated, overlapping steps as follows: organising the data, coding the data, thematic analysis, interpreting meaning, and drawing conclusions. The researcher discusses the first three steps below, while steps four and five form the subject of the remaining chapters.

Counsellors

Organising data

The researcher began by transcribing the recorded interviews and focus groups. She then imported these transcriptions into the NVivo Windows 12 software program ready for coding and analysis (Hoover & Morrow, 2015; Marshall & Rossman, 2011). The researcher coded and analysed the counsellor interviews and focus group themes sequentially, beginning with their

perspectives on male counsellors before moving to the currency and relevance of feminist practice in SASs.

Coding

After repeated readings of the transcripts, the researcher generated initial open codes arising from the data, which she then grouped into themes and subthemes (Marshall & Rossman, 2011). O'Leary (2004) observed that coding entailed 'working towards meaningful understanding [which] often involves both inductive and deductive processes' (p. 265). Thus, the researcher generated themes inductively – grouping codes into themes and subthemes as they emerged from the data – and deductively – relating codes and subthemes according to insights from the literature review, research questions, and her experience and knowledge. This included the importance of the relationship between the counsellor and service user, and issues of safety and power in sexual assault counselling.

The researcher collapsed overlapping coded data into a single code; for example, the data grouped under the themes of 'new concept' and 'feelings towards topic' were merged into the single theme 'new concept', as both sets of coded data related to the idea of male counsellors in SASs (and their feelings about this) being 'new' for the counsellors. The researcher continued this process until she had coded all the transcripts thus generating six main themes (about male counsellors in SASs), as shown in Table 7.3, and five themes (about the relevance and currency of feminist practice in contemporary SASs), as shown in Table 7.4.

Thematic analysis

From the counsellors' data regarding their views of male counsellors in SASs, six themes emerged as shown in Table 7.3:

1. Sexual assault as a gendered crime
2. Power imbalances and male privilege

3. Organisational changes and challenges
4. Possible benefits of a male counsellor
5. Challenges to feminist practice
6. Gender-related practice issues

Table 7.3: Themes – female counsellors

Theme	Sub-theme	References
Sexual assault as a gendered crime	(Direct mentions of) sexual assault as a gendered crime	24
	Safety concerns	15
	Trigger distress	11
	(Wary about) sharing personal information	7
	Engagement	4
	Crisis response	4
Power imbalances and male privilege	Power imbalances	27
	Workload imbalances	8
Organisational changes and challenges	(Entry of male counsellors posed) challenges for SASs	11
	New idea	18
	Ideas for change	17
	(Concerns about) community perceptions	8
	Employment criteria	2
	Difficult personality	2
Possible benefits of a male counsellor	(Direct references to) benefits	3
	Promoted healthy bounded relationships and positive male role models	49
	Corrected the misconception that all men were perpetrators	17
	Offered a (different) male perspective	10
	Having a male voice	8
Challenges to feminist practice	(Concerns about threats to) feminist practice	
	Compromised choice and empowerment	65
	Undermined the feminist voice	36
	Threatened feminist ideals	13
Gender-related issues in practice	(Direct mentions of) gender-related practice issues	8
	Concerns about male counsellor (due to gender issues)	41
	Not culturally appropriate (for indigenous service users)	14

The theme ‘sexual assault as a gendered crime’ had 24 references. The five subthemes relating to this theme were coded as: ‘safety concerns’ (15 references), ‘trigger’ (11 references), ‘sharing personal information’ (7 references), ‘engagement’ (4 references), and ‘crisis response’ (4 references). In total, the theme ‘sexual assault as a gendered crime’ had 65 references. The theme ‘power imbalances and male privilege’ had 35 references. This theme itself had 27 references and the subtheme of ‘workload imbalances’ had 8 references. ‘Organisational changes and challenges’ had 11 references with five subthemes: ‘new concept’ (18 references), ‘ideas for change’ (17 references), ‘community views’ (8 references), and ‘employment criteria’ and ‘difficult personality’ each with two references. In total, this theme contained 58 references.

The second largest number of references related to the theme ‘possible benefits of male counsellors’ (87 references). There were four subthemes: ‘promoted healthy bounded relationships and positive male role models’ (49 references), ‘corrected the misconception that all men were perpetrators’ (17 references), ‘offered a male perspective’ (10 references), and ‘having a male voice’ (8 references).

The ‘challenges to feminist practice’ theme contained three subthemes: ‘compromised choice and empowerment’ (65 references), ‘undermined the feminist voice’ (35 references), and ‘threatened feminist ideals’ (13 references), Hence, this theme held the largest number of references at 113. For the theme ‘gender-related practice issues’ (8 references), there were two sub-themes: ‘male concerns’ (41 references) and ‘not culturally appropriate’ (14 references). In total, this theme comprised 63 references.

As part of the interview, the researcher had invited the participants to engage in two whiteboard activities. One was simply brainstorming the first thoughts or words that came to mind when they considered the idea of male counsellors consulting with adult female service users in SASs. The second was to respond to a drawing of a male counsellor sitting in a chair

opposite an adult female service user, with their perceptions of possible communication from the counsellor and the service user. She photographed both these activities, once completed. In the analysis stage, the researcher noted not only the references to these activities in the NVivo coding, but also analysed the data manually by listing the frequency of the comments to determine commonly held views. In addition, she analysed the data manually in the transcriptions of the interviews and focus groups and highlighted positive and negative references. This analysis provided a bigger picture of female counsellors' perceptions of male counsellors in SASs. Of the eight interviews and focus groups, five contained mainly negative references towards the idea of male counsellors in SASs, while three contained mainly positive references.

From the counsellors' data regarding views on the relevance and currency of a feminist framework in contemporary SASs, the researcher identified five main themes, as shown in Table 7.4. The largest theme was of the counsellors' reflections on changes in SASs over the years, with 41 references.

Table 7.4: Relevance and currency of feminist framework in SASs

Theme	References
Changes in SAS	41
Feminist origins	19
Impact of management and structural context	15
Education	8
External structures	2

The counsellors also spoke about the feminist origins of SASs and their enduring influence (19 references). The third largest theme related to the impact of management and the structural context of the service on service delivery (15 references). Counsellors reflected on

the importance of education as a major component of their work and one which was informed by a sociopolitical lens (8 references) and some counsellors also referred to feminist practice and its influence on interagency work with other systems, such as courts (2 references).

Service users

Organising data

The researcher transcribed the data from the service-users' interviews and then imported them into the NVivo 12 program, as completed with the counsellor's data. She identified initial themes that followed the line of enquiry in the interviews, e.g., advice to others, positive and negative views, descriptions of feminist practice, views of counselling in this field, accounts of, and reasons for ending counselling, potential to consult a male counsellor in the future, and choice in engaging with a male counsellor.

Coding data

Further codes emerged as importing continued and the researcher reviewed the transcriptions, such as culture and comparison to female counsellors. Once coding commenced, it became evident that service users noted some similar concepts, concerns, and issues as the female counsellors. Where this occurred, these themes were included as sub-themes, e.g., 'gaining a male perspective', 'concerns about triggers', 'not all men are perpetrators', 'gender mattered at crisis stage', and 'choice and control'. She did this to highlight the similarities and differences in perspectives of counsellors and services users. Synthesis and clarity of the themes and codes and of the women's statements continued during the coding process.

Thematic analysis

As shown in Table 7.5, there were 112 references to the theme of perspectives of consulting a male counsellor, which included references to several sub-themes, including 'gender mattered

at crisis stage' (6 references), 'thoughts about consulting a male counsellor in the future' (12 references), 'does gender matter' (27 references), and 'comparison with female counsellors' (47 references). The sub theme 'does gender matter' also contained the theme 'choice of counsellor' (20 references). The theme of positives mentioned by the service-user participants contained 62 references. The researcher identified several sub-themes: 'men used a different approach' (29 references); 'gaining a male perspective' (13 references); 'men were direct and less emotional' (11 references); and 'not all men are perpetrators' (9 references). The theme of negatives mentioned by service-user participants contained 36 references with several sub-themes: 'differing perspectives' (15 references); 'termination issues' (13 references), and 'difficulties discussing sexual matters' (8 references).

Table 7.5: Themes – service users

Themes	Subthemes	No. of references
Perspective of consulting male counsellors	Comparison with female counsellors	47
	Does gender matter?	27
	Choice of counsellor	20
	Thoughts about consulting a male counsellor in the future	12
	Gender mattered at crisis stage	6
Positives	Men used different approaches/therapeutic experience	29
	Gaining a male perspective	13
	Men were direct and less emotional	11
	Not all men are perpetrators	9
Negatives	Differing perspectives/therapeutic experience	15
	Termination issues	13
	Difficulties discussing sexual matters	8
Feminist principles in action	Comfort	67
	Trust	36
	Safety	28
	Choice and control	14
	Concerns about triggering a traumatic response	4
	Counsellor not parading as an expert	4
	Respecting culture	1
Advice to others		12

The theme of feminist principles in action contained 154 references with the following sub-themes: ‘comfort’ (67 references); ‘trust’ (36 references); ‘safety’ (28 references); ‘choice and control’ (14 references); ‘counsellor not parading as an expert’ (4 references); ‘concerns about triggers’ (4 references); and ‘respecting culture’ (1 reference). The final theme was advice to other service users considering engaging with a male counsellor (12 references).

To enhance the trustworthiness and accuracy of the data, the researcher kept an online journal noting her reflections and observations pertaining to the data gathering and analysis stages and insights from consultation with her research supervisors (Hoover & Morrow, 2015; Marshall & Rossman, 2011). Reflexivity, where researchers used ‘self-reflections both about themselves and their reactions to others to uncover different types of knowledge’ (Beckman, 2014, p. 169) was another way of enhancing the trustworthiness of the data.

Limitations of the study

One limitation of the study was that it did not extend to male counsellors, as originally intended, as the NSW Health ethics committee did not provide approval for this, due to concerns surrounding privacy and confidentiality given the perceived small number of male counsellors employed in this field. The researcher, therefore, agreed to exclude this group of participants to enable the study to proceed in a timely manner. Even so, she believed their exclusion resulted in a missed opportunity to gain a valuable perspective and a full and holistic exploration of the research issue. The researcher hoped that male counsellors in private, government, and nongovernment SASs would be included in future studies on this important topic.

Relatedly, some SAS teams with male counsellors connected to their prevention services might have felt uncomfortable with female counsellors participating in the study. As no communication was forthcoming from those teams that declined to participate, such considerations were superfluous. Those teams might have felt uncomfortable expressing their

views on the inclusion of male counsellors in their service, especially if they were speaking against their colleagues. This might have compromised openness and transparency in the enquiry.

The study did not explore any consideration of the impact of sexuality on the service experience of service users who consulted male counsellors. Studies have shown that lesbian, gay, trans, and bisexual people experienced sexual assault and interpersonal violence at higher rates than heterosexual people did (Love et al., 2017). Therefore, it would be important to consider this aspect of a person's story and any relevance for service delivery to this target group. This would also be important given research showing that lesbian, gay, and trans survivors were less likely to access support services (Love et al., 2017).

The research could have placed further emphasis on Aboriginal women's experience and the impact of culture and government interactions on their experiences. The same was also true for people from non-English speaking backgrounds; again, more exploration into the impact of culture on their experience of consulting a male counsellor would be of value. Unfortunately, in this study, no female service-user participants identified as Aboriginal, so this was a huge gap, particularly given the statistics on the high level of sexual abuse perpetrated against this group. In addition, only one service-user participant identified as being from a non-English speaking background. This could be expanded in future studies to consider cultural implications for service-users' experiences of consulting a male counsellor about the issue of sexual abuse or sexual assault.

The study's focus on female counsellors and service users meant limiting sample size. Further, recruitment difficulties already outlined led to the exclusion of metropolitan services and an eventual focus on rural and regional SASs. Given geographical differences and service needs, this proved an advantage overall as it enabled a greater focus and more intense examination of this issue in rural and regional contexts.

Conclusion

This chapter outlined the study's methodology, the feminist theoretical framework guiding the research, and the qualitative approach and methods used. It described the location of the study, sampling methods, recruitment procedures, participants, data collection and analysis methods, and ethical considerations. Finally, it outlined the limitations of the study. The following two chapters discuss the findings from the counsellors and service users, respectively.

CHAPTER 8

Findings: Counsellors' perspectives

Because it is a … largely gendered crime, I guess they [male counsellors] would have to be comfortable sitting with that, and hearing about that, and about women's issues (C1)

It's just such a … privileged role – you sit in as a counsellor in a … private space … with … vulnerable people (C12)

As described in Chapter 7, the researcher conducted interviews where the services had only one counsellor and held focus group discussions where there was a team of counsellors; wherever possible, she attributes quotes to the counsellor, denoted by the letter C (C1-17) rather than the group. FG1, FG2, or FG3 refers to the group. Following this reporting format, then, this chapter presents the findings from female counsellors in SASs. Given the focus of the study, all the issues discussed related to the inclusion of male counsellors and ongoing relevance of feminist practice in SASs. The discussion follows several broad themes that emerged from the findings relating to:

- An enduring feminist perspective on sexual assault as a gendered crime, centrality of choice and empowerment, primacy of safety issues, and focus on power imbalances and male privilege
- Changes and challenges in employing male counsellors
- Possible benefits of male counsellors

- Ongoing relevance of feminism
- Threats to feminist practice
- Gender-related practice issues

Enduring feminist perspective on sexual assault

The counsellors attested the enduring relevance of feminism on practice, which the employment of male counsellors could undermine. The core features of feminist practice they discussed were the gendered and criminal nature of sexual assault, the centrality of choice and empowerment, primacy of safety, and focus on power imbalances and male privilege. They continued to see sexual assault as evidence of male dominance and women's oppression.

Sexual assault as a gendered crime

A core feminist principle underpinning practice was that sexual assault was a gendered crime, given '98% perpetrators are male' (C2). Therefore, a prime concern relating to male counsellors was whether people might see their inclusion in SASs as insensitive to the gendered and criminal nature of sexual assault. Their knowledge and experience of sexual assault made most of the counsellors wary of male counsellors:

> Why is he in this job, which could sidetrack her and be distracting, wondering if he is a victim or perpetrator (C4).

> There's probably less chance of your counsellor reminding you of the person that assaulted you if you are seeing a female (C11).

> Within the therapeutic side … it will have a lot of negative impact on the survivors (C14).

The counsellors thought men would be better suited to respond to issues as they arise in ongoing therapeutic intervention rather than in the initial acute crisis phase. They were concerned that similarities between the male counsellor and their abuser might trigger anxiety:

> Just being male might be triggering for some women (C1).

> If you look at the proportion of offenders that are male, it's more likely that you are going to end up with a male that might be the same age, or have the same colour hair, or have the same trousers on, or … that sort of stuff (C3).

> Just what I know about sexual assault dynamics and males often being offenders and just the triggers so some of those worries (C12).

Being in the privacy of the counselling space – behind closed doors (C12) – with a male might remind them of the secrecy of the abuse. Client-counsellor engagement and building a trusting relationship, even between female counsellors and female service users, was often difficult enough, without having to complicate things with the addition of male counsellors:

> I don't think the engagement will be just the same if it was a female. I think they'll find it hard … I don't think females will engage very well with men … because … offenders are mostly men … Just seeing a man who is similar to the offender … if the victim was sexually assaulted by a man, being in a counselling session with a man … would trigger the whole sexual assault (C13).

The counsellors wondered whether female service users would feel uncomfortable sharing private information with a male, when this was already difficult enough with female counsellors. C10 wondered about the 'appropriateness' of discussing respectful sexual interaction and consent: 'I wonder how those conversations would be had with a male clinician … and … just what that would sound like' (C10). Others wondered whether female service

users might find it 'too uncomfortable' to talk to male counsellors 'about intimate details' (C4) or 'the incident itself' (C13):

> Offenders are mostly men and … he might … experience women not talking about … … Some of them might find it quite confronting, don't know if they will be able to do that with men (C13).

> It would be quite awkward for a woman, or a survivor in general, talking to a male … about … private stuff (C14).

Some believed the mere presence of male counsellors might cause discomfort, even if the service user were seeing a female counsellor:

> When they are not expecting it … that could be quite confronting (C9).

> There would be some ... women who would find it harder to come where there is a male in the service (C11).

Whether the service had informed service users there were no male clinicians generated some discussion in FG1 and FG2.

Centrality of choice and empowerment

Given the counsellors' dominant view that sexual assault was evidence of male dominance and women's oppression, all the counsellors saw choice and empowerment as important elements of rights-based feminist sexual assault counselling:

> Because … people have the right to choice … particularly with sexual assault victims, they've had their rights … taken from them and … their ability to … control that situation (C1).

> Because feminism isn't about females, it's about equality ... we are talking about empowerment and women having choice is empowering (C2).

> In my mind feminism is about gender but I think the parts of feminism that I take into my practice are around empowerment and I think that choice allows people to feel empowered (C3).

> You are offering a choice (C5).

> Giving women a voice (C11).

> Feminism is about empowerment … where we're creating … social justice and having inclusivity and allowing people to have choice. It's not about females taking over the world … it's about rights and choice … a feminist practice … provides some choice and that's a good thing (C12).

> It's all about a matter of choice … both genders are given the same choices … and they're not discriminated against (C14).

> Not making assumptions about their needs and their experiences … It's about that capacity to have their own voice (C17).

The counsellors saw choice as empowering in that it gave service users control over their decisions in therapy:

> Your early intervention with people is to try and give them back a sense of their rights and their ownership over their body and their life and their choices (C1).

> It's … empowering that person and giving them back … so choice, choice, choice … That's a big part of … healing isn't it? Anyway, we base our training there [being] … choice … right from the beginning (C2).

> Putting them in the seat where they're … driving what's going on (C3).

> It would probably help them along with the healing because they've got that choice, they've got a choice of a male (C14).

> Empowerment … a sense of control over their choices (C16).

All counsellors agreed that feminist practice *could* include a choice of the gender of counsellor and having this option could be empowering:

> It is that agency over what that journey is going to look like and … having a male … counsellor as part of that can only … assist them to regain that control … over choice (C15).

> Because … people who have experienced abuse … [have] lost their sense of … empowerment, they've lost their sense of having … control … and, for them, to be able come into a service and even be … able to say, to me [what] … should be a simple thing, I would prefer to see a male (C16).

For C15, the absence of choice could cause further harm, 'because it … takes away their empowerment' and this could affect the therapeutic relationship: 'There will be no connection if they don't have a choice over whether they see a male or a female' (C15). Hence, it was important to inform service users of their choices so they could make informed decisions:

> Particularly if it's expressed that … you can change your mind, you're open to change your mind … for the clients to know in advance ... to say well I don't really feel comfortable or I'll give it a go it's okay, instead of just turning up for their appointment and being presented with a male counsellor (C14).

Informing service users of their choices from the outset could instil a positive view of the service, because, as C17 observed, first impressions counted. She wondered whether 'having the choice around the counsellors ... and … capturing those values of empowerment, of choice, of openness, may help set up a kind of positive experience of the service'. However, some were ambivalent about this:

> I initially want to say 'no' … that can't be right … [but] feminism is about empowerment (C12).

> It's kind of like on that fence at the same time … because it's kind of like 'yeah' it is and then it's like 'no' (C14).

Some counsellors were concerned that including male counsellors might reflect a change in SAS sensitivity to women's experience:

> We gave them a choice though, but maybe it will be perceived that we don't respect what women have been through … if we've got a male, are we saying to the wider community, oh well … we don't care about women's choices and safety? (C2)

> We know it's mainly men but let's just have men here anyway (C11).

Some thought women might not be confident enough to express their hesitation about a male counsellor. They might agree to this and then not return for further counselling:

> You will have clients who will be very uncomfortable with a male but may not say that and then they just … disappear because, for that reason but they haven't had the confidence to say I don't want to see a male (C2).

> I do wonder in this, because of the very nature of the work, whether that could be a negative for people, who, for women who are a bit submissive, whether they would feel like they didn't have a voice in saying no (C11).

Others were concerned that offering a male counsellor might, in itself, be harmful:

> Do we risk retraumatising them by even suggesting that or bringing that to them? (C9)

> Could actually scare 'em away (C14).

> Even if we thought … it could be in the best interests [a service user consulting a male counsellor] … could still … cause harm (C16).

> It could potentially make female clients feel less kind of safe in accessing the service … they may feel that knowing it's female only may help with their sense of safety (C17).

To avoid the risks and concerns of further harm, however, counsellors emphasised the need to be careful in offering a choice in gender of counsellor and the 'way you ask the question during the intake' (C5); 'if a woman was really against it, I don't think we should be forcing it' (C16).

FG2 still wondered how male counsellors would fit into a system established by women for women within a feminist understanding of male violence against women, though acknowledged the broadened awareness of sexual violence perpetrated against men. Some considered that not having male counsellors meant the service was not practising under a feminist framework. For example, C15 observed that 'not having male counsellors … doesn't really fit with feminism … it's more like falling into the trap of those assumptions … that women can only see women, and women can only feel safe with women'.

Discussants in FG3 felt that excluding male counsellors from SASs was discriminatory. In the past, female sexual assault counsellors had been labelled man-haters and stereotyped as

lesbians with hairy legs. In this respect, they wondered whether the exclusion of male counsellors had contributed to these stereotypes: 'falling into that a bit ... aligning with stereotypes … and myths … It's not actually challenging that on a higher kind of level' (C15).

Two counsellors highlighted that being able to offer a choice in the gender of counsellor could occur only in metropolitan areas, where there was a team of counsellors. Such choice was not available in rural areas, where there was only one counsellor in a service:

> I mean we couldn't offer anyone choice here because it's me (C3).

> It is very difficult considering this in places where there is only one position (C4).

Primacy of safety concerns

A core feminist rationale for female-only services related to safety concerns. Therefore, the counsellors were worried that service users might not feel safe with a male counsellor:

> My fear is that the service user may have their own fears about consulting … a male counsellor and this may stop them (C4).

> I think perps, mainly men … that's a safety issue (C8).

> Maybe triggering goes with safety too (C11).

> If I was a female victim … I would be thinking, am I safe? Is it safe for me to be talking about what happened? (C13)

Feeling unsafe related to the way in which service users perceived and received male counsellors:

> Sometimes the non-verbals could be misconstrued … if I was a male, she might think I was looking at her as a sexual being … some nonverbal gestures could be very misconstrued for vulnerable clients (C5).

> Could be threatening, if you move, are you going to touch me or are you going to do something because we are in a closed room (C11).

Counsellors wondered how male counsellors would connect with the experiences of female service users: 'I guess there's more point of difference between male counsellor and a female client … So, I wonder what it would look like for a male counsellor, whether there are some different ways that they might establish that connection' (C17).

However, some thought male counsellors would have their own safety issues, due to their vulnerability in a female-dominated workplace. Counsellors referred to other female-dominated workplaces, such as teaching and child protection that placed male employees in vulnerable positions, due to their gender (FG1, FG3). Generally, female service users (mainly in urban areas) had the option to see female detectives and doctors (C12, C3), if they wished. In some instances, service users had moved from seeing a male (e.g., a psychologist) to a female SAS counsellor, as they wanted a female therapist (C12). C4 drew attention to the history of males entering the nursing profession and wondered whether this situation was similar. C13 noted: 'Nobody wanted to know, but, as time went on, there was so much … media explaining male midwives and all that, and people are opening up to it now … they became comfortable'. 'Feminine driven' (C13) services needed to educate the community about the inclusion of males.

Power imbalances and male privilege

Issues of power and control were central to feminist practice, since men had more power than women generally. Hence, having male counsellors working with survivors of a mainly male-perpetrated crime seemed counterintuitive, 'particularly when they enjoy male privilege' (C6). Counsellors wondered how power imbalances and male privilege might influence the counselling relationship:

> It's about being able to … understand the power imbalance; sexual assault sits under that male privilege, patriarchal dominance, power (C5).

> When we are talking about power and control … power imbalances … it would take a very special person (C9).

> There is so much around white male privilege ... that, as workers, not even just female workers … we're up against, in terms of society … men who are abusers … a really male-driven court system … stereotypes that we're up against is all often male driven. There's a whole conversation you can have around masculinity and the starvation around some of that stuff … are they the right fit for the organisation and I worry that men often get roles that they're not right for (C12).

Participants in FG1 wondered how male counsellors might address power imbalances or whether their mere presence would reinforce them:

> Sometimes I wonder if we could get more done. If that conversation somebody had with a GP had been had with a male counsellor, would that have gone different (C10).

> She may feel that reinforced … blame and … power. The gender power may come back in for her because he's a male and you can't say 'no' to males and they're the dominant one … We kind of dance with the service users around how they're feeling … and … hold them, to a degree, but … with a male, they wouldn't be able to do that (C14).

The counsellors worried that male counsellors might have a 'blind spot' (C5) about male privilege and lack understanding of women's felt experience of the harm men caused. To be effective, male counsellors would have to acknowledge gendered power imbalances and see women as experts of their own experiences. Given professionals had 'a really privileged role' (C12) and worked 'with really vulnerable people' (C12), it was important that they maintained

a determined focus on supporting women, aware of their vulnerabilities. All the counsellors were concerned about the possibility that male counsellors might subject service users to further harm, albeit unintentionally. C6 believed male counsellors had to have 'a lot of insight … into the benefits of their male privilege' (C6). C10 thought male counsellors needed to acknowledge male power respectfully by apologising for the violent acts and disrespectful attitudes of 'males in general', who colluded with perpetrators or perpetrated violence against women. They had to be open about the power men held in society generally and aware of the way in which this influenced their relationships with female colleagues and service users, and their position within the team and service structure.

The counsellors also wondered whether the inclusion of men would change perceptions of sexual assault, diminish its gendered nature, and quash the structural view:

> It could diminish the criminal aspects of it, because you've got males working more, it could be that sense … like you're hearing all these comments at the moment, 'oh, just get used to it', 'it's just flirtatiousness', or 'it's just this or just that'. I wonder if they're in the wrong sort of voice, whether it could take us back down (C11).

C9 reflected on her negative experience of working alongside a male counsellor, noting 'it's … that gender thing around how they think and how they process'. She raised the possibility that service users might automatically opt for a male counsellor, assuming they were more 'expert' and could 'fix' their problem, thus placing themselves in a submissive position (C10). Too many men portrayed themselves as protectors in women's lives. Male counsellors would have to manage transference of this nature in the counselling relationship:

> I could think of a number of clients here, who, if asked [to choose between] Joe or … Jane, … would go [for] … the man … It's setting Joe up ... [by putting] expectations on him, [especially] if they're looking towards him to be like 'the male doctor's going

to take care of them, tell them what to do' … then they … have added problems as a counsellor (C6).

Changes and challenges in employing male counsellors

Shift to greater inclusivity

The idea of employing male counsellors in SASs was new to most of the counsellors and one many had not considered prior to this study: 'I never really stop to think about it' (C13). For most, SASs had always been female-only domains:

> My gut instinct says it was wrong (C1),
>
> We've just never had males, that's just the way it is … we should not be so rigid (C2).
>
> You're just caught up in, well, this is the way that it is, this is the way it has always been, legislation supports it so this is the way it's always going to be and until someone actually presents you with – but what if it was like this you don't, you don't think about it (C3).
>
> It's always been women working in sexual assault (C15).

Some counsellors felt uncomfortable talking about this, fearing labels of political incorrectness and 'man-hater' (C1, C11). Some were adamant they were not against men and questioned why things should change: 'Is it wrong to have an all-female service for something like this … what's wrong with that?' (C11). They found the idea 'weird' (C1), 'completely wrong' (C14), and 'controversial' (C17). Accepting a male counsellor might take some adjustment 'so I would probably find it a bit funny' (C14). Nevertheless, the conversation was 'relevant' (C15) and 'really beneficial in just opening up our thinking about this … I hadn't thought of it from an adult woman perspective' (C16). Rather than a negative prospect, the idea of male counsellors

made C14 ‘interested in talking to them about what got ‘em interested in working and how they’re finding it’.

They saw several challenges in having a male counsellor in sole-service positions and some thought male counsellors could be included only in services with counselling teams: ‘It could fit in quite well with current infrastructure but would have to be as part of a team not a sole worker’ (C4). They wondered how the community would perceive male counsellors ‘after we’ve had all females’ (C2). C2 thought the change might be a ‘shock’ to other workers, though it might also engender respect for their broad-mindedness:

> People would be shocked [at] who worked here because it’s always been so female dominated but … we’d get a bit more respect … they would find that encouraging, I hope … that we’re looking outside the square and that we’re being a bit more holistic in our care, and not so … one minded (C2).

In contrast, C3 felt that other services might mistrust a male counsellor working in an SAS and stop referring clients, or even allowing them to make their own decisions on this: ‘They will just assume that no victim wants to speak to a male’ (C3). C12 agreed: ‘I can imagine other services saying, “Oh, don’t go there. They’ve got male counsellors”’. C12 highlighted community ‘myths around who can do sexual assault’. The community might not be open to, or ready for, this different way of thinking and practising that SASs were considering and struggling with themselves, ‘let alone a ‘narrow-minded town [or] … conservative community’ (C12). Other professionals might be wary of, and not open to, the idea: ‘I don’t think a lot of practitioners would make it easy for male counsellors either … if they do come into the space. I think they’d be very wary’ (C12), as many workers in the area were part of the movement when SASs were first developed and this connection to the values and commitment to women’s support and needs of the time would influence their lack of ready acceptance.

On the other hand, C4 thought services might 'quadruple' if male counsellors were employed, with the male counsellor possibly the busiest in the service (C3). The option for service users to nominate their preference could potentially increase the demand on management to employ male counsellors. Further, some suggested that other services and professionals might recommend referral to the male counsellor; if they were in a rural position covering different SASs, this could result in a very high caseload for him.

The counsellors also wondered whether the team culture with feminist discussions among female counsellors might change, with more consideration given to language and how a male might perceive their conversations. They suggested that a male counsellor might take such discussions personally (FG1): 'Some of the feminist discussions we have may be confronting for men and maybe we might need to be more mindful of the way we express some of our ideas' (C6). They suggested that routine structures and processes would change with consideration given to the roles and functions of male counsellors, especially in the first interaction with the client:

> The process when we work out what they want is most important, really trying to suss it out that am I comfortable here with this person I'm talking to, and that is talking to a woman, and I don't know if he is a male if that is positive (C13).

The counsellors noted that providing a choice of gender would be an obvious change as there had been no such need for this before: 'We'd have to bring it in with the choice' (C2); 'giving that option … would be different' (C17). C3 agreed with 'giving them a choice and … not making it about the gender'. FG1 discussants thought 'you wouldn't give them the opt-out option, which is about the way we frame it, you'd give them the opt-in' (C5). They highlighted that most important was 'how we ask the question', so as not to 'trigger' the service user, or so 'submissive' clients would not just accede to the counsellor's proposal. For C15, the question could be 'quite depersonalising'; she (and C16) hoped that counsellors would inform service

users lest they be ‘shocked’ to see a male counsellor. C16 emphasised the importance of ‘finding a way to introducing that quite differently’ (C16), ‘talking them [male counsellors] up, as such’ (C17). C17 wondered whether the choice should come ‘at the referral stage or when we do the psychosocial assessment’. C2 and C15 thought a challenge would arise if the male counsellor were to have a difficult personality. C2 foresaw this as the only challenge:

> I don’t think that there would be many challenges, except if his personality was difficult (C2).

> I would probably find that hard having a real value clash around particularly sexual assault against … women (C15).

C1 and C3 thought recruitment and employment advertisements would have to change as the positions were ‘female only’: ‘Only the way we word our ads’ (C1); ‘they would have to [change] because you can’t even be male and apply for the position’ (C3). Some thought the male counsellor should hold a health-promotion position, until he had eased into the service (C3). He could liaise with regular referring agencies, attend meetings, and introduce himself in that way (FG3) ‘to kind of calm down us workers when there’s change ... It’s sad, isn’t it, we’re such a closeminded group of people and so protective of our clients (C3). The counsellors thought that consulting counsellors and service users regarding change would be a positive step: ‘I think that could work’ though it heralded ‘a big shift without any consultation with the people who are actually working with the clients ... or with the clients [directly]’ (C3). C3 believed it was important to introduce female service users to a male counsellor and his role, and to handle this sensitively to assist with the change, considering the language used and stage at which this would occur, whether at intake or following assessment (FG2). C14 also anticipated that ‘because it is more of a specific area … it probably would bring up quite interesting discussions around the effects, and the interpretation of the effects, on clients and

how we respond' (C14). Thus, services should implement measures to ensure that service users were comfortable with, and engaging in, this new service-delivery option:

> If there're clients feeling uncomfortable we are going to have to find out exactly how are we going to notice … so we would really have to look at processes … and how to manage that, what to do, because we don't want the client feeling more shame and blame [if the engagement is not working well] (C14).

C16 suggested that male counsellors conduct psychosocial assessments over the phone to break the ice and 'introduce a male in our service'.

FG1 expressed concern that including male counsellors would result eventually in men dominating the services, as the number of female counsellor positions reduced. Thus, their efforts in fighting for the establishment of these services and the rights of women would be lost. While some counsellors expressed such concerns, others felt that the limited number of men in the counselling profession made this unlikely (FG1). C4 and C16 foresaw no issues in changing service delivery to include male counsellors: 'I wouldn't see any challenges in working with a male' (C16). In reflecting on her previous experience of working alongside male counsellors within a multidisciplinary service, C15 wondered whether service users at SASs would know that having a male counsellor was 'different'. Perhaps practitioners wrongly assumed that service users knew that SASs only employed female counsellors.

Experiences of male counsellors

Some counsellors were aware of male counsellors employed in SASs or VAN (Violence and Neglect) services in metropolitan areas (FG1, C12, and FG3). They wondered how this had occurred when services advertised female-only positions. At times, SASs had employed male doctors (paediatricians and psychiatrists): 'My experience of the male professionals … is they're concerned about how victims will respond to them' (C1). C3 provided an example of a

male worker providing court support in the domestic violence field, who shared feedback from his client group that: 'A lot of the women going to court for AVOs felt very protected and safe having him there and that it was an opportunity that they probably wouldn't have asked for' (C3).

C6 wondered whether service users might perceive a male counsellor differently from a male doctor: 'They come in as the specialist and it would be interesting to see how, as one of the counsellors, it might be different'. She said a male counsellor had doubted whether he should be working in this area: 'He was struggling with "is it men's work or isn't it" and getting mixed messages around that and then wondering if he should be doing that or not' (C6). Overall, C6 thought 'it's generally been nice … most of us have had positive experiences … whenever I've had experience with males in our space, they have come in with a position of respect'.

Several counsellors who had had experiences of males in related services saw benefits in this. C3 and C5 had worked with male forensic examiners. Though different from counselling, they saw value in having male examiners:

> We have male doctors in our on-call forensic service that do the forensics … some of them are brilliant ... and speak to why this can be healing (C3).

> He gave the messages, better than the females, so … there can be some good clinical outcomes (C5).

C8 noted that SASs were not the only places where female survivors consulted professionals following sexual assault or abuse. Female survivors were seeing male workers at drug and alcohol, mental health, and psychiatric services: 'Whether they are working effectively or not I can't comment. I have certainly worked in generalist community health and had male mental health workers working … quite well and effectively' (C8).

C12 had encountered a male counsellor, who worked in a SAS, noting 'he did some amazing work … he often reflected on working within a feminist practice' (C12). She spoke of two contrasting experiences of males working in this field. One was in relation to male psychologists in the geographical area who had complaints made against them regarding child sex offences and the other was in relation to providing counselling through the Royal Commission: 'They understand not only what it was like to be a male but also some of the challenges to be a female, so I think they had a really good balance around that, and so they were equally driving a lot of feminist needs around, around both genders' (C12).

C16 also spoke about her experience of working with male counsellors in the field. She noted that, in some situations, the male counsellors worked with service users (mainly men), who preferred not to see a female. However, they also worked with female service users who, during the course of their therapy, raised sexual abuse as a part of their trauma history: 'When it came to a person that really stated that he didn't or she didn't want to see a female … [there were] three males who did a fair amount of work on past sexual assault' (C16). For C16, there were 'really beneficial' opportunities to consult male counsellors. There was still the perception, nevertheless, that the service was a women's space.

SASs not only worked directly with adult survivors of sexual assault or abuse, but also with children, parents, and carers. Therefore, counsellors thought male carers might feel supported by having a male counsellor in the service (C3, C16). Others considered that male counsellors could have a positive impact on other male health professionals, influencing their attitudes to, and understandings of, gender roles and sexual assault (C4). A male counsellor could be 'safe, especially for men … who have had female perpetrators' (C15) or who did not wish to see a female counsellor, such as adolescent males (C16). Again, they questioned why service users did not have the choice, when it was not good practice to make assumptions about

men wanting to see male counsellors and females wanting to see female counsellors: 'Why don't they have that choice?' (C16).

Undermining the feminist voice

Discussants in FG1 wondered whether having male counsellors might undermine the feminist voice and mean the service could no longer operate from a feminist framework. While acknowledging that men could work from a feminist perspective, C11 thought services would, inevitably, end up more trauma- than feminist-focused. However, counsellors were not always clear on what feminism and feminist practice entailed:

> It makes me think about 'what is feminism' … because … when I think of feminism, I still have this image of … extreme protesting in the 70s, even though I know intellectually that that's not what feminism is, so I've got this image and then what a feminist should be (C12).

> [It's] not really … a feminist style of working but then is that for the radical side - the feminist? (C14)

> There's a lot of misconceptions about what feminist, what feminism stands for and this idea that it … is around demonising men … which is not the case (C17).

Some counsellors thought that SASs were established on the premise that male and female service users preferred female counsellors, though queried where the idea came from: 'We're making some really big assumptions that women automatically want to see women as well or that … we may automatically engage better with and connect better with a woman because we're female' (C17). C11 queried whether this idea related to gender or personality traits: 'I don't know where that comes from, I don't know, do we have more empathy' (C11). In contrast, C6 had worked in a service with men who had experienced trauma and had not

wanted to speak with a female. She was not sure whether this was due to her gender or her (younger) age at the time. Others wondered whether services were falling into a trap of their own stereotyping and making unfounded assumptions that no longer fit with the multiple gender identities in society today. Some questioned whether the current gender-based employment criteria were discriminatory:

> Are people going to look back in 10 years' time when they see only females can apply … I don't know how that would look (C16).

> That doesn't mean it has to always be that way, or that that's the experience for everyone, so challenging that one-size-fits-all approach (C17).

The counsellors wondered how gender stereotypes, constructs, and roles influenced the counselling relationship in SASs:

> They felt more comfortable to speak to a female (C11).

> It's more social constructs of what it is to be a man and what it is to be a woman … men typically aren't in counselling roles so what kind of construct, how does that play out, into a typical feminist organisation (C12).

> You often hear how males have got a different style or a different approach … they just come across differently anyway, like they're brought up differently, so there's that social norm (C14).

C2 noted that female and male counsellors required the same skills, characteristics, and qualities:

> Kind, experienced, have good boundaries, um need to be a feminist, um need to be consistent. This is probably all very much what we have to be anyway … If you're kind and understanding, it wouldn't matter if you were male or female (C2).

> A lot of those interpersonal skills wouldn't necessarily change with the gender (C15).

Some counsellors challenged the idea that male counsellors might threaten long-established feminist practice:

> The feminist thing is … about being equal and open-minded and not being bloody-minded about one way or the other … [Male counsellors must be] aware of the male-female dynamic (C2).

> It provides some choice and that's a good thing, because sexual abuse is all around someone else's power and control … I still think there is still a real legacy of that feminist practice that hangs around … It's still happening now, it's still us; it's still women driving a lot of the sexual assault work (C12).

> It reconceptualises it (C15).

> A feminist approach to practice … is about choice and about empowerment (C17).

C3 saw feminist practice as an antidote to our patriarchal society and challenging this meant improving gender relations:

> There is a lot of male dominance in society and there's a lot of patriarchal ways that we still need to shift … For me, it's about empowering them regardless, because … I truly believe that leaving a counselling process at the end of counselling and still hating men means that I haven't done all of my job (C3).

C11 thought feminist practice was about delivering a service that stood up for women, where men did not intrude on that space: 'This is a women's service and you've got the right to come here and not to have a man encroaching in the service because of what you have been through' (C11).

Some counsellors felt that, largely, the practice of male and female counsellors would be the same, focused on engagement and developing rapport with the service user and providing direction of the session with clear expectations 'because you need … to build fair bit of rapport … before you can get into a lot of the work' (C16). For C12, ideal male counsellors would be 'really gentle kind men who … knew a lot about feminist practice'. She wondered whether a male counsellor would be 'thinking anything drastically different to what any person sitting in that chair is'. Those thoughts might be:

> Is it safe, is it okay for me, and can I trust this person? (C13)
>
> The victim's probably going to be thinking pretty much the same stuff as what a victim thinks when they see me (C3).
>
> They're all really similar things I think they would be thinking if I was sitting in front of them (C12).

C14 described a male counsellor in another service: '[He] hasn't got a very dominant personality. He's quite a caring soft man … so I've had quite a positive reaction working with someone that's a male in the same building' (C14). C14 wondered how male counsellors might fit into her rural community, if they did not fit the gender stereotype: 'Depending on what the type of the male worker is with how he'll be perceived in the community … they'd have to come across as a bit of blokey blokey to engage' (C14). C17 thought the presence of males might challenge gender stereotypes:

> Having males in counselling roles or social work roles or whatever also challenges some of those assumptions about who can provide that ... care and help because again it's very much dominated by women and there's a certain kind of softness associated with doing these jobs (C17).

C8 and C17 further noted that the female service user would probably worry about being judged by the counsellor, whether male or female, but that perhaps this applied more to a male counsellor: 'I think that question would come up with female counsellors too, that fear of being judged … what will he think?' (C17)

Some thought that female counsellors were better able to relate to and support female service users generally in a patriarchal society:

> How would a male understand, know what it's like to feel overpowered or powerless? (C4)

> I guess what we are trying to say, is that when we walk into a room, we identify with women really easily (C5).

> As a female, I mean it's innate that we sort of scan rooms, we are constantly looking at safety, men don't have that way of being (C7).

> As a woman you can empathise with that loss of power and control (C11).

> I guess a lot of that connection can come from shared experience, not in terms of having experienced sexual assault but around being, you know, a female in the world that we live in (C17).

One counsellor thought most female service users did not wish to see a male counsellor: We can't discount that most women that do come in here say they don't want to see a male … there can be healing done but lots of women do say to us they don't want to see a man' (C12).

C17 highlighted the importance of male counsellors having a feminist theoretical foundation and value base. She assumed that 'they probably wouldn't want to be a sexual assault counsellor if they weren't in line with those things'. C2 was sure that 'we wouldn't employ someone who didn't have feminist ideals' or adhere to a feminist framework. C5 thought 'it would take a very special guy … to work with these vulnerable women'. These qualities and ideals were far more important than their gender:

> Getting the right person is important; someone who is approachable, has a gentle manner, has respect for all, not an expert, not powerful … respectful relationship … I have met some really good men in this area, e.g., doctors and detectives. They were very respectful, their manner was caring and relaxed, showed they were there for you, that you are important to them, not rushed (C4).

> That would probably come down to the individual male counsellor ... their personality type … very compassionate … but … it comes back to personality, their own value system (C5).

> It shouldn't be just about your gender … you've got to be open … it's about being able to have those conversations (C11).

Male counsellors' concerns

Some counsellors reflected on concerns that male counsellors might have. Several considered that male counsellors might find it 'quite difficult' (C2), 'hard' (C2, C13), 'unsettling', 'different' (C15), and feel 'daunted' and 'nervous' (C15) working with female clients in sexual assault, for reasons already outlined. They stated that the male counsellor might even 'feel that rejection' (C13), wondering 'are they scared of me, do I look like the perpetrator' (C3), and am I 'going to be accepted' (C13). C13 questioned whether a man would 'be confident enough

to let her know that … I put the same interests at heart just like seeing a female counsellor' (C13). However, these initial feelings might resolve with experience: 'I think after a few years of experience that may wash away that fear' (C2). Others felt that male counsellors would be able to challenge this knowing 'I'm well trained in this. I know what I'm doing. This person has been told that I'm a male counsellor, they don't have a problem with that' (C3). The counsellors also believed that male counsellors would incorporate feminist thinking and gender awareness in their practice:

> What do I need to do to … shift things a little bit here? (C3)
>
> Trying his best to pick up on vibes/signs of being uncomfortable, trying to put her at ease (C4).
>
> Thinking is my gender an issue … what needs are there of hers? (C12)
>
> How can I make this transparent to make that person feel comfortable? (C13)

C13 considered that male counsellors' work was very different to that of other male service providers since SAS counselling involved 'unpacking' the violence and the harm instilled. This was different to going to a police station to make a report or statement, where the aim was to hold the offender accountable: 'When they come to us, it's almost like a healing process … they are looking for … the support they get from police is very different from when they come to counselling' (C13). C17 thought male counsellors might acknowledge their gender and what that might mean: '[It] might just be about naming that … I recognise that I am a man and that might potentially change your experience and I really hope we can talk about that' (C17). Even so, C15 believed a male counsellor would find working in a female-dominated team with a female clientele 'daunting' and wondered how he might feel about 'not necessarily having other men and … like be outnumbered' (C15).

Possible benefits of male counsellors

Despite their concerns already discussed, the counsellors thought having a male counsellor could be beneficial if SASs managed the issues this raised. Despite their perception that female counsellors were better able to connect with female service users, they nevertheless saw some benefits in having male counsellors, who:

- Promoted healthy relationships between men and women by providing a positive male role model and opportunity to have a safe relationship with a male.
- Corrected the misconception that all men were perpetrators.
- Offered a male perspective.
- Offered a male voice in the community.

Promoted healthy relationships

All the counsellors thought having a male counsellor would model and promote healthy relationships and boundaries with men:

> Be good for them to have a positive experience of a healthy relationship … with a man (C1).

> It's actually probably quite worthwhile having men in our service because a lot of, especially the women who have experienced historical sexual assault … and have had ... maybe several, which we see often, bad relationships after that … they've never in their life, often I find, experienced a healthy relationship with a male … They could learn what is a good relationship with a male for the first time in their life … This is what I'm hoping that that would give us (C2).

> It gives them a safe space to be exposed to a really positive interaction with a male over a long period of time in our services (C3).

> It gives victims a positive male role model, which is a huge benefit (C4).
>
> Here's your experience of a man who's completely abused you and you know taken away your trust … as an ideal male here's somebody whose maintaining confidentiality, being caring, being attentive … being a trustworthy male … creating that alternate experience (C10).
>
> I think healing, where abuse happens with men and relationship, then healing can happen in a relationship as well, and so that a male can do some really good work around that, if they are a safe person (C12).
>
> A positive role model within a male (C14).
>
> Giving women … a different experience of a male role model (C15).

An important component of modelling a healthy relationship was promoting effective relationship boundaries and connections. Because sexual assault is a crime of boundary violation, and because of the fragile *persona* of trauma survivors, it was important to 'keep the boundaries really clear' (C2). Female service users, especially those who had experienced childhood trauma with consequent attachment issues, often did not have well-established boundaries and this could cause difficulties. They might:

> Perceive the response from the male counsellor as something a bit more than just that professional relationship (C14).
>
> I was just thinking about the LGBTQI … like what if we had a transgender counsellor (C6) … [or] you know if you have a stereotypical attractive counsellor do you then run the risk of clients falling in love or that you know those other kind of risks that are out there? (C10).

Counsellors expressed concern about how to develop a safe and respectful relationship with well-enforced boundaries in the first place. They accepted that it would have to develop gradually, but would be very difficult to establish:

> [There might be issues with] transference and counter transference (C6).

> I think this sense of access to a trustworthy male, that could just go haywire very quick, that's a huge thing, how do you, how does someone come in and say 'look, trust me, I'm a male but I'm trustworthy' … I don't know how that would work (C11).

Effective therapy rested on developing respect, rapport, positive engagement, connection, and strong boundaries, regardless of the counsellor's gender:

> Trauma-informed care in general … is about connection, isn't it? (C15)

> If you're thinking of it from a female perspective that may be a bit anxious about seeing a male … there would have to be first of all respect and building that rapport with the male (C16).

The counsellors further observed that modelling a healthy relationship with a male was one area of therapeutic experience only male counsellors could do. Although female counsellors could discuss and explore healthy relationships with a male, such conversations did not carry the same weight as entering, growing, and experiencing a respectful, healthy relationship with a male. They also suggested that learning and experiencing this in therapy would flow into the service-users' real world and, hopefully, prevent them from forming further unhealthy relationships:

> [The service user then develops an idea of] who they are safe with, what that feels like, and then being able to take that and practice that out in the real world might be the

> difference with these people that are perpetual … getting into these relationships that are dangerous (C2).

The benefits could extend beyond counselling to groupwork, which might suit women who felt uncomfortable with a male counsellor:

> Have a therapeutic interaction without the trauma narrative in the room and have that healing experience with a male present … debunks some of the myths around sexual assault (C3).

> [A male counsellor could act as] a male advocate in a system (C6).

> Imagine having a male counsellor that could go to the schools … and have these conversations … [This could lead to] a cultural change because that's what's needed (C10).

Some counsellors thought children and significant others, particularly fathers, might also see the male counsellor as a positive role model (C14):

> They'd be a really good support … for our male carers … they'd be great (C3).

> It could be that you have a couple come in, if you have a joint session with a male and a female worker … it could be really worthwhile … you'd find lots of openings if it could happen (C16).

As a positive role model, the male counsellor would convey important messages about healthy and respectful (and unhealthy and disrespectful) behaviours:

> I don't know how we get a person to see a male but, if we're able to do that and they were able to have … a different perspective from a male [might be helpful] … It's not

> just role modelling of a male. It's actually them working with this client about abuse and about the dynamics of sexual assault and how it's not okay (C16).

Despite this optimism, the counsellors remained ambivalent: 'The benefits that our service or our clients could get out of having a male advocate … male role models … I don't think it's a good thing … if you looked at it in an individual basis' (FG1). Some counsellors struggled with the idea of male counsellors believing this might be very difficult for some female service users. For others, even if women did not wish to consult male counsellors, their very presence could promote models of healthy interaction between the genders as more male service users engaged with the service (C3, C13, and C14). The Inquiry into Responses to Institutionalised Child Sexual Abuse at the time of the study revealed a high incidence of child sexual abuse among male respondents who had not disclosed this before:

> [The inclusion of male counsellors might] encourage more male victims to come forward because they know they are going to a male counsellor (C13).

> It would be really good, particular highlighting for male victims or survivors to come forward, so I think it would probably assist male victims of sexual assault to come forward and not be so embarrassed, so to remove that stigma (C14).

Corrected the misconception that all men were perpetrators

The counsellors saw the potential for a male counsellor to correct the misconception that all men are perpetrators merely by modelling a healthy relationship in counselling:

> In our service [it] would be good to show clients … we have the balance, because that's what's normal out in the real world … We're, oh, no males, but I don't think it's really healthy in the long run, for anyone … If we had male counsellors, it would be showing that we believe that not all males are bad. Because … sometimes that's what comes

> across from us being all very female … it's hard for men who aren't perpetrators to … feel this awful responsibility and burden that it's all men (C2).
>
> If we can then shift your mindset so that not all men are viewed in the same way … We can talk until we are blue in the face in a counselling session about how not all men are abusers but … that's kind of the bricks and then you need the experiences to act as the mortar to solidify that shift of mindset (C3).
>
> It challenges the thinking that it is only women's problem (C4).
>
> I do wonder though … about the possibilities … in terms of when we are talking about creating an alternative, like getting them to kind of go back to see the world as safe and not every person is a perpetrator, and that some men can be trusted (C10).
>
> To have a man sitting in the room, where they're doing something right ... that's busting some of the myths around sexual assault (C12).
>
> Violence is very much a gendered phenomenon [for] service users and how it's … spoken about in the media and … having males as part of the service challenges that and … the idea that … men can work constructively and safely with women … Just having a male in the service is a powerful message in itself (C15).
>
> Because, you know, in sexual assault, it's so easy for people to view that all men are perpetrators, where, then, if you have a therapeutic relationship with a male, then you've got that length of time to see that he's a male role modelling respectful behaviours that aren't abusive (C16).

Being an all-female workforce might reinforce negative stereotypes of men as perpetrators. This made it more difficult for men to address and challenge that myth and increase their sense of responsibility for these offences. To have male counsellors in SASs could also contribute to

men's understanding of violence against women and, therefore, assist in challenging this form of oppression and society's structures that continued to allow it to flourish: 'We want men to be able to stand up for women and, I think, if they are educated in what's really going on for women, they're more likely to, but if we close them out, we're not going to get them on our side' (C2).

C3 and C14 compared the field of sexual assault to domestic and family violence, observing that, in the latter, there was a movement towards, and acceptance of, male workers. They noted the domestic violence field had:

> Taken on board that just because it's a gendered crime with predominantly male perpetrators doesn't mean that men also can't lead the … solving of this problem and I think that having a male would really kind of blow that idea out of the water… that we can't, that men are the problem not the solution (C3).

> I can see a plus side because it's showing and I suppose it reflects back on to those kind of typical arguments with males working with dv, like survivors of dv that they can represent ... and remove that stigma that all males are bad (C14).

Offered a male perspective

Some counsellors saw benefits in a male perspective:

> Because it's such a female-dominated area … we don't … ever get that opportunity to see how males … view the whole situation … it's very one way … so we're getting always the female perspective but I don't know if that's always healthy (C2).

> Input is quite good on a male perspective … having a presence of a male counsellor [in other service] is quite positive (C14).

> Male counsellors … provide that different experience (C17).

Both C14 and C16 saw positives for service users and the team in having a male perspective on parenting issues. Having a mix of genders in a team could benefit the whole service: 'that is always good, I guess, that diversity' (C17).

Because male counsellors might hold more sway than female counsellors in the workplace, the female counsellors perceived benefits of men advocating for women and educating other professionals and managers, particularly males in higher positions, though acknowledged that playing on male privilege in the organisational hierarchy was 'a double-edged sword' (C10):

> Men talking to men … in higher roles [might help them] … see from our perspective. If they're here on the ground and know what we are going through and what our clients are going through and they're sitting in those higher management powers, can they advocate, can they get us more cash, can they get us more resources (C10).

> I'm not saying this is right, but I have noticed that men, on occasions, do listen to other men more than sometimes they'll listen to women (C16).

Offered a male voice in the community

C1, C14, and FG3 thought male counsellors would be ideally suited to a community development role. C14 believed a male voice 'would have a really positive and probably a much stronger impact on … no violence … because they see another male saying it, it's not just like a female pushing it'. FG3 considered that male counsellors reflected community diversity and saw benefits in the community 'being able to observe the change of services over time and respond to the community needs' (C17). For C17, having male counsellors in SASs also challenged the view that sexual assault and abuse was a women's issue and could assist with shifting community's perceptions of who was responsible for this crime. C17 noted a sole focus on women made sexual violence a women's issue, when responsibility was 'a much

broader issue'. There was a need to shift responsibility 'from victims to perpetrators' and place the emphasis 'on men to address it in any form whether that's working therapeutically or addressing their own behaviour in their homes … by having that option … again challenges that notion … there is a role for men to play in supporting survivors' (C17).

Ongoing relevance of feminism

Not one of the counsellors thought that feminist practice was no longer relevant to SASs, despite changes over the years. They believed that, despite the challenges, SASs remained rooted in their feminist origins, due to ongoing education and consciousness raising.

Feminist origins

Some counsellors believed the feminist origins of SASs remained intact:

> It's the feminist movement that's put sexual assault on the agenda and brought sexual assault out into the open (C1).

> I know a lot of those people who drove that initial set up of sexual assault, are still driving a lot of the work now whether that's just within health or other key agencies … there's still a lot of females who are really protecting those ideals … to hold on to something that they worked really hard to achieve (C12).

Central to these ideals were SASs that supported women and gave them a voice. The imperative of fighting for women's rights remained paramount and educating the community and raising public awareness about sexual assault and violence against women generally. Counsellors identified these ideals and values in their practice and their understanding of the feminist framework.

> It's still quite central ... I'm a feminist. I can't see any other way forward (C2).

> Because if feminism is around allowing choice and control and knowing your rights and being empowered, then, yes, that's still relevant (C12).

> Only because the stats show that a large percentage of survivors are females and the perpetrators are males so it goes back to … [the] need … to help them regain that control so … definitely still needed (C14).

> It's even just that idea of being a human being in the world … that we're obviously talking about human behaviour and connection … The crux of what overrides our work always … comes back to feminism, whether we're working with males or females (C15).

> Raising women's voices and … increasing their rights and access … [It is] about equality generally … There's a huge … capacity for feminism to inform some of those experiences and externalise that, so rather than the person sitting there and internalising that this happened because of me … this is actually about the world I live in and what is considered to be acceptable or not (C17).

Education and consciousness raising

As noted above, education and raising awareness was a key feature of feminist practice and central to the historical origins of SASs. Counsellors in this study saw this as an important part of their practice, affirming its currency within a feminist framework:

> The shame and guilt part of being a victim is so huge and trying to re-educate people and change that thought that the victim isn't to blame (C2).

> I think acknowledging that, we do, and we do quite well, throughout the counselling process but particularly when we are looking at grooming and that sort of stuff with

clients and how the perpetrators created opportunity for them to do what they've done (C3).

All the psychoeducation we do … is around … the imbalance of power and I provide statistics around perpetrators, females and men, the imbalance in the legal system … also you're talking about … some of the myths out there, media, that's all gendered and patriarchal … all the messages we give around dispelling myths and stuff is very feminist (C5).

It's fundamental to the educational component, you know the psychoeducation (C10).

The whole framework is about empowering, giving back that power, whether that's through education … providing different strategies around how to cope with the trauma (C14).

You may not always use the words feminist or feminism, but we're talking about their experiences in that gender and what it means to be female … I don't think a day goes by that I don't talk to my clients about their experiences within the context of society and being a female in society and what that means … looking at the relevance of rape culture to their experiences of sexual assault (C17).

C2 believed education was part of the 'fight for the rights of all women in all areas of the community'. She highlighted her involvement in 'women's rights campaigns', running education groups about domestic violence and sexual assault (co-facilitated with another service), and information and awareness raising about consent, including programs like Lovebites developed by NAPCAN. Keeping up to date with research and literature was an important requirement for education programs with service users (C2).

C3 noted the requirements for sexual assault counsellors included social work and mandatory specialist training from the Education Centre Against Violence (ECAV), a NSW Health-provided training organisation in Westmead. Besides specialist training for Health sexual assault counsellors, ECAV developed and delivered violence prevention group training sessions to health and allied professionals.

Threats to feminist practice

The main challenges arose from changes in SAS policy, management, and practice, among them the entry of male counsellors and the shift to trauma-informed care. Counsellors reflected on these changes within SASs. For some, the changes had been 'really slow' (C1), while others had not been in the service long enough to comment: 'I don't know if I've worked in sexual assault long enough to give an answer' (C12). Some observed changes relating to sexual assault matters in the legal system and in the way in which it gathered forensic evidence, particularly in trying to maintain a DNA-free environment in which to collect the necessary specimens from victims who had just experienced an assault. Some saw positive changes in the focus on crisis counselling and face-to-face direct support for victims and survivors (C1).

Also, research into the field of neurobiology and its connection to trauma (i.e., how trauma affected the brain) was an evident change for SASs (C1). One counsellor explained how she saw the link between a feminist framework and this recently emerging data. She stated that it helped to highlight that women were not 'abnormal' or the 'other', but rather women's experiences of their lives, and how they felt about and perceived things after a trauma, were relevant and explainable by science. For her, the feminist connection did not mean 'we're better than anyone else'. It meant hearing women in the same way that 'men have been heard historically'. For her, feminist practice meant:

> Seeing women's responses and reactions to sexual assault as not catastrophising, dramatising, this is, this is trauma and … a lot of the work that people have done with Vietnam vets coming back from war and seeing the similarities between their trauma response and women's … trauma response to rape has really helped us, because it's shown yeah that this is a really damaging thing to people's brains, it's not just something that … I'll get over (C2).

C2 also saw Aboriginal women seeking support:

> That's helped … in the Aboriginal communities [where] there's that … awful thought well … it happened to me get over it, you'll be all right and grow up and you'll be fine but that's … hopefully, gradually changing as … more Aboriginal women are coming forward and getting help as well (C2).

C11 considered the increase in media and general community awareness as positive: 'It's more open in our society' (C11). C3 considered a change, not for the better, was that counsellors were 'less feminist [than] what we used to be'. Newer workers were less inclined to be politically active and vocal. Previous workers were:

> More proactive and vocal … than we're able to be … It comes down to time … We're probably still functioning at the same number of hours in positions as they were but with a lot more clients, a lot more pressure (C3).

Many of the counsellors agreed that the demand for service had increased over the years:

> Another increase we have seen over the years is the number of clients (C11).

> The need for counselling service has increased dramatically so that [there is a] lack of resources (C14).

> Everyone gets it, everyone's … busy (C15).

> [It is] getting harder and harder … with the number of intakes that are coming in … Everyone's under the pump (C17).

Discussants in FG1 thought increased demand had led to waiting lists with immediate access to counselling limited. The huge growth in client demand without a commensurate increase in resources had made a big impact on service delivery: 'We're not providing a service that's quite flexible for our clients' needs to heal … we're just not providing that flexibility for the individual's needs' (C14).

While FG3 discussants thought there was still flexibility in the work provided and no specified timeframe in which to conclude counselling, there had not been an increase in staff for many years, despite the increased workload. There was less time for community development, education, and awareness raising. As one counsellor explained: 'The number counters … don't prioritise that because it's not something that they can collect a statistic on' (C3).

There was less time for prevention and early intervention and groupwork and for preparation prior to consulting with a service user. Despite the increasing complexity of the work they were seeing, including an increase in 'significant' child protection factors, 'we don't get extra resources' (C17). FG3 discussants thought interagency partnerships, such as JIRT (Joint Investigation Response Team), now known as JCPRP (Joint Child Protection Response Program), and the Health Child Wellbeing Unit (CWU) were a positive change: '[CWU] provides a great resource for us as well, to consult with and … it helps me to have … a stronger child focus' (C17). In addition, FG3 discussants mentioned changes in FACS (Family and Community Services), now known as the Department of Communities and Justice (DCJ), threshold of reporting risk of significant harm rather than reporting risk of harm, and the flow-on effect of this on SAS work: 'The way that the child protection sector is structured so with

FACS … changing their threshold but also being so overwhelmed and under resourced themselves that that has a flow on effect to our work' (C17).

As with a lack of resource growth over the years, the training budget had not increased to enable counsellors to keep up to date with the research and literature in the field: 'We don't have a budget for training or for resources … I've certainly seen health tighten the purse strings and there has been less and less available for workers' (C1). Professionals were less inclined to work for SASs or to remain in the service, due to inadequate resourcing that was 'incongruent' with a feminist framework: 'People coming into sexual assault services obviously have an interest in this area or a passion … and I think worker burnout is around politics … rather than the work itself …. Workers aren't supported enough to remain in this work' (C1). C1 suggested that such support inhered, for example, in the provision of paid external supervision for SAS counsellors. FG1 discussants also felt the connection between SASs throughout the state had been 'eroded' over the years which then diminished the 'feminist perspective [and everyone] working from the same framework' (C8).

In contrast, C16 described the connection maintained between local SASs as positive: 'That still works really well, I think that, that hasn't changed over time'. However, she admitted that, due to workload demands, often they were unable to attend the meetings, which no longer occurred as frequently as before: 'I haven't been able to get to the [meeting] but I think they're good to go to for networking you know, and I think it's only because of the amount of work we're all doing that they're, they're bimonthly now' (C16). C16 saw involvement in other meetings as positive, having felt 'quite isolated' previously. A further change identified was the influence of pornography on the nature of the work at SASs: 'I don't think you can not acknowledge the access to porn and what that's done to this generation and our young females and what that they think sex is and what sex looks like' (C10).

The main change for C12 was ‘male counsellors, definitely’ (C12). C1 believed, if the pool of potential applicants was broadened by the addition of male counsellors, they might see speedier recruitment for positions, as many openings remained vacant, because of a lack of suitably qualified workers: ‘Some of our positions are very very difficult to fill; some of them have stayed vacant for years because we can’t fill them with suitably qualified females’ (C1). C3 said she would like to see counsellors becoming politically active once again:

> Back then … feminists were viewed as men-haters, which is not true, but there was something about being female and … vocal that lent itself to being called a man-hater … That was used to attack the credibility of our services, at times, and … undermine the professionalism … It would be good to be able to be out there doing that with a … much more evolved society that now doesn’t view people being a bit political and having a say as being a man-hater (C3).

Looking forward, C2 hoped that SASs could continue to keep women’s voices and issues central, while also acknowledging that men could be victims of sexual abuse and assault: ‘Having a female perspective … taking into account that men are also victims is a really good way of looking at our bigger picture’ (C2).

Despite past and impending changes, the counsellors noted SAS employment criteria still fit the feminist ‘female-only’ framework: ‘Yes, it is still very specific’ (C13). Further, human rights and social justice lay at the heart of the policies and procedures for the empowerment of women: ‘In terms of our policies and procedures, we are still operating under the same ones that we were when I started … I think it’s quite ridiculous, although most of it is still quite relevant … but, yes, certainly very outdated’ (C1). Nevertheless, there had been challenges to feminist practice through prioritised service-user agreements, where adult survivors of childhood sexual abuse were lowest on the list of priorities, and changes in management. Some lamented the lack of consultation between policy makers, managers, and

practitioners at the coalface, which resulted in policies out of touch with the lived experience of service users. C5 believed female managers did not necessarily support feminist practice:

> I see women in power abusing it, because these are all women, and I'm talking women that worked in a sexual assault service as a counsellor, 20 or 30 years ago, now making decisions 'cause they've lost touch at the Ministry because of the pressures from the Cabinet down … and … notoriously, we tend to believe it's more men than women but, when you actually do see it from women, it is really sad, because it impacts then on the service that is trying to work from a feminist perspective … The bigger system is not feminist friendly … As much as we try to be feminist friendly, we're working in a system that just can't be … Not all women are feminist either, not every woman comes from that approach, but there's a sense that, because women have worked in that area before, then obviously, they know about that feminist approach but … it gets lost as they get up into that management level … We're working in a system that's quite an anxious system … it's a pressure cooker in a way (C5).

There appeared to be a fracture in the system between management and frontline clinicians:

> Turnover of staff has changed, the structure is now more about numbers, more demands from management to counsellors about paperwork, now it's more admin than seeing clients, consulting takes money (C4).

> It's all the administrative stuff that now is an expectation that is taking all the time (C5).

> [Lack of] understanding [from management] of what we do, too, because something that is taking us with these policies and stuff away from our core business is all this documentation and stats trying to prove what we do, and that we're effective (C10).

> It's … become finance based rather than client based (C11).

FG1 discussants noted that, while feminist therapy could sit within a trauma-informed approach, this did not mean feminist practice remained a priority, even though 'the feminist stuff does sit underneath it' (C5). Some counsellors were confused as to how these frameworks could work together, when the 'policy and the framework … is more around the systems and the trauma-focused stuff' (C10). 'In general, we are working with [a] trauma focus a lot more' (C11). The counsellors felt ill at ease managers' – at different levels of management – understanding of the feminist framework underpinning SAS policy: 'The people on the ground, who are trying to inform from the bottom up, have no voice … and that's really disempowering and really disappointing … because we've worked hard' (C5). C9 saw management as a 'dictatorship': 'Management get up there … and that whole consultation process [feminists valued] gets completely left out' (C9). C16 agreed that the service system was not as feminist as it could be. Proposed changes to provide flexible working times for SAS counsellors with family and carer responsibilities and enable service users in full-time employment to access services had been unsuccessful.

Other gender-related issues

Workplace relations

The counsellors talked about the impact of unequal gender relationships in the workplace. FG1 discussed how patriarchy and male privilege affected men's and women's positions in the organisational hierarchy. They believed men would be promoted at women's expense, due to the presumption that men were more knowledgeable and capable than women:

> In our hierarchical system, male social workers and male psychologists … go straight up to management … Everyone just assumes the man is the boss and, often, the man *is* the boss, unfortunately (C6).

> If we introduce men into our service that … diminishes the pathway for … women … to step up into those positions (C9).

> Men move very quickly through the ranks into certain specialist roles without always having the right credentials, so there's a little bit of worry around that (C12).

Counsellors expressed concern that they would have to defer to 'expert males': 'When there is a man in the room … suddenly … he's the expert' (C6). Though they challenged this daily, they still had to live with it (C5).

The counsellors believed organisations favoured men because they were less likely to take extended (paternity) leave and, unlike women, would seldom return to work in a part-time capacity:

> If you think from an organisational perspective, I guess you know benefits of having a male that is a benefit to a service ... because, when you think about it functionally, our clients want to come and see somebody consistently; they want somebody to be here regularly. The males are taking less time off to take care of the kids when they're sick because that's left to their wives (C10).

Counsellors compared their situation with that of other female-dominated professions, such as teaching and nursing, which granted male workers further privileges because of their minority position: 'The males are treated with even more privilege and … poached and given positions of power, because there aren't so many of them' (C10). Opening counsellor positions to men and removing the female-only requirement might 'change the balance', especially if males were 'put into those very small single-service or two-service positions' (C8). It might also change the focus and content of their work with males reaching management positions and making decisions surrounding service delivery and counselling practice. They wondered whether they would end up 'doing more court stuff [and] … professional … side of things'

(C10) and were concerned that law courts might give more weight to male 'expert witnesses' (C6): 'Would their evidence be considered more ... than ours' (C10).

For some counsellors, the introduction of male counsellors would compromise the fair distribution and management of caseloads within the team:

> [A male counsellor] might seem like having a token male or seen as taking female positions (C4).

> There certainly were instances in my last job where, for whatever reason, one of the men couldn't take … particular clients. There were workload issues, so I imagine there would be workload differences (C12).

> Workload balance would be very, very different … The male counsellor might not expect as many clients as we would have (C13).

> You may have … one person in the team with only a few referrals … the other two would have a higher workload (C16).

Counsellors also wondered how the organisation and management would handle differences in caseload between male and female counsellors and questioned whether it was 'viable for them to have somebody … who only gets two clients' (C13). They highlighted the importance of 'good management skills' and avoidance of 'favouritism' (C4) and wondered whether a male counsellor might be trapped into only seeing male service users rather than having a diverse caseload:

> Like clients declining a male counsellor and that then … contributing to the worker only getting … a very narrow … range of clients, because … we know that having a diverse caseload is important as part of … sustaining your practice and developing your skills (C17).

To conclude this section, there was some concern that the inclusion of male counsellors might sustain male privilege in the workplace and result in unequal caseloads. This would make it difficult to balance workloads within the team.

Cultural appropriateness

Many counsellors stated explicitly that, *due to gender norms and expectations*, it would not be culturally appropriate or acceptable for Aboriginal women to consult a male counsellor (C1, C2, C4, and C9):

> It would not be culturally appropriate to have a male sexual assault counsellor … Victims wouldn't want to see him, wouldn't want to discuss certain aspects of their history (C1).
>
> Aboriginal women would prefer to speak to another Aboriginal woman or someone that they felt comfortable with (C2).
>
> Culturally it is about Indigenous women not talking to a male about women's business (C4).
>
> I think culturally it's a real barrier, I think you … wouldn't get past that culturally (C9).

Non-feminist legal system

Looking more broadly, some counsellors identified court-provided support as feminist practice in action, though, generally, saw the legal system as 'so not feminist' (C3): 'Even when it goes to court, that's starting to look more into the feminist approach with the providing the safety, and putting those kind of protective factors in for survivors of sexual assault' (C14). However, C3 noted the (dis)connection between SAS interventions and a non-feminist legal system that stifled feminist input:

> We support our victims going through that process and it's often sometimes paralysing because you almost imagine that you can bring a feminist perspective to the legal system for them, like kind of be that window of … things not being so male dominant … the legal system is the legal system is the legal system and that's just the way it is and there's not really a great deal of room to move (C3).

Conclusion

This chapter outlined the female counsellors' perspective on male counsellors and feminist practice in SASs. Overall, they expressed more negative than positive sentiments about the prospect of male counsellors in SASs. They expressed some hesitation and, at times, reluctance about the idea of male counsellor entering the counselling space, and spoke to particular challenges if this were to occur in rural or remote areas. However, despite their concerns, they perceived benefits in having a male voice in the workplace and community. Though having a choice of counsellor did not fit neatly within the historical structure of SASs, it cohered with inclusive feminist practice. They believed male counsellors were better placed in ongoing counselling than in the acute crisis phase. They would be more acceptable if they displayed 'feminine' qualities like kindness, empathy, approachability, compassion, caring, a gentle manner, respect, and power sharing and used their generic skills within a feminist framework focused on choice, empowerment, safety, power imbalances, and male privilege. All attested the ongoing relevance of feminist practice though agreed that management no longer supported political activism, groupwork, or community interagency work. All emphasised increased workloads and referrals without commensurate support from managers that did not understand the complexity of service-users' lives. Despite the policy changes toward trauma-informed practice resulting from advances in neuroscientific research and the theory of complex trauma,

the neoliberal thrust to do more with less prevailed. The next chapter presents the findings from the service users.

CHAPTER 9

Findings: Service-users' perspectives

It's less about the gender of the person and it's more about the connection that you are able to make with them (Gwynneth)

They tell me what it involves and give me ownership of agreeing to this … They are very factual in how to move forward and not just by talking about it … There was no more wallowing … There is no judgement. There is acceptance (Tanya)

This chapter describes the findings from the interviews with the service users. As already outlined, all had had an experience of a male counsellor in external services, as the presence of male counsellors in NSW SASs was rare. The main themes identified were:

- Perspectives on consulting a male counsellor
- Positives of consulting a male counsellor
- Negatives of consulting a male counsellor
- Feminist principles in counselling
- Advice to other service users

Perspectives on consulting a male counsellor

Exploring gender issues in sexual assault counselling, as this study did, implied questions surrounding whether the gender of the counsellor mattered. The service users talked about the sensitivities and complexities surrounding their experience of male counsellors working in

sexual assault. They also reflected on what led them to consult a male counsellor in the first place. Having direct referrals to a male counsellor, Em, Becky, Gwynneth, Shirley, and Toni felt they had some choice in the matter:

> I called victims services and asked them if I could change counsellor and they said, 'yes', and then they came with male counsellor… and I said, 'okay, I try' (Em).

> GP then sent me to a psychiatrist … he was male so that's sort of how I got there … I don't think there were any female psychiatrists in the region I lived in, a little bit rural, so, maybe there was only a few to pick from anyway … I don't even think I got the option to see a female psychiatrist, it was just here you go, go see this guy … I did say to mum … 'is there a female we can see'. I think I actually said that to the doctor … and she's like, 'oh, unfortunately, the closest female is in [area]' and that was just going to be too much sort of pressure and time and stuff on mum, as well as … around school and … as it was, some of my appointments were during school hours, so I had to get a special letter … it was just too difficult, basically, to get to [area] … I think, if I had … only known men to be absolute assholes … I would have (gone to [area]) but because that was the only really horrible … person I'd had in my life that was a male, I was like, oh, okay, we'll give it a try (Becky).

> I was seeing somebody else, but they were privately run, and I had gone through my free sessions … they put in a form so that … because of the extended trauma, I would get as many sessions as required … Because of location, it was easiest for me to get to [the male counsellor] (Gwynneth).

> I went to my doctor to get the next … 10 sessions and that was when I was referred to the male counsellor [through the mental health care plan] … at that point, since previously already going through therapy, I felt quite confident in speaking to a male

about it … because I'd already had the initial … steps and … foundation [with a female therapist, which was very helpful] I just … needed some support and somebody to … … re-evaluate why the triggers are happening, and how to … cope with it [sic] (Shirley).

It was … random. I said I don't care. I was more interested that they could bulk bill and all of the other financial pressures and it wasn't until after I got there that I clicked that I've had better experiences with male counsellors than female … so there was no real strong emotion either way … I used to do that; it gets tiring … and then you end up disappointed (Toni).

Figure 9.1: Case vignette - Toni

Toni had engaged with therapy in private and government services, since the age of 13 years, for anxiety and depression, though she had also sought support for sexual abuse and assault, when needed. Her GP had referred her to a male counsellor via a mental health care plan. Until she met the male counsellor, whom she had been seeing for the past three years, she felt disenchanted with the whole counselling process and helping system. She was still seeing the male counsellor at the time of the research interview.

Jackie was already consulting a male counsellor about other issues, when she decided to discuss her history of abuse with him: 'I was referred to him … by my GP … through the mental health plan … now I see him under NDIS' (Jackie).

Figure 9.2: Case vignette - Jackie

Jackie had first received counselling from a government SAS when she was a teenager. Over the next 20 years, she had been in and out of government therapy services. Five years ago, she started seeing a male counsellor privately following a referral from her

GP via a mental health plan. The issues arising from the sexual abuse in childhood had continued to emerge through the years and had led her to re-engage with therapy as needed. These issues had contributed to, and influenced, other aspects of her life for which she had sought support from other services, such as mental health and family counselling and support services. While she was consulting the private male counsellor about other general life issues, the focus of counselling returned to her experience of childhood sexual abuse triggered by a family member's disclosure of sexual abuse. At the time of research interview, Jackie was still consulting the male therapist under the NDIS.

Victoria had chosen a male counsellor she knew through her mum because he was familiar with her family history:

> I wanted to talk about my fears with a male … I didn't really have any … idea … how [he] was going to [help], or what I was going to get from him. All I knew, within myself, was that it's a problem … I thought I was okay and this anxiety and fear … resurfaces … I don't want to continue to experience that and, so, talking to him about it and being open, and being vulnerable … and sharing these uncomfortable … unpleasant experiences with him because I never talk to males about this before … I need to let these things out with a male to know that I'm okay … because I'm challenging myself, I'm getting out of the comfortability … I just thought it would help because I do want to feel comfortable and … confident in the company, in the presence, of men and … thought I'll just go and see [him] (Victoria).

Figure 9.3: Case vignette - Victoria

Victoria had engaged with over five female therapists, seeking support for domestic violence related issues. She had recently commenced therapy with a male counsellor known to her mother, as he knew her family history. Victoria had been feeling well,

however re-engaged with therapy when she began to feel anxious again. In therapy, Victoria developed and practised strategies to manage her anxiety, address trust issues, and build safety and respect in her relationships with men. She was still seeing the male counsellor at the time of the research interview.

In contrast to the other service-users, Patricia and Tanya felt they did not have a choice in the gender of their counsellor. Patricia said, 'I did not feel like I had much choice in seeing him - he was highly respected psychiatrist'.

Figure 9.4: Case vignette - Patricia

Patricia, aged in her 50s, had received treatment in a psychiatric unit when she was 23-years old. She had experienced childhood sexual abuse perpetrated by a family member. During her stay in the unit, she had engaged with a young female psychiatrist whom she found to be understanding and respectful. Once discharged, she returned to the country town in which she lived. Following a referral, she consulted a highly respected male psychiatrist feeling that she had little choice in the matter. This engagement did not go well for Patricia. Unlike her previous psychiatrist, she found him cold, difficult, and destructive. Nevertheless, she continued to see him for counselling and medication review, hoping things might improve, all the while wondering what she was doing wrong to receive such a negative response. Patricia felt he did not listen to her but would sit at his desk and write. On one occasion, he had taken a phone call during their consultation. This was the last straw for Patricia. She realised she had not done anything wrong and decided to stop seeing him. However, due to this negative experience, she had not sought counselling again for another 10 years. During that time, she had not spoken to anyone about the sexual abuse and suffered from suicidal thoughts and self-destructive behaviours. It was only when a close friend expressed concern and encouraged Patricia to access counselling again that she sought support from a female counsellor. It was then she finally began to heal.

Tanya's female counsellor had 'left suddenly and he had space on his books … not my choice'. Nevertheless, therapy was a positive experience for her. Now, her preference would be to see a male counsellor.

Figure 9.5: Case vignette - Tanya

> Tanya commenced counselling in her 20s following several experiences of sexual assault. Over this time, she had approached government and private counselling services and had seen several female counsellors. Despite her negative experience with female counsellors, she had not planned to see a male counsellor, when her female counsellor suddenly left and a male colleague took her place. Nevertheless, she had found the male therapist helpful and liked working with him. One reason for this was that male counsellors had not judged her when she had disengaged from, and returned, to counselling. She remained engaged with the private male counsellor at the time of the research interview.

Helen said, initially, she was seeing her male counsellor for anxiety issues following her sexual assault. When it felt right to acknowledge what had happened and explore this further, she decided to return to him because 'it's just so much easier … he already knows everything … I didn't have to establish all that' (Helen). She thought it was not:

> Impossible for a male to be able to counsel a victim of sexual assault; whether they are a woman or a man … I don't think it's something that should be discouraged … no one should be forced to talk to a man, if they don't want to… You don't want to make people feel uncomfortable by having a male presence, but, also, that male hasn't done anything [wrong]. He's there to help (Helen).

However, she thought it important that service users had a choice in the matter:

It really … depends on the person [and] who they feel more comfortable talking to. I completely understand where … women come from, if they do not want to talk to a man … It should be the decision of the person seeking help and there should be options ... because it's such a broad thing. Not everyone's going to feel comfortable talking to a woman, the same as not everyone's going to be comfortable talking to a man … I definitely think there should be the option (Helen).

Figure 9.6: Case vignette - Helen

Helen had engaged with a male counsellor during her late teens and into her 20s. She had also participated in counselling as a child in response to family issues and difficulties she had experienced at the time. While in therapy for anxiety issues, Helen had experienced a sexual assault. She had disclosed this to the male counsellor she was seeing at the time. It had taken Helen a while to acknowledge and process what had occurred and that it was, indeed, a sexual assault. So she had only shared this information with her male counsellor a year after the event. She found that, because she had already established a relationship with him, she felt comfortable enough to explore this issue with him also. She had not felt a need to seek a female counsellor for support and had continued to see the male counsellor until things became better for her at which time her engagement with him dwindled, with sessions missed, until she finally stopped attending.

Jackie, too, thought choice was important, though believed that younger women seeking counselling should have a female counsellor. She explained:

You're going through enough as it is … forming a foundation with counsellors is hard enough, let alone when you are on this subject [sexual assault] … When they're younger, I wouldn't give them the choice. I would just throw a female counsellor at

> them but, as they're getting older … give them that option … would you feel comfortable talking to a male or a female? (Jackie).

Jackie acknowledged that being offered a choice and expected to make a decision about the gender of the counsellor could put service users in a difficult position:

> You can't assume either … The way I see it, the majority of people I've spoken to prefer to see a female, but when it's historical cases, I've got heaps of friends that are talking to counsellors and they are male and female (Jackie).

Jackie returned to the age factor:

> This is hard to say because … you can't predict [people's age], but when you've got an older-looking female counsellor, when you are younger [20 and under, it's] very hard to open up to an older female … when the counsellor is closer in age to the client … [the] user has more confidence [in her]. That's my personal experience (Jackie).

For some service users, it was not that gender was the issue but rather that counsellors were suitably qualified for, and experienced in, sexual assault counselling. This applied equally to other professionals, such as doctors: 'Everybody goes to university and learns the same stuff and they all do the degree' (Helen). For Helen, regardless of gender, it was important to be able to talk to a professional removed from, and not emotionally involved in, the situation: 'I didn't like opening up to my family because I didn't want them to worry. I wanted to talk to someone separate from that … and they're [counsellors] not going to get upset or worried'. Helen continued:

> It's not like, oh, I would have preferred a female police … I've never really been like that. Like even … with doctors and stuff, and they're like, 'would you prefer a female doctor?' No, they're a doctor … I am probably a bit too trusting in that sense … They're

> a doctor, they're not supposed to do anything dodgy. So … [he or she] sees this stuff every day (Helen).

Helen expressed reservations about making a police report, not because of concerns about the police officer's gender, but because she worried about the process and uncertainty: 'I was a little apprehensive when talking to the police because of sometimes how things go down but I was only there to make a report, not to file charges'. The counsellor's gender had not had any influence on Helen's experience: 'It was more about his character … it was never really like a gender thing … It's never been … they wouldn't understand because they're a man'. For her, the most important considerations were the counsellor's personality and a positive therapeutic relationship. However, Helen had found talking to a male about sex 'awkward', though thought it 'could be because … I was a teenager' at the time.

Gender was not an issue for Shirley, Helen, Em, Toni, Victoria, Gwynneth, and Becky: 'I don't see the sex at all, I just see them' (Em); 'there wasn't really much to do with him being … male, like it was very asexual, if that makes sense' (Shirley); 'I didn't put a lot of thought into the gender, I was, oh, what's the word I want, disenchanted with the concept by this point. Like I said, I've been shuffled between services a lot' (Toni); and 'over time, it went from me seeing him first as being a male to me seeing him as a psychologist who was male' (Gwynneth). Em thought some women would choose not to see a male counsellor even though, for her, the nature of the interaction was more important than the counsellor's gender.

Figure 9.7: Case vignette - Em

> Em, aged in her 40s, was a Thai woman, who had limited support in Australia. Her husband had sexually assaulted her; he was an abusive, violent man. She had initially spoken to her GP about the abuse. Subsequently, she went to a government agency that had referred her to a female counsellor. She felt uncomfortable with this counsellor;

she felt ashamed and judged. She felt that the counsellor was advocating that she hate all men because of her experience with her ex-husband. Em could not relate to this so she had started seeing a male counsellor in the same program, which she found was a much better fit for her. Once she started to feel comfortable with him, she liked that she could listen and learn from his male perspective. Em had also consulted a female counsellor at a government SAS and liked that she could hear both a male and female perspective so continued to see both counsellors.

Similarly, Victoria said, 'I'm just going to go with the flow … I just see him as another counsellor who I'm going to commit myself to and just take it from there'. For Becky, 'it wasn't a big deal that he was a male … there was no other … options [sic] … there were but they were too far away … wasn't practical [due to geographical distance to see a female clinician]'. Reflecting on her experience of meeting with the male counsellor, Becky said she had not:

> Thought about his gender after that. He was very soft spoken. He seemed really nice and caring and like not in a creepy way or anything like that. He seemed genuinely concerned that someone had done that to me (Becky).

Figure 9.8: Case vignette - Becky

Becky, aged in her 30s, had suffered childhood sexual abuse by a family member. She lived in a rural area so had limited choices in whom she could consult. She was 18-years old when she first engaged in therapy with the only psychiatrist in her area, who happened to be male. Thus, she felt she had not had a choice in the matter. She had also met with female counsellors from a government agency, who assisted her with court preparation. While her first therapeutic experience was daunting initially, Becky soon felt comfortable with him. The waiting area was calm and soothing, filled with candles and soft classical music, and the male counsellor had not resembled her abuser in any way. She found him to be caring and genuine. She ended her engagement with him as she could no longer afford his fees and had subsequently moved out of the area.

Though Shirley had been nervous about seeing a male counsellor, she said, 'once I set my mind to something, I'm going to do it, so … I'm going in … and then we'll sort of see how we go'. She had found the initial experience of talking to a new (male) counsellor 'slightly confronting', though thought this a common response.

Figure 9.9: Case vignette - Shirley

> A male who was close to the family and considered a family member had assaulted Shirley as a child; she had also been a victim of assault as an adult. Now in her 30s, she reflected on her experience with the male counsellor to whom her GP had referred her via a mental health care plan. She found this a good experience; she felt safe and respected once she had overcome her nervousness. She had continued to see him as she felt comfortable with him and found that sharing her story with a male was validating for her. It was not until she felt he had reached the limit of his expertise, lacking specific training in this area, that she ceased counselling with him and returned to a prior female counsellor, who had the necessary therapeutic skills. Shirley stated that if she had continued with the male counsellor, she would have lost confidence in him.

In contrast, the counsellor's gender 'definitely' had an influence on Tanya's counselling experience, as explained below. Finally, Helen highlighted that, just as not all men were perpetrators, so too was sexual assault not just a women's issue:

> To say that only women should be able to deal with it is … almost invalidating the experiences of people who might have experienced sexual assault from a woman or … a man who has experienced sexual assault from a man … Even though sexual assault isn't just a women's issue, it is primarily … It happens to more women than it does men and it's usually a man who does it, so obviously you probably don't need as many in that field (Helen).

Gender mattered at the acute crisis stage

Several respondents thought they would rather see a female counsellor in the immediate crisis, following an attack – perpetrated by a man – when 'the trauma was raw'. For Helen, seeing a male counsellor during this critical stage would have made the situation even 'harder to deal with':

> It would have been really difficult in the beginning so I probably would have preferred … a female counsellor … because it would have … felt more like an attack … I just would have been … a little bit more comfortable, … if I had a male counsellor … I wouldn't have … been able to recover … It would be a little bit more difficult … just because of the recentness of it happening … I'm sure that a lot of women … have … this distrust from men after that happens and … I'm sure it's the same the other way around. If it happened to a man, he probably wouldn't trust women, even if they weren't out to get them [sic]. It's … because your body … is telling you … it's dangerous … Your body doesn't really know. It gets confused after that stuff happens (Helen).

Likewise, Toni explained:

> If you're calling a crisis line 10 minutes after something's happened, you aren't at the point of wanting to progress. You need to immediately process and deal with that, then in that case, you might still be in that place where you only feel safe with someone of the same gender … Six months later you might be in a different place. Everyone has their own path of how they respond and that's something you'd want to look into (Toni).

Jackie stated:

> I'd prefer to be in a female role, if I was talking about the physical part of the sexual assault and if it was raw and it was real, and it was new … [With a] male counsellor, I

> would shut down because … the male has just done that act on me, so the last person I want to talk to is a male … but when it's an historical thing, and it's been spoken about, it kind of flows just that little bit better (Jackie).

Jackie returned to the issue of age, saying that, if someone had referred her to a male counsellor at the time of the assault, when she was still in her teens, she would not have gone:

> But then I would make no effort to see someone else, because I'd … feel, well, you're referring me to a male, well that means I've only got that to go from. You don't want to be a person to pick and choose a counsellor, when you're trying to deal with this … I know that that's something you can do, but you need to build that relationship and you can't try and build a relationship and go nuh nuh, this isn't working, let me try another one, this isn't working (Jackie).

Comparison with female counsellors

The service users talked about the differences between their experiences with male and female counsellors. Patricia preferred her female counsellor:

> She was lovely, understanding … 20 years younger, hippy like, cool, introduced herself by her first name. The male was Dr So and So … [He] was very cold … I was blaming myself and comparing him to the female psychiatrist … There is common knowledge, connection with [the] female counsellor; when walking in, she will understand regarding power … [She] had a feminist stance … open with not having the answers, message of 'I am here to listen' and the male counsellor did not have a feminist stance (Patricia).

Em, on the other hand, had connected better with a male counsellor and was put off by a female counsellor's negativity toward men:

> I feel like she hate men; she going to make me hate every man in the world … She just push … the men away … attacks male bad, and I feel uncomfortable … and I said, 'oh my god, if I keep seeing her, I will have no men around' … My friend take me to see her and my friend is male, and she says, oh he not good for you blah, blah. But he is my friend, not my husband … it's like all the men, all men bad … all men in Australia so bad blah blah. I did feel uncomfortable because, for me, you cannot judge anyone, until you know them … It not good what she say, that man is not good (Em).

Jackie found talking about sexual issues with a male counsellor difficult, especially when 'going into details … whereas, if I was with a female, it would probably flow just a little bit better'. Jackie found 'women have "the poor you" response … whereas men have the, okay, so what are the underlying issues and how can we deal with it' approach. She continued: 'I'm really not sure because I haven't seen an actual female counsellor in regard to the sexual assault'. However, she had consulted female counsellors on other issues: 'I don't want to sound cruel here, but I … feel with women counsellors, they're beating around the bush … They're not getting straight to the point. They're not being [direct]' (Jackie). It had been over two decades since she had last seen a female counsellor and had developed coping skills. She had 'learnt to manage it' and sort of knew what to do. However, she seemed ambivalent:

> I've probably had a better experience talking about it this time [with a male counsellor] than I have in the past with female counsellors … 'cause … with women … we feel sorry for 'em, whereas a man [was there] … to do a job … [and] not be personal … you do need that personal relationship with your counsellor but, with a male, it does make it just that little bit harder to say things that you wouldn't normally say, or that you would say in front of a female (Jackie).

Jackie was, however, very positive about her male counsellor:

> It's been a great experience; it's been a better experience … When you are dealing with a sexual assault of such a historical thing, you're at that point in your life [where] you don't care if it's [a] male or female. You just want to get it out there. You just need to offload it, and I think, in older women, it doesn't really matter … [However] even older, if you referred me to a male counsellor to talk specifically about this subject, I would find it very difficult to begin with, until I had that relationship confirmed, whereas with a female counsellor the story just flows.
>
> Interviewer: So, do you think it would take you longer to establish that relationship with a male counsellor?
>
> Jackie: Definitely, yep … My experience is, when I've spoken with female counsellors in this subject, the conversation flows because you're talking to another female who you … can relate [to] or understand, or have some kind of 'I get what you're going through', so you don't need that relationship, that's more important with a male counsellor … to be able to feel confident enough to be able to open up and say everything that you need to say and not be hesitant to say it because you're talking to a male, just so that you feel comfortable enough to go yep this is it, don't like saying it but that's it (Jackie).

Jackie thought it important that counsellors maintained their positions so if the client came back five years later, she could see someone who knew her history.

Despite her initial concerns about triggers, discussed below, Becky thought there were no differences between speaking to male or female counsellors: 'He seemed genuinely caring', as were the females she had seen: 'Personally I just don't see it … even now, if someone was to say to me, "oh, I'm going to refer you to a male therapist or whatever", I'd be, "oh, that's fine"'.

Gwynneth tended to compare herself to her female counsellors. She felt she could talk to them, but 'when it did happen, it felt like I was very ashamed. I felt like I wasn't good enough … whereas with the male counsellor, there wasn't really anything to compare to'. She continued:

> [It] was a big fear of mine – going in to doing psychology …. These … female counsellors … haven't had anything happen to them … they're perfect and I'm gross and it was just a thing of [name of counsellor] helping me realise that people have lives. Stuff happens and they're professionals and they can leave that at home sort of thing (Gwynneth).

In her experience, female counsellors tended to focus more on feelings than male counsellors:

> Whenever a female counsellor asked me, 'how do you feel', I would be like, 'I feel shit' …and he goes, 'okay, so what are some positive things that we can do towards not feeling like shit. What are some things that you enjoy doing?'. Yep, so whenever I'm stressed, I do that … He was solution focused … he would actively listen and, then, instead of coming back to it, he would look towards what could be done … so that I don't feel as bad, whereas with the female counsellors, they'd listen and then they'd ask, and then they'd listen and then they'd ask, and then they'd listen and then they'd ask. There was no … helping towards … [a] goal-orientated sort of experience (Gwynneth).

Figure 9.10: Case vignette - Gwynneth

Gwynneth, aged in her late teens to early 20s, explained that she had seen a male counsellor following a referral to a government organisation. She had not chosen this counsellor; her mother had made this decision for her, due to his accessibility. Gwynneth disclosed childhood sexual abuse by a family member. She had seen many

> counsellors throughout her childhood. She described the male counsellor she had seen as an adult as supportive and one of the better counsellors with whom she had engaged. She had stayed with him the longest. He was younger than the offender and the female counsellors she had seen, describing this as positive to her counselling experience. She had ceased counselling with the male counsellor when her depression had lifted and she was feeling well.

Whereas, Gwynneth's male counsellor had been 'understanding, empathetic, and supportive', Victoria felt freer expressing her emotions with a female counsellor. She tended to hold back with a male counsellor. However, on reflection, time had passed, and life was not as stressful as when she was seeing a female counsellor:

> I'm in a place where … I can just see these patterns … I can recognise it and … address it with him and bring these things to surface and … start to let them go, just get rid of all that, the hurt and … the person that I've become, that had become you know distant (Victoria).

Victoria did not see 'why a male would be any less effective' than a female counsellor, whereas Shirley found men offered a different perspective: 'I learned different things and different strategies from him than what I did with her'. Female counsellors had destroyed Tanya's faith in counselling:

> One cried. One focused on other issues, so I felt like I couldn't go into that issue. I saw three or four counsellors and it was like banging my head against a wall … Now I only go to a male counsellor … I hit a brick wall with the holistic approach from female counsellors … I can say I don't agree with them [male counsellors], and I might not go for a while, but then, when I return, I am accepted. With male counsellors, I am able to return and there is no judgement; there is acceptance. I tried this with a female counsellor but felt animosity there … It felt more like an experiment with female

> counsellors … [and] getting to counselling is half the work done [so with male counsellors] money is … well spent on getting better, value for money or value for work. They say let's talk about it, let's focus on [the] main issue and don't get distracted. For female counsellors, it's where do we start, when you have a history of childhood trauma and adult trauma (Tanya).

Tanya said that female counsellors had been 'emotionally moved by my story':

> One picked up a tissue and said, 'you're lucky to still be here'. It is too much for some counsellors. One harped on about some of her own values. For male counsellors, they can be quite concrete and certain, which I don't agree with, but they balance this by when I return, we can talk about it, if I have confidence or not to talk about it, and it's been okay. I had one say I don't think it's going to work. There wasn't any connection, but he was honest about it (Tanya).

Tanya found a 'different space with a female. It's all sensory and ambient, about empathy and unpacking, empathetic listener'. Male counsellors paid less attention to creating a 'soft and cosy' space. They were more goal-focused than nurturing:

> Let's get away from [the] emotional side. Let's look more towards a resolution. Their focus is: I want to hear what you want to say but where do you want to be in five-years … There is less verbalising of it with a male. They related to me and focused on the presenting issue … They conduct it like a business, they want results (Tanya).

Toni found it easier to work with a male counsellor. It was less textbook than 'how did that make you feel?':

> I found when I've spoken to female counsellors about this sort of stuff, there was a lot more, almost projection of how I should be feeling about it, how I should respond. I

> think they were just trying to validate the response they expected but it wasn't the response I had. I found with the two male counsellors I've spoken to, they were a lot more open to let me just explain how I've responded myself; there was less of that assumption (Toni).

With male counsellors, Toni experienced a lot more silence and less questioning. Rather, they 'let me speak, to let me get my words together'. Female counsellors tended to focus more on reliving the experience and were more anger based:

> What I've experienced with the two male counsellors I've spoken about, there's more about process and move on … I'd say it feels less judgemental and more open … and restorative [and more solution focused] … Women like to talk about our emotions and we just talk about it … I'll use the internet and random people online to talk about and just talk it out … whereas in the counselling context you … want to progress (Toni).

Thoughts about consulting a male counsellor in the future

Most service users (Helen, Gwynneth, Em, Jackie, Becky, Victoria, Shirley, Tanya, and Toni) were positive about their experiences and would consult a male counsellor in the future: 'Yes, happy to do it' (Em). Toni had seen a few male counsellors over the years. Jackie said, 'I would be okay to see a male. If that was the circumstance, I wouldn't hesitate now. It doesn't make a difference to me'. Becky said:

> It doesn't worry me. I think now, being older, and … having learnt a few life lessons, it doesn't really matter to me … if it was a male or a female … because I've had a male therapist … they're a counsellor, that's their job. They're not going to be biased to you, why should you be biased to them, just based on their gender? (Becky)

It had been ‘a good experience’ for Becky: ‘He was very helpful and …if someone said … he’s going to be … in [local area] … I’d probably go and say, hi, and thanks for all the help and look at me now’. For many, the main factor was connection with the counsellor, not gender:

> It just depends on who it was … and the connection … I could go and see a female counsellor and then I’d just be like, no not really, not really feeling you … I would want someone who has a background in … relationships, domestic violence, sexual assault, abuse, things like that (Victoria).

Shirley did not have a gender preference: ‘I very much feel … when it comes to a counsellor it’s very much a personal relationship … I’m sure you can have male … and female counsellors’. Tanya would ‘definitely see a male counsellor in the future. But some male counsellors I didn’t gel with. Definitely comes down to relationship … my preference is for male’. Patricia would not consult a male counsellor again ‘because of that experience’.

Positives of consulting a male counsellor

Realising that not all men were perpetrators

Respondents found it helpful to have a positive experience with a male. It brought home that not all men were perpetrators:

> Just because I’ve been sexually abused by a male doesn’t mean I should hate all men or that men are horrible or anything like that … obviously I don’t believe that, I’m married … you know and there’s some really great men out there … who have this stigma attached to them even though they … haven’t done anything … I don’t think you can just be like all men are bad (Becky).

For Becky, having a male counsellor might:

> have been good … because it showed that … there are other males out there that can be trusted … besides your … immediate family … that hadn't abused you … because there was the trust that got built up … it was okay to trust men (Becky).

Becky had had positive male role models in her life that allowed her to feel comfortable to explore therapy with a male:

> Personally, with my relationship with men, there wasn't like a huge string of horrible men. There was just kind of this one horrible person so I feel maybe if I had … like a string of bad male role models to go off it may be different to have therapy from a man but because there was only that one person who was really horrible to me … my father was always nice to me … other male relatives were always nice to me and … so it was just that one person really for me … so I feel if that had of been different, I may have been … I really don't want to see a male (Becky).

Gwynneth said:

> Because I was just so paranoid that every single male support in my life was going to be manipulative, it took a while for me to see that, okay, [name of counsellor] is a nice person and he is just doing his job … He was good to have a male support person who hadn't I feel like personally hadn't let me down or disappeared or stuff like that (Gwynneth).

Tanya was 'always on guard around men, but I do have a safe positive relationship with my father'. Toni expressed similar sentiments. Knowing not all men were perpetrators had influenced her engagement with a male counsellor: 'I know it was one fucking arsehole. It was not half of that species'. She mentioned female counsellors questioning her about how she handled 'being around men … that kept coming up from people who sort of specialised in this

area'. Em's counsellor had explained that not all men were bad noting he had tried 'to make me think more than I normally do, like before you start a relationship, be careful and, yeah, follow your heart is good but be careful'.

Gaining a male perspective

A positive was gaining a male perspective:

> It's good to have male in this section … he know what male like, when I speak to him and he know exactly what male going to act like … Male counsellor understand male side … He explain to me what male like and … for me, it probably is better for he can explain to me exactly what male like and what they are going to act. Sometime we as female cannot see inside male and what they like but if there is male and male they can look in the eye and see what this guy like … so we can see the lady, what she like but sometime 80-70% correct, but they just know (Em).

Em said, 'he make me think, okay, slow down, think more careful … because I do that with my husband … believe in every word he said'. Seeing a male counsellor had helped Em better understand men:

> It's made me stronger, like before in my mind why I not … think like that for long time … It made me think … oh, he love me that why he want sex with me and then I think other way … that just sometime like someone wake you up from sleep … big strong words, or words make a bang … He say those words to me and make me cry but make me stronger and make me can see what happen (Em).

This realisation had been important to Em's healing and recovery. Others had had similar positive experiences:

> Talking to him about my little brother, trying a male perspective on why my older brother was being such a little shit sometimes (Gwynneth).

> I just remember, he came at it with a different perspective and he was able to sort of, like. I'd already done two years of therapy with a female and he posed questions that we didn't even sort of cover … [This] opened my eyes … resolidifying the fact that it wasn't me … which is essentially what you want, but … there were just questions and stuff that we sort of went over that I don't think a female psychiatrist would … broach, maybe … because I don't think she'd ever sort of, we hadn't sort of gone down that track (Shirley).

Helen's male counsellor had not provided 'a gendered perspective on anything like even when talking about relationships and things … that was never … a gendered perspective. I don't know, there was never advices (*sic*) or males tend to think this way'.

Engaging in a therapeutic experience with male counsellors

Seeing a male counsellor had been a positive experience for most service users,: 'It was a good experience in a bad situation' (Gwynneth); 'I had an overall good experience' (Shirley); and 'I don't think my experience seeking help has been hindered by having a man to talk to, like it would just be the same if I was talking to a woman who had the same personality I guess … it was still really helpful' (Helen). For Helen, it was 'eye opening, giving me a lot of strategies to deal with the … trauma':

> I just liked having someone who can understand and empathise but doesn't like get upset or makes it about themselves and stuff …Certain people in my life I don't open up to because it just kind of turns into a counselling session for them and I just prefer to talk to him about it (Helen).

Em's (male) counsellor had challenged her way of thinking and encouraged her to gain new understandings, particularly in future relationships: 'He told me it's not like … all men are bad … I need to be careful … He make me understand my situation … He direct[ed] my brain to think [in a] different way, for myself'. The biggest thing for Em was her counsellor telling her she did not want 'to hate all the men'. It was possible to meet and have other relationships with men, 'not just become partners, we can become friends' (Em).

Becky's counsellor had been helpful: 'He certainly helped get my life back sort of on track and not you know the chronic crying and … made me feel like there was hope and that life wasn't …worth killing myself … there was something to live for'.

Gwynneth was happy her counsellor had not used an exposure therapy approach, as 'often, with PTSD, therapists … will ask you to relive the trauma and [my counsellor] was different … he didn't push me to relive it'. Instead, he had focused on holding and conveying a sense of hope and of looking towards the future: 'He's helped me towards the approach of … looking forward to stuff rather than looking back on stuff' (Gwynneth).

Victoria found it helpful to experience and challenge anxiety *in vivo* with a male counsellor present, as she had experienced in real-life situations:

> I've experienced this with, in the presence of other men, and what it's important to me is to get through that, and in a safe space with another man to, okay, I feel it but it's alright, and I can, it helps give me that strength to face it if I'm outside (Victoria).

Shirley found being able to share her story with a male counsellor 'validating', because she had not had the opportunity to disclose to a male. Having a male counsellor enabled this to happen:

> Just telling another male is, I don't think I'd actually had that experience you know … explaining to a male that this is what's happened to me … I hadn't actually face to face

> told somebody of the male gender ... I think it was for the fact it was the first sort of male … I'd already dealt with the fact that the original person was already calling me a liar, and was already denying that it had ever occurred, and so that was already putting doubt on some people of the fact why you lying, so to sort of have somebody just be, just immediately, like there was no doubt, no questioning, there was no are you sure (Shirley).

For Shirley, this had been a meaningful experience:

> Well, it probably really stems from the fact that my birth father isn't exactly around and the grandfather that I was close to died … when I was a teenager … I really didn't have many [male role models] … my stepdad, he's good, but we're very much still at arm's length, so to have somebody that I … tell – male sort of authority … I got benefit out of it because I had already seen a counsellor … If I was coming right off the bat … there probably would have been a bit more trepidation about [it]. In saying that, I'm very forthright when I have to be and … it initially helped because I had already had the counselling (Shirley).

Like Gwynneth's, Shirley's male counsellor had not pushed exposure therapy:

> At first, there was a lot of … the approach of basically trying to relive the event and then sort of modify the response, which did not gel for me at all. It was like, okay, we're not going to do that, let's focus on the now rather than trying almost to change the past (Shirley).

Toni liked that the male counsellor had not provided 'scripted' responses or assumed a particular understanding, explaining:

> It's that relationship where they don't try to put, no, that's not how I want to put this. It's not assuming that they understand what happened and also about not giving a text, an almost scripted response to not understanding (Toni).

In her experience, a male counsellor 'created less of that assumption, less presumptiveness, which has been something I've found helpful and more of a space where it's reciprocal. We can actually bounce rather than question response'. She described the interaction as 'a conversation. It's very much a two-way conversation'. Her male counsellor had a:

> less structured approach … less of a trauma … framework response and [was] more open … He was a lot more willing to ask, 'how have you responded' rather than going straight for the 'it was a trauma. Here's the trauma response, here's the research backed treatment' (Toni).

Gwynneth said her counsellor used a strengths-based approach, explaining why this was helpful for her:

> He used a survivor's mentality approach, so, … whenever I said I felt like a victim, he would pause me and say you are not a victim, you're a survivor of the assault … It was good. It was nice hearing that, especially since all my other support networks were just trying to help me through the court case and … it did feel like … I was the victim. I was the person who was assaulted. There was no looking at what the future would bring (Gwynneth).

Gwynneth liked that her counsellor had looked to life beyond the assault. Helen had found the experience of consulting with a male counsellor a 'relief, eye opening, helpful, and frustrated [sic] … Honestly, I think the main thing was relief, relief that … once I told him, once he … confirmed that for me, I was … okay'.

Finding that men were direct and less emotional and judgemental

For Jackie 'the positive is of him being direct and straight to the point, not pussy footing around it, y'know not feeling sorry for me but feeling more of an understanding'. Jackie recalled when she had first met her male counsellor, he had referred her to the mental health team: 'So … right from the start, it's like, if you don't like it, then there are other places to go but this is what I feel is what you need right now and that's just how it is' (Jackie).

Some women found men less emotional; they were less likely to be influenced emotionally by their story, and less judgemental of them or their situation. Toni said she found her male counsellor 'less judgemental and more open [and] restorative', while Tanya found his approach fit better for her. As Helen explained:

> Maybe there's … a preconceived thought even though it's … not true … subconsciously, there's less judgement from a man. Men are always perceived like blasé … whereas … women … are perceived as more … judgemental even though … I know that's not true … It probably helped a little bit that I was able to talk to him [rather than dismissively believing] … he doesn't care (Helen).

Helen valued her male counsellor's 'unbiased perspective':

> In a way, I guess a woman could empathise more with sexual assault to a point where it's maybe too empathetic but men, who might have never felt, who had never gone through that, or never felt the kind of feelings of fear that even women who don't have an experience of that feel … it could be a more helpful perspective … when … giving advice and how to deal with it (Helen).

For Tanya, too, 'emotion is not too transparent. They are able to handle emotions. Now I only go to male counsellors'. She explained further:

> For me, they stop the emotion, which is helpful, as I sometimes stay within this at home for a few days at a time. I can disclose information. They have a more clinical attitude. It's like 'that's happened, now what. Let's not live it over and over again.' They don't want to be traumatised. Their body language doesn't scream victimisation, or 'oh poor you', or 'how sad'. Female counsellors, it is all over their body language. There is no judgement with men. I don't have to justify being okay with a male counsellor. I can say, 'yeah, it's shit'. I don't have to unpack it, I don't have to go into it, I can just leave it there with him (Tanya).

Tanya said she did not want a counsellor who empathised and fostered emotion, believing 'it's okay for me to fall apart. I want someone who will stop me from crying'. Shirley also had found her male counsellor less emotional:

> Again, I find it difficult to put it down specifically to gender, a positive would be, again going back to horrific gender stereotypes that male counsellors I've seen tend to be more solution focused rather than talking about, oh, that seems really dismissive to say talking about emotions (Shirley).

Jackie found her male counsellor's understated reaction helpful:

> It's such a traumatic thing still to talk about now and [my counsellor's] reaction is … it's not, oh, that's sad or … there wasn't extra sympathy … like he has said, 'y'know that's quite a traumatic experience for anyone to go through', which is correct. It doesn't matter what experience you've had (Jackie).

For Jackie, the fact that she had already talked with her friends meant she felt more prepared to share her story with her male counsellor:

> I just talk to friends because I've got friends that relate to what I've been through and when you've got a friend that's sort of on that same page it makes it easier for that language to flow … but I also find that after talking to a friend about something like that when I next go see a counsellor it's easier to talk about because I've already had the friend thing … so it just makes it that little bit easier to flow (Jackie).

Negatives of consulting a male counsellor

Different therapeutic experience

Some services users had had negative experiences. Helen did not agree with her male counsellor on her progress. Though he regularly checked in with how she was doing, and she told him she did not feel very well, he would continue to describe her progress as 'good' and say she was 'doing really well considering what's happened'. This 'made me believe in my head … there's nothing I can do about it. I'm always going to have those feelings' (Helen). Reflecting on this, Helen observed that:

> He thought I was progressing further through the trauma than I really felt I was. Maybe that was me just coming to terms with the fact that I have trauma and that's not going away … I'd tell him about … certain things that were … concerning to me … and he seemed to … think it was normal … when I really felt like … something was wrong and he was [thinking] … that is a normal thing to go through … I don't know about that (Helen).

Helen thought 'they may not have experienced what we've gone through so … men wouldn't understand to an extent'. Patricia had had a similar experience:

> I felt that he didn't know where I was coming from. I don't think he understood about issues of powerlessness … He came across as very powerful, extremely professional, with a big timber desk, old style image of a psychiatrist, not relaxed (Patricia).

Patricia was the only service-user who was extremely negative about her experience. She found her male counsellor a 'cold, ultra-professional, stern' man, who 'didn't seem to care'. She had not felt safe in the therapeutic relationship:

> There was a power imbalance, him being a male, and I felt so vulnerable … tried to talk myself into not dwelling on fact he was male … took 10 years to go back to counselling (Patricia).

Despite Em's positive experience and helpful therapeutic relationship with her male counsellor, she expressed initial apprehension about 'his image'. On meeting him, she had wondered whether he'd be able to help her: 'How can he help me?

Victoria had not liked the continual paraphrasing that occurred but, other than that, could not 'think of certain … negatives at the moment'. Tanya thought there were not enough male counsellors in this field, or counselling generally.

Difficulties discussing sexual matters

Jackie's negative experience inhered in not being able to express the details of the sexual assault when her counsellor requested that she 'go through this'. It was very difficult for her to give words to body parts and she found this even more difficult with a male:

> Probably the hardest thing about … the male counsellor role is when they actually want you to talk about the experience itself. Talking about the emotions and the mental part of it is the kind of easy bit but explaining to a male counsellor the physical aspects of what happened was hard for me because I found the words to say were not just hard for

> me in the first place but made even harder being him a male like I can't even say the words now but genitals … it's like it's a swear word to me and it was made very harder (sic) … 'cause he used to make me … go through it so that I could get used to saying these words but being with … a male it felt almost impossible to say those words (Jackie).

Jackie had found this 'confronting' and believed it would take a while to feel comfortable enough to talk about this aspect of a sexual assault with a male counsellor:

> Jackie: I think even after being with a male counsellor for six months, I still don't think I could physically say what actually happened, telling the physical part of it.
>
> Interviewer: Yeah, you would need longer than the six months?
>
> Jackie: Oh god yeah.

For Gwynneth, the only negative was not feeling comfortable talking about sexual issues: 'I personally wasn't comfortable enough to talk to him about certain things, like female health … The only thing that was kind of unhelpful was the difficulty in talking about the sexual issues, yeah, and intimacy'. Hence, Gwynneth had taken the opportunity to speak to a female counsellor about sexual issues. In contrast, Toni had not found the offer of a female counsellor helpful:

> I think the biggest issue by far, the constant 'we have a female counsellor if you need it' … If the conversation naturally moves into that area [of sexual assault or abuse], there'll be the 'I'm just going to remind you we have a female counsellor here' and I've got to be like almost defensive, like no, we have that clinical relationship, I trust you, I don't want to go next door just to talk about one issue when there's five others we are talking about here (Toni).

Toni continued:

> Their [male counsellors'] own, I don't want to say, discomfort, but maybe that's the best way to put it. Their discomfort with working in this area … This happened more at first that need to constantly reassure that this is a safe space. You can leave if you need to, which doesn't come up on any other topic … They are all things that I understand in any context you can just walk out but it's only on that one subject are the constant reassurances come up … It almost creates that vibe that they are not comfortable talking about it (Toni).

Issues with termination

For Becky, the only negative was the way the counsellor ended the relationship without advising her that she might need to return to therapy in the future. Hence, when she 'relapsed' a few years later, Becky said:

> I got that sort of sense – that sort of false sense of security, that life was going to be great from now on. And then, of course, that didn't turn out right … I forget what the actual wording was, but it was like, oh, you're cured now kind of thing and that's kind of just stuck with me you know all these years later, like well, no, don't think there is a cure. It may have just been a back-handed comment that he didn't mean to come out but it's just sitting there, it's just still there you know 20 years later but … it's probably one of those things he didn't even mean to sort of, or jokingly said, and it's just stuck there, it's just buried in my brain and I've never forgotten it, especially when I … had a relapse and had to be put back on anti-depressants and had to see another person (Becky).

Half of the women were no longer engaged in counselling. For Helen, the counselling had just petered out though, for others, ending had been a conscious decision (Patricia, Becky, Gwynneth, and Shirley). Patricia had decided to cease counselling with the male counsellor due to his behaviour, e.g., taking a phone call during the session, and her lack of felt connection with him. Becky's decision was more about finances and Gwynneth said she (and her counsellor) felt she no longer needed to continue attending. Shirley felt the male counsellor lacked the required expertise or training for this therapeutic field. Thus, she had located a previous counsellor that did have the necessary qualifications. The other half (Em, Jackie, Victoria, Tanya, and Toni) were still engaged with their male counsellors.

Service-users' descriptions of therapeutic approaches

While the researcher did not ask direct questions about the therapeutic approaches their counsellors used, some service users mentioned these during the course of the interviews, including elements of feminist and trauma-informed approaches.

Core feminist techniques and principles

Their responses demonstrated the inclusion of feminist therapeutic elements, including the three core techniques Egan (2016, 2019) identified, namely, use of power, shifting self-blame, and working between individuals and structures. They also mentioned principles such as not parading as an expert, choice and control, trust, safety, comfort, concerns about triggering, and respecting culture.

Use of power

Egan (2016) noted feminist therapists enabled 'the victim to regain the power lost through the experience of sexual assault' (p. 100). The service users in this study saw this awareness of

power in different ways, one being they felt they had the power to decide on the content of the sessions, and what and how much they shared their experiences. For example:

> He let me talk and he listen to me; he not stop me at all. He just let me go and talk and talk, talk, talk, until I finish, and he just let me say this important thing (Em).

> There was no pressure to talk about the abuse to start with … I think if he had have pushed me to talk about things when I wasn't ready or didn't want to, yeah, it wouldn't have gone down very well (Becky).

> And the subject sort of came up and I shut him down almost instantly, unless I was ready to talk about it and unless I was ready to disclose what was going on, there was nothing you could say that would change that (Jackie).

These examples highlighted the importance, for survivors, of choosing to share their story with a counsellor in their own time. Jackie spoke about consulting a different male counsellor than her current one, where she had not felt ready to explore her experience of childhood sexual abuse. Others saw an awareness of power in whether the counsellors assumed an authoritative position in their work together. For example, Patricia said:

> Just letting me win in small situations [e.g., playing checkers] so that I felt … I wasn't powerless, I had … some sort of control [and] he wrote while he spoke. He never like hid his notes; they were always out in front of him. If I wanted to, I was able to see that he was writing stuff down; he never hid stuff, which was good in my situation (Patricia).

Patricia had had a negative experience with a male counsellor: He had a 'knows-everything attitude, he told me what to do, he was the expert'. In contrast, Helen said her counsellor 'wasn't trying to be like a (sic) authority figure'. Gwynneth said: 'It was nice to hear that I had

some control over the situation … I was put into that situation of powerlessness [so] it was nice to feel like I had control … it was nice to have … option[s].

Some service users referred to the counsellor's ability to use therapeutic approaches flexibly and the choice and control this invited:

> Letting me feel, however I feel, and not stopping; not trying to push anything onto me (Victoria).

> He used a certain approach where, often with PTSD therapists, they will ask you to relive the trauma and [he] was different … he didn't push me to relive it. He let me do bits and pieces at my own time, and I found that that approach was very good for me (Gwynneth).

Gwynneth was referring to exposure therapy. She said she had not wanted to do this, so her counsellor had not forced her into it. Her counsellor was solution focused and would actively listen to her. Tanya and Toni also mentioned solution-focused therapy:

> They tell me what it involves and give me ownership of agreeing to this [and] they have a real focus trajectory – let's get away from emotional side, let's look more towards a resolution. Their focus is 'I want to hear what you want to say but where do you want to be in five years' time?' (Tanya)

> What I've experienced with the two male counsellors I've spoken about [is] there's more about process and move on … women like to talk about our emotions and we just talk about it and guys are like 'what's the solution?' (Toni).

Toni reflected on previous counsellors and their approaches, e.g., ACT and TF-CBT:

> He was a lot more on the 'maybe just accept all this stuff, just accept everything', I assume it was radical acceptance but it seemed more like give in [and] the approach of

> basically trying to relive the event and then sort of modify the response which did not gel for me at all (Toni).

Toni was referring to TF-CBT or perhaps exposure therapy. These approaches involved the development of a trauma narrative or 'talk therapy'. Some therapists viewed talking about the event as cathartic and healing. Toni appreciated the counsellor asking her how she found these approaches, rather than coming from an expert position, defining her situation as traumatic, viewing it from a research and evidence base. Helen said her counsellors gave 'suggestions and advice and he is really big on mindfulness'.

Counsellor not parading as an expert

Egan (2019) asserted that counsellors who were careful not to take on the role of expert were able to promote women's ability to choose and make their own decisions about what was helpful for them. She noted that feminists designed this way of working to counteract dominant patriarchal organisations and their hierarchical power structures. Egan (2019) said this approach had 'a long history in feminist work against male violence' (p. 175), where feminist practitioners and researchers regarded clients as the experts of their own experience. Helen liked the fact that her counsellor had not behaved as an 'authority figure'. Gwynneth acknowledged that her counsellor was definitely a mental health expert, but, when it came to 'small stuff', he would ask for her opinion – 'it felt nice to be asked'. She appreciated that her counsellor had not pretended to have all the answers and was very open. Toni felt she and her therapist were 'equals'.

Choice and control

Female counsellors had talked about the importance of choice and control and service users, too, mentioned this element of clinical practice. Helen was able to choose the direction and focus of the sessions and could go at her own pace. This made for a 'laid-back environment …

like I was able to talk about it and not feel like I had to talk about it really seriously … not really any pressure' (Helen). Becky said:

> We didn't … get down into the nitty gritty stuff … for a few therapy sessions. The first few sessions were … about school and home life … so … there was no pressure to talk about the abuse to start with. I don't think he actually ever brought it up unless I did, so, if it was something I wanted to discuss that day, we'd talk about it, but if I didn't bring it up, he didn't bring it up either (Becky).

Becky felt respected and in control of the sessions:

> I think that was important. I still like being in control of things, and I think if he had have pushed me to talk about things when I wasn't ready or didn't want to, yeah, it wouldn't have gone down very well (Becky).

Gwynneth said her counsellor let her proceed at her own pace:

> I found that that approach was very good for me … Some days I would come in and he would understand that I didn't want to talk about the assault, and I would just want to talk about normal … things, so that I felt like I wasn't a victim (Gwynneth).

Gwynneth knew she had a right to see another counsellor should she feel uncomfortable and found this helpful: 'He has told me multiple times, if I ever feel uncomfortable that … it is within my right to see somebody else'. Having options and discussing these, helped Gwynneth feel in control in the counselling relationship:

> He always gave me options, especially with my medication, when I was on it … He said that my professional opinion is that it would be good for you to go on the medications, but no-one is forcing you to, because it's not just a one-off … solution.

> There are other things that we can do … I think it was nice to have an option (Gwynneth).

Gwynneth described the effect of these interactions on her, her awareness of her counsellor's power and, importantly, how he used it in the sessions:

> I know if I ever got to the stage of … actually saying to him, … 'I do want to commit suicide', … at the end, he does have the power and control to put me into some sort of help centre but … an experience I'd had with a previous psychologist, when I told them I didn't feel like eating, they immediately went … 'you are suicidal and we're doing this to you'. I just immediately felt like I had no choice in the situation, whereas [name of counsellor] knew that I wasn't actually going to hurt myself. I was just feeling really powerless and … we'd play checkers or something like that … I knew he'd let me win (Gwynneth).

Gwynneth also felt in control of the therapeutic approach taken:

> One of the positives was probably just the fact that he … never talked about stuff that made me uncomfortable and, whenever we talked about the issue of guys or me being afraid of older gentlemen, he never pushed me trying to like do that, like if you're scared of spiders … exposure (Gwynneth).

Toni, too, felt in control of the therapeutic approach, which had a positive impact on the counselling relationship:

> At the start, I was quite willing to talk about … these other people suggested DBT. This is why I didn't get along with DBT, so it was like I'm familiar with a lot of the therapy models, what they're targeting and … I have enough insight to say 'this is where the

> issues are for me', which come back to that whole mutual respect and being able to talk at that higher, more detached academic level (Toni).

Victoria referred to having the time and space in her counselling session she needed. She liked to talk to her counsellor, without always having to look at him:

> I want to see him. Sometimes I don't want to look at him, because I find that that might be easier for me to express myself … I feel uncomfortable … with certain people and I wouldn't say necessarily with all men but I … feel uncomfortable when I'm being watched and, if I'm not facing him, then I can, I just feel what I want to say is expressed much more easily and it has been something that I've struggled with a lot … being able to speak. I can stutter (Victoria).

Victoria's counsellor had just let her feel, however, not stopping her or trying to push anything onto her:

> Not trying to redirect the question, or ask me anything more when … I can't think … If I shut down, it will be me talking just for the sake of talking, because I don't, you know, your brain goes into like a jumble (Victoria).

It was clear that these service users had spent time in counselling from the terms they used in describing their experiences, such as 'redirect the question', ask 'how do you feel', and 'solution-focused'.

Shifting self-blame

The second element of feminist counselling Egan (2016, 2019) identified was the use of techniques to counter self-blame and shift culpability onto the perpetrator. The service-users' comments attested their counsellor's use of blame-shifting techniques:

> It was mostly talking through how to process that without … internalising and blaming (Toni).

> When he say, 'oh, your husband only just want sex, he doesn't love you, only sex' … he explained that my husband make me feel guilty and I give sex later … I woke up to that (Em).

Naming and explaining the problem, which, in Em's case was her ex-husband's tactics to coerce her to have sex, was helpful. Em realised this was sexual assault and it was not her fault.

Helen described how helpful it was when her male counsellor confirmed her feelings about her sexual assault. This dispelled her confusion and uncertainty. Naming the problem meant Helen could make sense of what was happening and not see herself as the problem; she came to the realisation there was nothing wrong with her. Helen expressed her 'relief' at this insight.

Gwynneth's counsellor used a strengths-based approach to prompt her to see herself as a survivor and recognise her strength in surviving what had happened to her. He shifted responsibility off the 'victim' onto the offender by emphasising that something was done to Gwynneth, and she had survived it. Gwynneth's counsellor had also used a family systems approach, helping her acknowledge other people's roles in her life and situations, and other supports in her network. This approach lightened the load by shifting self-blame and placing the responsibility on the perpetrator. Gwynneth realised her symptoms were not due to personal deficits and it was his responsibility to change his behaviour.

Working between individuals and structures

The third feminist counselling practice Egan (2016) mentioned was awareness of the interplay between individuals and social structures that supported sexual assault, as well as the systems with which victims and survivors came into contact. In her description of therapy above,

Gwynneth referred to the blame-shifting approach as particularly helpful. It had helped her fulfil her role as a witness in the sexual assault trial, which could be a very distressing and retraumatising experience. Gwynneth had also mentioned her counsellor's future-oriented focus reminded her not to lose hope for the future, and what it had to offer; that this present too would pass. For the most part, the male counsellors used these elements of feminist therapeutic practice, though how they worked between individuals and structures was least evident in the service-users' indirect accounts of their counselling experience. Egan (2019) noted that feminist counsellors:

> Hold a political lens to the problem of sexual assault when they intervene at the most intensely localised site of gendered power relations ... evident in the sensitivity to the power dynamics in the counselling relationship, in the focus on enabling the victim to regain a sense of power and control, and in the nuanced way in which they work with the complexities of self-blame. It is also evident in the awareness of the ways the structural articulates into and shapes specific situations and the experiences of the individuals with whom they work (p. 176).

Trust

All the service users talked about the importance of trust, noting this took time to develop (Em, Victoria, Jackie, Toni, Helen, and Becky). Em had not trusted her counsellor at first, felt 'okay' the second time she saw him, but then trust developed 'little bit by little bit, and now I can speak to him about anything'. Likewise, Jackie said 'it's that relationship … I can feel comfortable to swear in front of him, but I don't feel comfortable to say some words'. Victoria and Jackie both said that making the session a bit 'light' was helpful, for example talking about casual everyday things or sharing something small about himself. Similarly, Gwynneth spoke of discussing trivial issues before feeling able to disclose more serious matters as trust grew:

‘It developed over just being able to tell him like the really small stuff’. Helen was open and honest from the start because she trusted her male counsellor and had no reservations about the counselling process:

> I think a big reason why I could trust my counsellor was because I was willing to just open up about everything. I know not everyone is like that and that can be … a barrier. You just don’t want to talk about it, but you need to let other people know (Helen).

Informed by her own, and her family’s, experiences of mental ill health and connection with formal supports, trust was a simple issue for Helen:

> I just trust counsellors in general. I know what goes on … I know they’re not allowed to tell other people that kind of stuff … I’m just aware of what counsellors and psychologist do. I think people have … these really medieval ideas about what a psychologist is, a shrink, that kind of stuff. They’re not trying to make you braindead or they’re not trying to use your information against you … They’re there to help (Helen).

Victoria believed counsellors had to maintain confidentiality. They had a ‘duty of care that you can’t talk about what goes [on] outside [of counselling]’. For Helen, it was a matter of ‘I’d rather talk about it in all honesty than … suffer’:

> He had … all this information about me that kind of made it like he knew what I was going through and how I thought … I think that was like a reason why I was able to trust him. I was able to … progress as we went along (Helen).

For Helen, the counsellor’s interest in her ‘as a person’ enhanced her trust in him: ‘He’s always just really friendly, just wanted to know about people around me, what I do and that kind of stuff’. Gwynneth valued her counsellor’s attentiveness:

> Whenever I'd bring something up, he'd refer back to something else that I'd said and it felt nice to be heard and acknowledged, so he was a very good active listener … We'd spend the last 10 minutes of a session doing … a wind down … where I'd just talk about … random stuff like video games … He'd always remember what game we were … last talking about … It felt like more than just that one side you know, a whole field of … spectrums (Gwynneth).

Gwynneth appreciated her male counsellor acknowledging more than just the abuse, as there was a lot more to her than this. Victoria had also valued her counsellor's ability to remember things about her and this helped build trust:

> He remembers things what I've said … Last time I saw him, I was working on a recycled art project and he asked me about that and how my garden was, and so that made me feel good that he remembered just those small little things and … it's not means for trusting somebody but he's a counsellor … I don't have anything else to base it on, and it would be the same if it was a female as well, I don't have anything other than that hour … but it's what he remembers (Victoria).

Patricia, however, found 'there was no trust or rapport. He had huge walls up himself, like I'm here to do a job and take your money, and this won't affect me … He didn't show kindness, was cold and sterile'. Em's counsellor had encouraged her to speak, which helped her develop trust in him:

> He said it's okay to speak about what happened … and don't be shy. In my culture we are very shy about that … and go for it … the way he look at me and the way he speak … there is no gap between us anymore, I talk [about] everything (Em).

Jackie had a history of working with her male counsellor on other issues, so when she spoke about the childhood abuse, the trust 'just flowed', though she still felt uncomfortable talking about it:

> It … just comes out … naturally, unless you want the gritty details, then it's a case of I'm sitting back and … the body language changes and you can tell that I'm uncomfortable but I'm at that point now I force myself to talk about it (Jackie).

Jackie trusted in the relationship, as her counsellor came to understand her over time:

> By the previous conversations that I've had talking with him about other issues, and that's usually where you start … with the small stuff and … see … how is he going to handle this, how is he going to deal with this, what's he going to do, how's he going to react to it, so yeah … that had already been tested so when it came time to talk about it, it was like well this is easy to do … I'd built that relationship (Jackie).

Jackie trusted her counsellor enough to delve into her abuse in their work together. His 'consistency' helped develop trust: 'I've been seeing him for so long and that's just a pattern, like he's consistent … the way he counsels … his manner'. The environment of the counselling space also helped:

> [It's] not a government building … the building doesn't look old and run down … [but is] bright and cheerful … His office is relaxed … I feel so comfortable in that environment … He's got … a comfortable seat and he just makes sure that you're comfortable (Jackie).

Jackie continued:

> All in all, it's helped so much, and it's really got me back to where I needed to be … I think if I'd gone and seen a separate counsellor to talk about the sexual assault I don't

> think I would have … because you get to that point, it's like, oh my god, I don't want to do this again and again and again, it's like you got to build that relationship, and build that trust … but, in turn, you've also got to talk about it but you can't talk about it if you don't have those foundations to begin with (Jackie).

Becky said her counsellor was 'caring … in a professional manner'. She appreciated the boundaries in their relationship, which enhanced trust:

> Besides when we shook hands when I first met, I don't think he ever … shook my hand again … and there was always a nice distance between his chair and my chair … wasn't invading my personal space or anything like that. I feel like that was important. I think if he had have been … sitting too close … it would have made me uncomfortable but he was always at a nice distance away and so I suppose … the trust just developed over … time (Becky).

Gwynneth and Shirley both mentioned that their counsellors exhibited an understanding of personal boundaries and had displayed this in their interactions in therapy:

> I've had experiences with older men, where they are overly touchy feely … even people in a business … sector, but there was [sic] boundaries already in place … like your bubble, you know how you've got your personal space bubble … He just had a good understanding of where my boundaries were (Shirley).

Gwynneth's counsellor had 'open body language' and 'he never judged me or pitied me'. He had never blamed her for her difficult relationship with her mother or her as the 'problem'. Rather, he deflected responsibility and agency onto her mother, providing clear avenues to address issues as they arose, suggesting parenting groups, for example.

Victoria was seeing a male counsellor to rebuild 'trust with a male ... There's a little bit of chat before we get into it … He just has a really … calm way of speaking'. Shirley had mixed feelings, noting that trust had developed merely because she 'kept going back'. She had participated in, and trusted, his therapeutic approach. However, he did not have the expertise to address the main issue of her childhood abuse:

> I feel that trust was developed; it was just I felt like I wasn't going to get the best help for why I was going there … because of the fact that, while we did have many good points, I feel like he was not trained in what I need and we would very much circle back to things that were probably more his strong suit, like work problems and those sorts of things … He did help me, in some aspects … but … he was just a regular counsellor that wasn't specialised (Shirley).

Shirley continued:

> I think if I had continued to go, I would have lost confidence but for the initial sessions, where he was helpful, like it was good for a short term but it was not for a long term … because I don't think he … [had] much experience [in dealing with abuse].

In an interesting comparison, Toni found her male counsellor's lack of expertise in this field a positive for her:

> His immediate response … was 'this isn't my speciality, you can contact [named a service]' and it was that admittance of 'this isn't my speciality area' that got me to trust, okay I'm not going to get a textbook response … and immediately suggested you know there's another female counsellor at this practice … I think it was the … sincerity in admitting limitations, admitting 'oh this is interesting, I might look into that, I wasn't familiar with that' [that hooked me in] (Toni).

Toni continued:

> Because I've read, I have tried the self-help of reading those standard responses, the 'this is how you will possibly respond, there is no right response but this is how you will likely respond to an assault' and I didn't really resonate with them so having a person, a perspective that wasn't, I guess, fluent in that discourse, who I could actually bounce my thoughts off without sort of getting … pigeon holed [was helpful] (Toni).

For Toni, trust developed 'through a lot of not necessarily focused discussion but honest discussion and we might have had two, three layers of removal from what's actually going on'.

Safety

Trust created a sense of safety. For Helen, her counsellor made her feel safe by 'not freaking out' when she shared things with him, e.g., relating to her drug-taking behaviour. Rather, he would offer advice and suggestions. He would offer an empathic but measured response that made her feel accepted and not judged. He 'would express … concern', where appropriate, about issues they identified in their work together. He communicated in a way that showed 'I need to work on this stuff'. Safety developed via 'a mix, the environment was pretty nice, nice chairs and comfy, you know like always checking in, and that would kind of get me thinking … about how I am actually feeling'. Helen said the structure of their interaction, of checking in and providing space to reflect on how she was going, enabled her sense of safety to grow: 'There would be the check in and maybe we'd … review what we talked about the session before and then he'd ask what I wanted to talk about'.

For Em, the counselling relationship was safe for her. This and the ethos of confidentiality was important to this:

> I feel safe with my counsellor and I feel very confident with him … it's like confidential … He explained to me as I came to see him about confidentiality in the first place … that I can talk with him about everything, that I can let it out because confidential and he explained that in the first time I think … as soon as I see him I feel more safe (Em).

Em said her counsellor was a 'very good support … He tried to make me strong and … have life again, after this happen (*sic*)'. He had tried to help her understand that some men were good and, nevertheless, it was wise to be cautious when entering relationships:

> [He tried] to make me see I can have my own life … because I am scared to have relationship and I don't want to have that happen again … that the past is the past and [I] need to learn from what has happened in the past, and I got lesson from that, I got experience and from that next time you will be better (Em).

Jackie spoke about the 'calmness … where the counselling is, his room, like the building, the area' was conducive to trust and safety.

Becky's foundation of good relationships with males had helped her feel safe in the therapeutic relationship with the male counsellor: 'I didn't see all men as abusers or horrible people or anything like that, so, … it was okay to be safe with a male … just … not my stepfather'. Gwynneth had difficulties with trust and safety in the first few sessions:

> With the first session … you have to go through … an overlay of what's happened … and so, after that first session, I felt really nervous because it was like, if this is what it's going to be like every single time, I don't even want to come back and so he took a step back and we did small … trust-building exercises just so that I was in a situation where he's not some stranger that I'm having to tell my deepest insecurities to (Gwynneth).

Ultimately, Gwynneth thought ‘it was important for [her counsellor] that I felt safe and comfortable before we talked about [the abuse]’. Victoria felt safe and anxious. Her counsellor had helped her through this. She said her counsellor’s interventions had ‘been reassuring’. He had given her space and time in the session to respond to, and manage, anxiety. That definitely had helped her feel safe.

Shirley also felt safe in her relationship with the male counsellor noting this was ‘really subjective … I honestly couldn’t put it into words why I felt safe. I just did’. Tanya ‘felt protected … just their maleness I found enabling. It was a safe space, it wasn’t ‘joozed’ up, I saw results with this approach’. She experienced a connection with a male approach to counselling.

Toni said she had ‘never really factored gender into’ the counselling relationship. She was aware of abuse from counsellors: ‘Maybe it’s because I have that background where I spent a lovely six months of reading into all the cases where psychologists have been sued for inappropriate conduct’. She thought you could ‘build up that safety just through … chit chat, very surface-level stuff in the first few sessions … You can … tell relatively soon … if it will progress to feeling that way but you can … build up a mutual respect’. Trust in the relationship developed by ‘testing the waters’ and checking the counsellor’s responses, as Toni explained:

> I guess you talk about stuff with that element of distance, like you’ll talk about something that is totally personal, but you talk in that abstract, you know how people do this, that second person distance (Toni).

It was better to be able to talk with the counsellor in a way that both were able to share their knowledge and experience on certain subjects: ‘Sometimes it was just talking more like peers than in that clinical setting … It created that safety that we’re on the same level. I’m not necessarily scared that you’re going to report me or all of that shit’. Toni concluded:

> It's just been a mutual respect … If I say I'm okay even if what I'm saying might be considered on a textbook checklist to be a red flag, there's that respect that I will get help if it is [needed] … which means I feel safe to actually discuss [it] (Toni).

Comfort

The service-users talked about boundaries, respect, and their counsellors making them feel comfortable, e.g., offering them a drink, ensuring the air conditioning was okay, chairs were comfortable, the room was bright and calm, and respect for personal space. Boundaries, like personal space, were important in sexual assault counselling, as the assault was a violation of the private space of the body. Therefore, it was essential that counsellors respect this and model a strong sensitivity to personal boundaries in the therapy room. It was important that they remain aware of their position of authority and professional role. Maintaining personal boundaries demonstrated respect and awareness of power dynamics. Feminist therapists brought these issues to the attention of the psychotherapeutic community in the 1970s and 1980s. In time, they became part of professional behaviour and codes of ethics (Brown, 2008).

When sharing sensitive issues, establishing a safe, comfortable environment was a major cornerstone of feminist practice. All but one of the service-users felt comfortable sharing their experiences with a male counsellor, once they had established a relationship, even though all felt uncomfortable sharing their stories of sexual assault. Helen said talking about sexual abuse would be uncomfortable with anyone: 'It didn't feel like, oh, like I'm uncomfortable because he is a man … I'm uncomfortable because this is an uncomfortable thing I'm talking about'. Helen had only shared her story with men, namely, her boyfriend, male counsellor, and police, as there were no female police officers at the station when she reported the assault. Victoria felt it was okay to 'feel anxious or uncomfortable, at times':

> It's not for the whole duration and I can speak to him openly, but you know it's just anxiety. All of a sudden it just happens and it's not necessarily anything that he's done or said … or maybe it is and I'm just not aware of it but he notices as well, because I become sort of withdrawn or like, if I'm sitting on the lounge or something and you know my body starts to close and I get very tense and so I guess he kind of, by him acknowledging that also, bringing it to my attention, it then gives me that, okay, yep, alright, and I can just … get up you know and kind of breathe or something and when I do that it makes me feel just like relieved (Victoria).

She continued:

> He can see that … I'm not okay and … it makes me feel, now that I'm thinking about it, acknowledged and cared for, in a way, like if something, if I've been feeling, if it's happened to me when I'm outside and I'm in company of people that … I know or just someone to … notice and say, 'is everything alright?' can really make a difference in just getting through it (Victoria).

Em had felt uncomfortable when she first met with her male counsellor and was concerned that he might be like the first (female) counsellor she had had:

> When I change to him, I say, 'oh my god, don't be like the first time, the first lady and then it was uncomfortable' … The first day with him I feel uncomfortable because like I don't know how to speak to man … In my mind, that power, I just think he male he probably stand by male … he probably not stand by female … because sometime the male not understand female at all … he probably not stand by me (Em).

Patricia described her experience as 'difficult, cold, [and] destructive'. Overall, Jackie had had a good experience with her current male counsellor. It was important for her to feel comfortable

to share her story. Hence, she had not disclosed to male counsellors in the past until she was ready:

> I'm okay and more comfortable to talk about it because like I said I have had that past experience with so many counsellors … It's because it's a historical sexual assault, so it's been spoken about it. It's been dealt with several times, so, the more I talk about it, the easier it becomes. It's still just the physical, saying the physical part of what actually happened [that is hard] … Other than explaining the physical part of it, it's been really good. I've had a good experience from it (Jackie).

Jackie continued:

> Usually, when you're talking about such a heavy subject, going to the appointment you feel heavy, leaving the appointment [with a male counsellor] you feel heavy … it's heavy … but it's okay … [even though it's] difficult … confronting, I'd say challenging but challenging is like difficult … direct … I'm confident to talk to him about that (Jackie).

For Becky, it was a 'bit daunting at first, because I didn't know what to expect. Even now I like to know what to expect'. Becky felt comfortable once she felt the male counsellor's body language conveyed genuine care. She found his responses to her accounts of the abuse validating:

> Things like … 'oh, that's not right' or … 'that's not how a normal stepfather should behave' … he didn't specifically say … 'what a horrible person that was', but just sort of slight … that's not normal … behaviour from that kind of person, so, just … little messages like that, I suppose (Becky).

Becky continued:

> He was always sort of relaxed … but I noticed a few times he did have this … grimace on his face like, 'wow, someone actually did that'… just sort of like a displeasure look across his face and I mean it was gone in an instant … [It showed] that the behaviour that my stepfather had done wasn't gelling with him … wasn't sitting nicely or …he wasn't approving or … a slight disapproving … flash would come across his face (Becky).

Becky found this reassuring:

> You're sitting there talking about these horrible things that, only recently, you've discovered were horrible things because the person told you that that was normal and, then, to have someone else, like someone outside the family have those little flashes of … how horrendous sort of look across his face … as sort of reassuring that I was doing the right thing … I had done the right thing telling mum and I'd done the right thing by talking to the police and that sort of thing, so, it was just reassuring (Becky).

Gwynneth, who had seen a male counsellor for nearly four years, which was much longer than others, described her counsellor as 'understanding, empathetic, and supportive', despite initial feelings of anxiety:

> At first, it was really awkward, just trying to lower that boundary but … over time it went from me seeing him first as being a male to me seeing him as a psychologist who was male … It took a while for me to stop seeing him as just a guy and to see him as a psychologist who was also male (Gwynneth).

Victoria said she had made:

> Progress … acknowledging myself and the struggles that I've had with men, and I'm facing it … and … re-building trust with men and that's what I want … to be able to

> feel comfortable and confident and not be afraid, you know just safe [with men] (Victoria).

Shirley described her counsellor as offering a 'different perspective … respectful … comforting'. Likewise, Tanya said:

> It was confronting, counsellor being a man, but also felt that it was like I can tell my Dad that … I wasn't comfortable to begin with, but it's how they present … They say I don't have to be like this for the rest of my life. There is going to be relief. We will get you off medications and reduce anxieties, for example, we will do work (Tanya).

Seeing her male counsellor about other issues had helped Helen feel comfortable sharing information about the sexual assault with him: 'I had seen him and talked about other stuff so it … wasn't too difficult to open up like that'. For Helen, 'it became a lot easier to talk about it … We just started with the basics, just getting to know me and, as that time went on, I was just able to like go more in depth'. Em, too, began to feel comfortable with a male counsellor after four sessions with him. Jackie said:

> It took me that long to feel comfortable to talk to him so if I was to, if I'd been referred to him and that was the first subject it probably wouldn't come out as easily without having that already formed relationship that I had with my counsellor (Jackie).

Most felt comfortable once they had established a relationship with their counsellors. Jackie said:

> He understood me as a person and how my brain worked … He just had a better understanding of who I was, so, he kind of knew how to deal with talking about the sexual assault, I felt, in a more sensitive manner (Jackie).

Jackie's initial discussions with her counsellor about the impact of her family member's sexual assault allowed time for her to become comfortable with him: 'I think it's because I was talking about another sexual assault victim and case [and] that brought my case up and then gave me the confidence to talk to him'. She was encouraged by his response to these issues: 'It's like a level of understanding, like I understood the way that he works with his psychology. It just made it so much easier that I already spoken to him of previous experience on the other case'. She recounted how she had come to share her story:

> Well, it was triggered, so, I kind of had no choice but to deal with it … or it was a case of bottle it all up and … find another service but I didn't want to have to do that so I had to build the trust up within myself to feel comfortable to disclose that information to him … but because we had been talking about other sexual assault cases, it made the conversation flow that little bit better … I felt comfortable talking in his presence … because I established that really good relationship with him (Jackie).

She continued:

> The relationship was already established and I was comfortable enough to be able to talk to him in regards of the incident and all the emotions and everything else that went with it … all I can say is that it's the relationship we formed and I felt comfortable to talk with him, I felt comfortable in his presence (Jackie).

Jackie said her counsellor had made every effort to ensure her comfort:

> [He] makes sure the aircon is on the right temperature, if I want a drink or anything, yeah, and he doesn't put pressure on me … He doesn't put pressure on what we're going to talk about … It's [his] personality as well, like he just has that, he has that calm, cool, but I'll tell it how it is … because I'll talk about some things and he'll just

> say, ‘oh well, that’s just everyday normal life, y’know that’s just sad’ … It’s a case of you think you’re struggling, and he says, ‘no, it’s just life’ (Jackie).

She continued:

> I’ve explained to you the building environment and its [name] neighbourhood centre and it’s just in a beautiful, like the drive there, gets you in that [sigh] ‘cause it’s … in an area where it’s quiet, it’s peaceful, its comfortable (Jackie).

She compared this to government services:

> But when I’ve used the sexual assault service, the buildings that they have used, feel like death to me, which have made them almost near impossible to get out the information that you need to get out because you’re in this environment and your like I don’t like this, like the building and where it is you don’t think is important, but it really is (Jackie).

Jackie highlighted the significance of this for her:

> I can’t emphasise, now until I’ve pointed it out, the environment, like it really does make a difference and I even think even to begin with, even if it’s like, if this was me and it was a sexual assault the last place I would want to do my first session is in a building of structure and things where I, take them to a beach or take them to a park, put them in that … more informal … I think being too formal, like I think the option should be given – do you want to have counselling here or is there somewhere else that you feel more comfortable, but then you’ve also got to cover your butt for your safety, and your wellbeing as well … but that’s just a suggestion (Jackie).

Becky also recounted how the counselling space contributed to her comfort:

> I just remember the waiting room was playing classical music and just sort of calming sort of atmosphere like there was (*sic*) candles and stuff … I think, at first, I was like, oh, this is a bit weird but then I was like actually this is quite nice, it's soothing … I think it might have rubbed off a little bit because if I'm stressed, I will play classical music (Becky).

Shirley also commented on this:

> It sort of took place at his private residence but it was like in a sort of updated garagey sort of thing so like it has office space but it didn't come across as odd … As I said with the conversations about the chair, he said he took very great care to make sure he had nice comfortable chairs so that it was one of those conversations that sort of stick in … He said he sat in a lot of chairs to make sure we were comfortable when we came there. So, it's sort of like he pre-thought, he wasn't going to have hard uncomfortable chairs, to make sure that we felt comfortable (Becky).

Gwynneth recalled how her counsellor had said:

> I don't want to do anything that you're uncomfortable with because that's when he went over like what my rights are as … a person seeking counselling. He said I never want to do anything that you're uncomfortable with. You're not being forced to be here, you can stop at any time and … we can transfer you to somebody else, a female counsellor if you're more comfortable with that … I felt comfortable enough with the fact that somebody'd said it to me (Gwynneth).

Gwynneth continued:

> He picked up on what my verbal and non-verbal tics were, so whenever he could tell that I was truly uncomfortable with something, he'd say, 'do you want to take a break,

> do you want us to talk about something else' … He'd repeat the fact that … I don't have to talk about it if I don't want to … It felt like I was able to again have control over the situation and it just … made me feel … he knew what I felt comfortable to say and … what we could approach at another time (Gwynneth).

By checking in with her, he had shown a good understanding of her and the way in which she worked. Not only had gender not intruded, for Helen, but also sexual assault was not the only factor:

> It was never … unless I wanted it to be … the centre of our conversations … He would also check in, see how I'm doing, and I would let him know what was going on but it didn't have to be like the only thing we talked about (Helen).

Em felt encouraged to share her story:

> He speak to me, and talk to me about, I tell him about me and my husband and he tell me, 'it's okay, just get this out, like you can get out everything you want to say, just say it' … He made me feel comfortable and let it out and after I told him, and he faced back … he just knew what to say. For some people, it's like tough, but for him it was okay to deliver like that (Em).

Em's counsellor had made her feel comfortable by giving her space to talk and offering her a cup of tea:

> It's good to make you feel comfortable, like you see a friend … It's like home, when you walk in the room, and he say, 'hi, I'm ready for you, you like some cup of tea'. Oh, I feel like it like home, happy and thank you, every time that I go see him … and he make it himself and make for me if I say yes and he don't ask what is it called, ask reception but all by himself … It just feel like home (Em).

Her counsellor was comfortable himself to say when he did not understand her language: 'So, he tried to understand and tried to accept even when I make mistake, he accept that and make me confident to speak'. He had also helped her to find the right words, for her to communicate accurately: 'When I speak not correct word, he say okay this one, or do you mean that one right and I say yeah that one'. For Em, this meant he was not judging her. Once, she felt comfortable with her counsellor, gender no longer mattered:

> I feel comfortable, I feel confident, I don't see his as male … just a counsellor, nothing else … make me comfortable … I think in the same way if female counsellor see the male client I think the same thing, can bring together, for me not sex, just unisex (Em).

Jackie knew of her counsellor's experience and understanding, due to her previous engagement with him in relation to other issues. She said he had 'more of an understanding [of] … a female victim's point of view'. She felt comfortable enough 'to open up with him' noting she 'probably would have hesitated a hell of a lot more' had he been 'a lot younger and inexperienced'.

Most service-users found it difficult to discuss sexual issues. Helen was as uncomfortable talking about sexual issues with a male counsellor as she would be with a female counsellor, but felt able to talk about the sexual abuse:

> The fact that it was a man didn't really bother me. I think the way he kind of presented himself was like sexless in a way (Helen).

> The only thing I really didn't feel comfortable talking to him about where he actually got me to see somebody else about was like the actual sexual side of it (Gwynneth).

Gwynneth continued:

> It was good that he knew that he didn't have all the answers for everything and that it was important that he didn't just like monopolise everything. That he knew that he didn't have the answers for it and it wasn't his exact field so he was able to with my consent to get me to talk to somebody else about that specific thing (Gwynneth).

Other than that, Gwynneth thought gender had not had any influence on her counselling experience. Shirley's counsellor had made her feel comfortable:

> It's the vibe, it's the sort of surroundings and that sort of thing you know, he wasn't aggressive, he wasn't, he was just [gentle] … in sort of the way he spoke, it was very much a vibe sort of thing obviously instead of like actually physically comforting me … I think we developed a good rapport (Shirley).

Toni's counsellor also made her comfortable:

> It's such an all-encompassing thing that you can't … pick out specific elements. It's personality, it's the way that he'll use my own phrases back even if I start swearing my head off, a quote from last session, no don't stop swearing. Yeah, it's just a very comfortable atmosphere … It's just even little things like having a nice dimly lit office, water, the awkwardness of being able to hear the physios yelling next door. Yeah, it's a holistic thing that you can't break up into individual elements, even simple things like just being reassuring without being, without using those almost-standard phrases, validation without the 'that must be really difficult, how does that feel'. Once you start seeing enough counsellors you start seeing there's those phrases they teach you (Toni).

For Toni, the opportunity for a general chat in the initial part of each session, before serious exploration and discussion, engendered a relaxed environment and allowed her to feel

comfortable to talk about the main issue of sexual assault with him. In contrast, Patricia felt very uncomfortable with her experience:

> I was worried about what I was saying. I was so uncomfortable with him … thought hang in there … thought he's not even listening, he was doing other things, sitting at his desk and writing, and then took a phone call (Patricia).

Concerns about triggering a traumatic reaction

There was some concern among female counsellors, as discussed in Chapter 8, that the presence of a male counsellor could trigger a traumatic reaction because he was a reminder of the man who had perpetrated the abuse. Service users also raised this concern. Becky met her counsellor and realised 'he didn't look anything like my abuser':

> It did concern me that he would be like an old man type person and that's kind of what my abuser looked like. He was an old man, scruffy beard, and … balding type … in the back of my mind was, oh god, please don't let him have a beard … and be old … He [male counsellor] had grey hair but that didn't bother me. My abuser didn't have grey hair, he was just balding, so, I think that was initially before having met him. Initially, I was like, oh, I hope he doesn't look like him. I can't, I don't think I'll be able to see him again (Becky).

Luckily, Becky's counsellor was a 'clean cut, professional-type looking person, is very soft spoken'. Similarly, for Gwynneth, the counsellor's age was a trigger. She had consulted a younger male counsellor, 'because my abuse was with an older person. I was able to sort of distance myself from that with the younger male psychologist' (Gwynneth). Shirley expressed similar concerns:

> There was a bit of hesitation because of the fact that my second assault was by an elderly male and I still had a few triggers towards that but I found that he was incredibly respectful and … he just had a vibe, an air of just nothing, I didn't get that bad vibe (Shirley).

Respecting culture

Feminists were mindful of the influence of culture on human experience. Only Em mentioned culture as a consideration in her experience of a male counsellor. She was the only respondent who was from a non-English speaking background. She talked about the way in which cultural barriers could influence the therapy engagement and process. From her perspective and culture, she explained that, as a Thai lady, 'our culture is we cannot speak about sex with anybody. Yeah, in my country … it's a secret inside the bedroom. You cannot speak out … about sex with anybody'. Nevertheless, Em was able to establish a safe and respectful therapeutic relationship, possibly because 'I'm not shy'.

Trauma-informed approach

As noted in the Complementary Guidelines to Practice (Kezelman & Stavropolous, 2019b), the counsellor's ability to tolerate emotional discomfort and distress, and to provide a genuine and authentic response of reassurance in a bounded and respectful manner, was important to trauma counselling. Such responses were evident in the service-users' accounts:

> Feeling … frozen … but he … helped me … relax and say 'it's okay to move' … if I need space [or] to … get up and do something or stretch. I'm okay to do that, and I know it seems silly, it's just like something comes over me and my brain … give me that strength to face it, if I'm outside [and] my body starts to close and I get very tense … by him acknowledging that … bringing it to my attention … gives me that, okay,

> yep, alright … I can just get up … and … breathe … when I do that, it makes me feel … relieved (Victoria).

In this example, the counsellor demonstrated his knowledge that trauma was stored in the body; he provided the opportunity for the body to move to release the felt trauma within. He also showed that he could model distress-tolerance techniques in therapy to show survivors how to manage their symptoms in everyday situations. Helen's experience highlighted that her counsellor's primary focus on symptoms was a misstep, because he misread her feelings about her progress:

> He said I'm doing … really well considering what's happened; I'm not showing signs of PTSD and things like that, but I didn't feel good … even though we probably had different ideas about how I was doing … it was still really helpful (Helen).

Helen intimated that perhaps her counsellor did not know the answers to her questions:

> I would ask him if it was normal; this doesn't feel normal, but he seemed to think that was fine … when I really felt like … something was wrong and he was like that is a normal thing to go through … I don't know about that (Helen).

Perhaps he lacked training in sexual assault or a trauma-informed approach.

Several of the service users said the counsellor had not explored their feelings or emotions, rather focusing on symptom relief; the service users were comfortable with this. This was part of the stage 1 phase of stabilisation, which, in some cases, might be all that the service user wanted. However, a holistic healing journey might rest on a more comprehensive therapeutic experience, combining feminist and trauma-informed practice, provided the timing was right for the service user to process the trauma memories fully to achieve complete recovery.

Advice to others

Three main themes were evident in the advice that service users offered, namely, the importance of the therapeutic relationship; giving the male counsellor a chance; and individual choice. Four service users emphasised the primary importance of the *therapeutic relationship* and connection, not gender:

> Just talk with whoever you feel comfortable with, it's all about how you feel (Helen).

> Keep shopping 'til you connect; whether it is a male or female counsellor, make sure respect is there, don't give up (Patricia).

> I would very much reiterate the fact that it's to do with the click; If it's a good counsellor, they'll lead you in a way that you can feel comfortable enough to talk about your experience and why you're in that sort of situation … [and getting the right counsellor] because once that happens, [it's] magic (Shirley).

> I one hundred percent believe that I would not be alive today if I had not been gently nudged towards … therapy and, in the long run, it's less about the gender of the person and it's more about the connection that you are able to make with them … it's just about trying to build a rapport with the person that you are seeing because it is a very emotional private situation so just don't feel ashamed if you find somebody that you don't like and don't stick with them 'cause, at the end of the day, all you're doing is hurting yourself … They're a professional first; they understand that they can't help everybody (Gwynneth).

Four encouraged others to *give male counsellors a chance* and highlighted that they were professionally trained for this role:

Give it a go first … Trust them in the first place. Give them chance to do their job first (Em).

Give it a try … don't cancel the person out just because they're male … They could have more understanding than … a female could …. If you don't like the person, move on. There's lots of them out there, so … I wouldn't disclude (sic) someone just because they're male (Becky).

To not be afraid, not allow your experiences to stop you from seeking help. Trust your instincts … don't let fear take control of your life … It's okay, seeing a male isn't … a bad thing … [and] why not see a male … … … it's predominantly men who commit these crimes but not all men are like that and men … have horrible things done to them too, and why do we … [believe] a woman needs to … support another women (sic) … A man who is loving and caring and commits and dedicates himself to being in a role … to help men and women who have experienced this … like, why not? (Victoria)

There is nothing to be afraid of. If anything, they're going to be easier to talk to about it than talking to a female … (Jackie).

Two service users acknowledged it was a matter of choice and was good to have options, even though preferences might differ for each person:

Depends on their victimisation, how they were victimised. I would tell them that I see a male counsellor and it works for my personality. I would say what the options are that are available. If you want to learn how to walk down the street and not jump behind the tree, see a male counsellor (Tanya).

Think as much as you can in that sort of situation about what it is you want from counselling ... If you are the sort of person who'd greatly benefit from … just talking

about what happened, from my experience, a female counsellor would be the way to go. If you want that more … progress-based response, then male counsellors can be very useful (Toni).

Overall, the service users advised others to give male counsellors a go, based on their positive experiences. Even those who had had a negative experience with a male counsellor encouraged others to consider this option.

Conclusion

This chapter discussed the service-users' experiences of, and perspectives on, consulting male counsellors on sexual assault or sexual abuse. Most had had positive experiences. Only one had had a completely negative experience. Two service users spoke about issues of access and the difficulties arising when geographic location limited therapeutic services (and therefore choice). They provided their opinions on whether gender mattered. Most thought it was not the central issue, though believed it was better to see a female counsellor in the immediate crisis following an assault. Several service users compared their experiences with male and female counsellors noting men tended to take a behavioural, solution-focused approach, moving discussions toward life beyond assault, while female counsellors focused more on reliving the abuse and the associated emotions. Some were more comfortable with their male counsellor's approach, while others had had negative experiences of female counsellors. Service users also reflected on language used by counsellors and judgements made which then shaped a negative therapeutic relationship. Most service users would consult a male counsellor in the future. Positive consequences included understanding that not all men were perpetrators; it helped to gain a male perspective; and they liked male counsellors' therapeutic approaches, especially their tendency to be more direct and less emotional and judgemental than female counsellors. Negative consequences included differences in perspective, difficulties discussing sexual

assault details and intimacy, and termination issues. The service users talked about the feminist principles of power, the male counsellor not parading as an expert, and having choice and control in their therapy, of shifting blame and responsibility, and influence between individuals and structures. Further, service users spoke of trust, safety, comfort, concerns about triggering a traumatic reaction, and respecting culture. All encouraged service users to consider male counsellors, though not in the crisis stage. The following chapter discusses the findings presented in Chapters 8 and 9, the conclusions and recommendations of the study, and suggestions for future research.

CHAPTER 10

Discussion, conclusions, and recommendations

It's good to have male in this section (Em)

Policies are shifting … I always see it as like this: [Feminism] sits in our heart, this is the approach that we take … but the policy and the framework … is more around the systems and trauma-focused stuff (C10)

In Chapter 1, the researcher outlined her assumptions going into the study that led her to target two 'expert' participant groups to hear their views on whether feminist-informed practice had survived policy changes relating to an increasingly managerial workplace, new modes of practice, and greater inclusivity. Chapters 8 and 9 told their story from their perspective and presented the findings on:

- Female counsellors' views on the entry of male counsellors into SASs and the impact of greater inclusivity on organisational culture and management, employment policy, and feminist practice.
- Female service-users' experiences of, and reflections on, therapy with a male counsellor, their perceptions of the (positive and negative) impact of gender on the counselling experience, and whether it involved elements of feminist practice and facilitated healing.

The female counsellors provided rich and detailed information on the inclusion of male counsellors in government SASs and their impact. The female service users provided experience-based accounts of their consultations with male counsellors in the private and NGO sphere.

Discussion of findings

Table 10.1 outlines the findings in relation to the research questions (RQ) and the structure for the discussion that follows.

Table 10.1: Areas addressed and key findings

RQ	Counsellors	RQ	Service users
1.	Views on the inclusion of male counsellors in SASs. **Key findings**: The counsellors expressed concerns though perceived benefits of male counsellors. ***Related findings***: ▪ Lack of managerial support, equitable promotion opportunities, and fair work distribution ▪ Challenges to transforming SAS inclusivity (particularly in rural areas) ▪ Infusing policy with feminist discourse for ease of transformation	3.	Experiences of therapy and perceived (positive and negative) impacts of having a male counsellor **Key findings**: ▪ Service users were less concerned about male counsellors than the counsellor participants ▪ A relational connection was more important than gender ***Related findings:*** ▪ Choice was important, though limited, in rural and remote areas
2.	Perspective on an enduring feminist philosophy in SASs. **Key finding**: Feminism continued to hold currency in SASs ***Related findings***: ▪ Lack of clarity about feminist practice ▪ Implications of being stuck in 1970s radical feminism ▪ Gender, not feminism, was the issue ▪ Challenges to retaining the feminist part of trauma-informed practice ▪ Threats from medical, forensic, and judicial influences	4.	Elements of feminist practice, if any, experienced **Key finding**: Service users mentioned aspects of feminist practice within their descriptions of therapeutic experience that contributed to a positive and effective service response.

RQ 1: Counsellor's views on the inclusion of male counsellors in SASs

Concerns and perceived benefits

The counsellors expressed concern about the changed SAS landscape. The inclusion of male counsellors would muddy the waters for them, given their feminist focus on issues of gender-based power and control, supported by statistics that most perpetrators were male. They were concerned that men would not understand survivors' positions, given their lack of exposure to structural powerlessness resulting from men exercising power over women: 'As a female … it's innate that we sort of scan rooms; we are constantly looking at safety. Men don't have that way of being, knowing what that's like' (C7). Ironically, they dismissed the fact that males, too, experienced sexual assault, personal violations, and others exercising power over them.

Despite their concerns, the female counsellors would be more likely to accept male counsellors with the requisite qualifications, expertise, experience, and training, this being their expectation of all counsellors in the specialised field of sexual assault. Nevertheless, the idea of male counsellors working with female service users perplexed them. Despite their discomfort, some emphasised that they were not against men or 'man haters' (C1 and C11); 'this is hard; I'm trying to think of some positives, too, but I just can't [avoid] that internal argument that that's completely wrong' (C14). They questioned whether SASs would still be safe spaces with male counsellors around. Literature also raised questions about safety with the presence of male (or transgender) survivors in the belief that gender-inclusive waiting areas would no longer be safe spaces for female survivors (e.g., Gottschalk, 2009). However, most SASs had gender-inclusive waiting areas for multidisciplinary health services and people had become accustomed to seeing male survivors, so the counsellors no longer considered this an issue.

Inclusive feminist practice was also about increasing opportunities for men to assume caring roles and share family responsibilities. Challenging sex-role stereotypes and the social structures creating them implied it would be desirable to have more male carers accompanying their children to SASs. It also meant acknowledging that men filled multiple roles: they were survivors, carers, counsellors, and significant others to friends and family members to whom they were siblings, partners, and grandparents. Therefore, some counsellors thought an increase in the number of men in the SAS waiting area was a mark of progress in gender relations. The findings of this study supported the claim that male counsellors in SASs might benefit individuals, services, and communities.

The counsellors believed the inclusion of male counsellors in SASs might increase awareness that men and boys also experienced sexual assault and abuse. A male counsellor might increase men's confidence in engaging with the service and in raising awareness about sexual assault. The Royal Commission's findings that most victims of institutional sexual abuse were men (64.3% of the 6875 private sessions) indicated that the time was right to engage men more fully in SASs. The NSW Sexual Assault Strategy (2018-2021) acknowledged that men faced barriers in disclosing, and seeking support for, sexual assault noting:

> While specialist sexual assault services in NSW can support male victims and survivors, the community may not perceive these services as accessible for men. Reasons for this include services historically having a focus on women's responses to assault and abuse. Improving access for men to specialist services is important to ensure they are responded to appropriately (NSW Government, 2018a, p. 23).

In discussing their views on the inclusion of male counsellors in SASs, the counsellors talked about their concerns relating to:

- The lack of managerial support, equitable promotion opportunities, and fair work distribution
- Challenges to transforming SAS inclusivity.
- Infusing policy with feminist discourse for ease of transformation.

Concerns about the lack of managerial support, equitable promotion opportunities, and fair work distribution

The counsellors viewed the changes in SASs, including the prospective employment of male counsellors, as part of the shift to greater inclusivity within the broader service and social environment. They blamed the threats to feminist practice on the further embedding of economic rationalism and managerialist workplaces. They believed that managers focused on numbers and economic efficiency rather than the complex issues surrounding sexual assault and best practices to address them. Their lack of understanding left little room to support the continued evolution of feminist practice. The absence of evidence on the effectiveness of (ideology-based) feminist practice made protecting it doubly difficult. Twenty years earlier, Egan and Hoatson (1999) noted similar issues to those raised in this study, among them the contentious inclusion of men in feminist services and the enduring relevance of feminist practice principles. The feminist service participants in Egan and Hoatson's (1999) study commented on their decreased ability to undertake community development, a core feminist function, due to the large demand for individual counselling and corresponding measurable outputs favoured by managers bound by an economic rationalist agenda. The counsellors in this study noted that shifting priorities within SASs had eclipsed management support for feminist practices incompatible with a trauma focus.

Beyond this, given feminists' longstanding concerns about men's progression in organisational hierarchies, the counsellors were worried that male counsellors would rise more

quickly through the ranks than women, noting the higher percentage of males in professional and managerial positions in the services sector generally:

> Men's experiences in female-dominated occupations contrast with women's experiences in male-dominated occupations … The *glass escalator* [original emphasis] refers to the advantages and enticements for career mobility that White men encounter when they enter female-dominated occupations (Thompson & Armato, 2012, p. 158).

They were also concerned this would have a domino effect, leaving them at the coalface with high workloads and resource pressures. Nevertheless, the counsellors believed their presence could add value within the organisational structure, as male clinicians could inform management on what they needed to provide an effective and productive response. They believed that management would listen to male counsellors' feedback and would be more likely to act upon it than they would to theirs.

Another area where counsellors experienced little managerial support was in relation to trauma and its impacts on victims and survivors. Quadara and Hunter (2016) pointed to this need in the policy-driven transition to trauma-based care. The counsellors believed that SAS managers did not have the necessary understanding, knowledge, and awareness needed to support frontline workers, though this might eventuate with growing evidence on effective therapeutic approaches to the trauma of sexual assault. Only then would the organisational hierarchy correspondingly increase the resources essential to an optimal service response and prevention of retraumatisation. The counsellors believed this increased understanding would also invite a more complete and responsive approach for the SAS team and ensure organisational support, opportunities for self-care, appropriate supervision, and balanced workloads to prevent vicarious trauma.

Challenges to transforming SAS inclusivity

Historically, gender-based SASs laid claim to diversity and inclusivity though all the while engaging in exclusionary practices toward male counsellors and perpetrators. They justified this with their safety-first approach, arguing that encounters with males, whether as counsellors or perpetrators, would be traumatic for female service users. The NSW Health Policies and Procedures (2020) clearly noted the historic exclusion of men on safety-and-security grounds though this no longer applied to male counsellors. The counsellors had not encountered many male counsellors in SASs though some were aware of their presence in the private sphere.

When this study commenced, the researcher believed there were few male counsellors undertaking sexual assault work. The HNE ethics committee appeared to agree, hence its decision not to approve the proposed exploration of male counsellors' views, due to concerns about confidentiality and anonymity. However, the fact that the researcher was able to recruit seven service-user participants in just three months by advertising on one university campus showed there were many more male counsellors than first thought.

Counsellors considered the challenge of inclusive practice in rural areas. On the one hand, they identified the difficulty that male counsellors might have in establishing themselves in rural communities which had a distinct model of masculinity that differed from the normative male identity proffered in a therapeutic context, as discussed in this thesis. Counsellors further identified that male counsellors might encounter a cool reception from other service groups that disregarded the value of men in this field, particularly in 'conservative' and 'closed-minded' communities. On the other hand, counsellors expressed concern that key agencies might jump at this new option, see SASs as being up-to-date and well-informed, prioritise male counsellors to the detriment of female-counsellor options, and overwhelm them with high workloads. Rural counsellors were clear, however, that choosing a male or female counsellor would not be an option for survivors in their communities, as they

were single-clinician services and resources and funding budgets would not allow for the employment of an additional counsellor.

Infusing policy with feminist discourse for ease of transformation

The influence of feminist discourse was evident in NSW Health's (2020) longstanding view that sexual assault was the 'gendered abuse of power and an act of humiliation and control' (p. 224). It was 'underpinned by gender inequality and acts to express and reinforce gendered power relations regardless of the gender identity of the victim or perpetrator' (p. 25). The policy and procedures reinforced this structural-feminist perspective, as discussed in Chapter 2. Thus, the counsellors believed the translation of inclusive policy, such as male counsellors' entry into SASs, was possible within the structural-feminist approach they favoured. However, the new influence of postmodern feminist and masculinities discourse had led to a broadened focus on women *and men* and recognition that gendered power relations affected all relationships noting men were 'also subjected to stereotypes and dominating social expectations around traditional models of masculinity' (NASASV, 2015, in NSW Health, 2020, p. 225). As Leser (2019) noted, challenging social attitudes meant 'helping a whole new generation of boys grow up in a more integrated way, where both their masculine and feminine qualities are celebrated, and where ideas around consent, mutuality, healthy communication and respect are first and second nature' (p. 294). The inclusion of male counsellors reflected these changing norms on gender-based violence (Quadara & Wall, 2012). There was a constant need to expose the complex social conditions and public attitudes that perpetuated sexual assault for men and women alike through evidence-based programs rather than *ideological awareness raising* (in reference to second-wave radical feminist activism) (NSW Health, 2020). However, as Leser (2019) noted, 'more than a century of feminist activism has not prevented a gross gender imbalance in most walks of life, nor has it prevented millions of women suffering at the hands of men' (p. 8). Thus, feminists still believed that:

> The social climate that contributes to gender inequality and men's rape of women and girls is partially responsible for creating harmful beliefs (e.g., rape myths) and negative social reactions (e.g., blame) toward victims of sexual assault and abuse. [Thus] without larger societal change in social norms and institutional and organizational practices … society will remain an unsafe place for women (Ullman, 2010, p. 150).

RQ 2: Counsellors' perspective on an enduring feminist philosophy in SAS counselling practices

Feminism continued to hold currency in SASs

As in Egan's (2015) prior study of counsellors in NSW SASs, this study found that feminism still held currency: It was 'written into the apparatus that governs the sector' (Egan, 2019, p. 175). The counsellors in her study spoke of the importance of: re-establishing service-user control, conducting power analyses in sexual assault work, responding to the self-blame service users brought to therapy, connecting the personal and political within the therapy intervention, and adopting a non-expert approach to reduce power imbalances. Egan (2015, 2016, 2019) interpreted this as evidence that feminism remained embedded in SASs. Though she found persistent myths about, and challenges to, feminist consciousness-raising practice, there remained a strong adherence to, and 'taken-for-grantedness' of, feminism even though it was sometimes not obvious in practice:

> Sexual assault was understood as an abuse of power and an act of gendered violence that, although committed by individuals, is part of a system of structural inequality in which men (as a category) are advantaged and hold more power than women and children. Thus, radical feminist analyses of sexual assault, the form of feminism most closely associated with second-wave feminist work against sexual violence, appear to

> have retained their currency in the field of sexual assault service provision (Egan, 2016, p. 100).

The researcher observed the same phenomenon in this study:

> Interviewer: Particularly if you look at that feminist way of operating, are there parts of that that aren't there anymore?
>
> Counsellor: No, I think it's still quite central … I'm a feminist. I can't see any other way forward (C2).

The counsellors in this study attested the robustness and adaptability of feminism in its infusion in contemporary policy on trauma-informed practice. [Egan (2015) had conducted her interviews with counsellors in 2008-2009, when trauma-informed practice had just begun to inform SAS work]. Nevertheless, the counsellors felt a constant need to pressurise management to maintain the feminist ethos in frontline clinical service delivery. They lamented the loss of key aspects of 1970s radical feminism, including community development, groupwork, interagency connection, and community and political agitation. They saw this as part of the change in workplace culture, increased workloads, limited resources, and lack of managerial support. The counsellors in Egan's (2009) study did not mention the changing workplace culture or constant need to influence management to maintain a feminist ethos. As in this study, Egan (2019) found definitions of feminism reminiscent of the second-wave of the 1970s and 1980s with nostalgic comparisons to the strategies used by grassroots activist women's organisations, even though feminist theory had continued to evolve. Hence, the counsellors in this study still believed women should provide therapy for women. They were ambivalent about whether male and female counsellors should provide sexual assault counselling though they recognised that men could, and did, work from a feminist framework.

Despite feminists' rejection of mental health models that pathologised and blamed victims, the counsellors in this study accepted the links between feminism, trauma, and mental health that had originated when PTSD first appeared in the DSM-III in 1980:

> Its presence owed its existence to two groups of therapists … veterans administration mental health workers [and] feminist therapists who had been treating the survivors of the war at home – women survivors of sexual assault, domestic violence, childhood abuse, and workplace harassment … Feminist therapists had created names for these experiences, including rape trauma … and battered women's syndrome … Feminist practitioners identified interpersonal violence as a source of trauma: feminist theory moved the locus of the problem of interpersonal violence from its historical location in the victim's personality to the misogyny of the culture expressed through the actions of perpetrators of violence … The diagnosis of psychological trauma as it exists today and the explicit inclusion of interpersonal violence among traumatic stressors both have their roots in feminist practice (Brown, 2008, p. 296).

Egan's (2019) historical documentary review of child sexual abuse from the 1980s onwards found numerous pages of feminist analysis of patriarchy, power, and violence that challenged (deficit mental health) discourse on family dysfunction and questioned whether SASs' embrace of mental health perspectives could still be 'feminist' (Egan, 2019, p. 170). Nevertheless, her Foucauldian analysis discerned several themes on 'common sense', 'self-evident', 'embedded feminist knowledge' (Egan, 2019, p. 173) within SASs. She found:

1. Power analyses of sexual violence as a crime and counselling and intervention 'premised on and guided by the understanding that sexual assault is enabled through systemic structural inequalities' (Egan, 2019, p. 176).

2. Avoidance of the expert role in favour of a collaborative approach to facilitate women's choice and autonomy; this was key to second-wave feminist 'individual and collective practices … to challenge and provide alternatives to the hierarchical power structures associated with mainstream patriarchal institutions' (Egan, 2019, p. 175).
3. Using approaches to enable survivor choice and control, even though contemporary SASs were no longer 'collectively' organised services in NSW. Nevertheless, 'working differently with power … facilitating choice and control – has not only survived the incorporation of the services into the contemporary governance structures of the state, but has been written into the apparatus that governs the sector' (Egan, 2019, p. 175).

The counsellors in this study emphasised the need for male counsellors to be aware of gender-related privilege and recognise structural (systemic) oppression of, and discrimination against, women, due to their gender and other oppressive forces. Men, too, should examine the systems and structures of privilege and, in therapy, explore how these operated 'in an oppressive manner' (Brown, 2008, p. 295). This was part of recognising and acknowledging power and choice in their interactions with service users, treating them with respect and dignity, and seeing them as experts of their own stories. They wanted male counsellors to embrace these and other aspects of feminist practice, such as the focus on structural inequalities enabling sexual assault 'whether the intervention focuses on an individual victim or the community level' (Egan, 2019, p. 176). They wanted them to see sexual assault as a crime, an act of violence for which the offender was 'solely responsible' (Egan, 2019, p. 173). They wanted them to shift the responsibility from the victim to the offender and, in therapy, to believe the victim rather than subject her to repeated questioning about her 'role' in the assault and to

understand ‘the experience of forced sex … as an act of criminal violence, not as “just sex”’ (Egan, 2019, p. 174).

NSW Health (2020) highlighted the importance of placing responsibility on perpetrators though completely absent was any intervention with them: ‘Adults who have perpetrated sexual assault or sexually harmed another person will not ordinarily be provided with a response for ongoing therapeutic interventions from a SAS’ (p. 80). It emphasised that ‘responsibility and accountability for sexual assault rests with the perpetrator but the prevention of such violence is the responsibility of the community and society as a whole’ (NSW Health, 2020, p. 264).

The counsellors in this study were involved in community programs, though wanted to do more; managerial and caseload pressures prevented engagement in community activism to address wider political and structural issues. They recognised the value of male counsellors’ presence in challenging sexual assault and myths about it. They wanted them to stand up and protest against men’s violence against women. Counsellors considered that this would enhance awareness raising about violence against women and the struggle for gender equality more generally. Relatedly, the counsellors’ discussed the ongoing relevance of, and threats to, feminist practice:

- Lack of clarity about feminist practice
- Implications of being stuck in 1970s radical feminism
- Gender, not feminism, was the issue
- Challenges to retaining the feminist part of trauma-informed practice
- Threats from medical, forensic, and judicial influences

Lack of clarity about feminist practice

The counsellors were often unclear about feminist practice. As in Egan's (2015) study, the researcher had to infer this from their descriptions of their practice, such as their focus on choice, power, women's stories, and a non-expert approach. The counsellors had not kept up to date with advances in feminist scholarship and remained rooted in 1970s activist feminist ideals not necessarily shared by service users. Nevertheless, most claimed that feminism had undergirded SASs since their inception and grounded their practice at a time when 'violence against men was not a known quantity' (C6). The counsellors interpreted sexual assault as a crime of violence against women and explained its causes in terms of the patriarchal social structure, male dominance, women's oppression, and gender stereotyping. However, they had difficulty understanding and defining feminism, and found questions about feminist practice difficult to answer. Some were unsure: I am 'completely on the fence' (C7). Others attested the enduring relevance of explaining women's oppression in terms of patriarchy noting that women remained subject to discrimination and sex-role stereotyping that conditioned them into certain roles.

While female counsellors expressed concern about the power that male counsellors could exert in the counselling space, and their ability to (intentionally or not) abuse or take advantage of this position, they did not consider that female counsellors could (and had been known to) abuse their position (of power) in this context. Some counsellors quite clearly expressed concern about women in management positions that had 'lost touch' (C5) with client needs and emphasised that female managers were prone to abuse their positional power within the hierarchical organisational system.

Finally, most saw choice as the core feminist principle lending support to Egan's (2019) finding that 'working with victims in ways that enable choice and control remains central to contemporary feminist sexual assault work' (p. 175). However, the size and geographic

location of the service played a role when it came to the choice of the counsellor's gender. Two counsellors in rural SASs highlighted that this choice only pertained in metropolitan areas, where there were teams of workers. They assumed that a female counsellor would occupy the role when there was only one counsellor in a service. Service users also emphasised the importance of choice in therapy and some could not see why services would not provide this, including the option to choose a male or female counsellor, although some understood the difficulties of this in rural areas.

Implications of being stuck in 1970s radical feminism

Second-wave feminism adhered to a binary notion of gender rooted in biological differences between the sexes and focused on the body as a site of oppression of, and sexual violence against, women. Therefore, early SASs challenged oppression and advocated for women's right to reclaim autonomy over their bodies. The counsellors believed that this anti-oppressive stance remained relevant, given the persistence of violence against women:

> When I think of feminism, I still have this image of … extreme protesting in the 70s, even though I know intellectually that that's not what feminism is, so, I've got this image [of] … what a feminist should be (C12).

This second-wave feminist image flowed from perceived differences between men and women. It led to the assumption that women were better at helping women than men because only women understood women's experiences or had the 'feminine' personality characteristics suited to sexual assault counselling. Women were more understanding, empathic, and caring than men, who were self-focused, rational (rather than emotional), and action oriented (doing rather than being with, sitting, and listening). To compound this, the women's movement had fought to liberate women from male dominance and nowhere was this more visible than in

sexual assault, where men used sexual violence to dominate and control women. Thus, second-wave feminists had a unidirectional view of power.

Contemporary feminist thought had advanced beyond the radical feminist ideals undergirding SASs, not least the assumption that all women understood all women or that every woman shared the same experiences. It acknowledged that men, too, were aware of, and understood issues and inherent feelings surrounding sexual violence, especially boys and men who had survived abuse by their fathers, clergy, teachers, siblings, and even mothers. It extended analyses of women's oppression beyond patriarchy, power, and male dominance to the intersecting experiences of classism, racism, ableism, ageism, and heterosexism acknowledging that women (and men) endured multiple oppressions. Increasingly conscious of the diversity of women's experiences, 'they argued against the idea of one essential experience of women and began to recognize a plurality of women's lived experiences … [and believed that] listening to the experiences of the "other" leads to a more complete understanding' (Hesse-Biber, 2012, p. 13). With a more evolved understanding of cultural constructions of gender and sexual violence, due to advances in science, research, and feminist scholarship, contemporary feminists had a broader understanding of violence perpetrated against women, children, and men that weakened arguments for female employee-dominated services and called for greater inclusivity with open employment practices and engagement with transgender clients:

> Given that rape ideologies exist as a part of broader patriarchal power structures, discourses on sex and gender, masculinity and femininity, sexuality and heterosexuality, sexism and racism, and other systems of social oppression must be addressed through similar individual and institutional-level approaches (Gavey, 2005, in Edwards et al., 2011, p. 770).

Contemporary feminists challenged binary sex-role stereotyping noting the fluidity of roles arising from cultural constructions of gender:

> In the first decade of the 21st century, feminists expanded their focus on difference to include issues of sexual preference and disability, as well as nationality and geographical region. There is also a growing awareness among feminist researchers of the importance of women's experiences in a global context with respect to issues of imperialism, colonialism, and national identity (Hesse-Biber, 2012, p. 14).

Further, contemporary feminism benefited from the insights of masculinity studies about what it meant to be a man and how organisational, structural, and political contexts shaped individual, interactional, and relational norms about male (and female) behaviour. The inclusion of male counsellors in violence prevention arose in the context of renewed understanding of men's role in challenging patriarchy and promoting gender equality and equity and safe and respectful sexual relationships. As Gates (2019) observed, male allies were essential. Masculinity studies highlighted:

> The necessity for men to redefine masculinity, to imagine new forms of sexual and erotic expression, to produce a masculinity whose desire is no longer dependent on oppression, no longer policed by homophobia, and one that no longer resorts to violence and misogyny to maintain its sense of coherence (Chapman & Rutherford, 1988, in Gamble, 2001, p. 57).

Gender, not feminism, was the issue

The participants in this study all agreed that gender was a central issue in sexual assault but this did not mean men could not be counsellors. Feminists highlighted that women's struggle for equality meant opening diverse roles and removing negative assumptions and stereotypes for both genders and accepting alternative views of masculinity. These issues were as important

for men, who needed to consider their role in perpetuating discrimination against women (Gamble, 2001). Heath (in Gamble, 2001) stated that 'men have a necessary relationship to feminism – the point after all is that it should change them too' (p. 57). It was also erroneous to assume that *only* women were knowledgeable about, and could speak for, women: 'Knowledge is made possible and sustained by irreducible difference, not identity' (Gamble, 2001, p. 58). Further, Fenton (in Gamble, 2001) wrote that 'embracing difference within feminism has taught us that all women do not see the world in the same way nor do all women see the world differently from all men. Women and men share cultural outlooks' (p. 106). Here *gender and not feminism was the issue*. There were differences between concerns about gender and concerns about feminism. This might explain why counsellors expressed more hesitation than service users about male counsellors. The counsellors were ambivalent about male sexual assault counsellors' competence in establishing a safe, effective therapeutic relationship and questioned whether they would understand women's oppression in a patriarchal society, again attesting their second-wave feminist ideals. However, third-wave feminists claimed it was not possible for all women to understand all women and it was important for those who thought this way to recognise their error. The counsellors' central belief in informed choice leant support to the idea that gender rather than feminism was the issue. Similarly, service users valued their entitlement to choose between options.

Challenges to retaining the feminist part of trauma-informed practice

Trauma-informed practice in SASs, though feminist informed, had neutralised the critical sociological focus on gender and replaced it with neuroscientific and psychological trauma terminology that distilled the radical feminist stance on violence against women. This opened the door to male counsellors in SASs, increased the focus on psychological explanations and trauma-informed practice, and reduced the radical social work ethos. However, the counsellors saw potential in having a male counsellor on the team to role model a safe and respectful

relationship with adult female service users, perhaps for the first time. As Hill (2019) observed, for women who had 'been abused by male partners in the past, the realisation that it's happening again is sickening – [male counsellors could change the] … feeling that there are no good men in the world, and that they are fated to endure the same experience over and over again' (p. 64). Indeed, service users supported this claim, asserting that they already knew that not all men were abusers and their male counsellors had helped them realise this; they had reinforced safe and respectful relationships between genders.

The counsellors believed the feminist frameworks and perspectives undergirding SASs from their inception had translated well to trauma-informed counselling. NSW Health (2020) had infused SASs' trauma-informed approach with feminist arguments about supporting client choice, autonomy, and control noting it was wise not to 'make assumptions about what the client needs' (p. 30). It reiterated feminist arguments about 'dealing directly with issues of power, such as recognising that the greater the power difference the greater the sense of threat … [and related this to] the need for precautions to reduce the likelihood of being a further *source of trauma* [emphasis added]' (NSW Health, 2020, p. 243). Further, it reinforced feminist arguments about client participation, noting that building on client strengths, knowledge, and lived experience involved 'actively seeking the participation of the client, family and community in planning and delivering interventions and in providing feedback about what has been achieved' (NSW Health, 2020, p. 244). It noted the usefulness of an intersectional framework, once again echoing feminist arguments about survivors' 'complex experiences and identities' (Love et al., 2017, p. 176) and multiple oppressions compounding discriminatory practices, where, *inter alia,* sexuality, ability, race, class, culture, and gender were elements of women's disadvantage.

Gamble (2001) highlighted that second-wave radical feminists had overlooked these multiple oppressions by 'oversimplifying male patriarchy' (p. 145) and not examining social

norms and structures that positioned men in powerful and influential roles. This was important, especially when challenging crimes of violence against women, including the way SASs incorporated men into the service, to avoid repeating past mistakes and ensure equality, equity, and fairness in service provision and workplace practices. Thus, NSW Health (2020) had embedded a trauma-informed feminist framework in the systems and structures of SASs. It attested the ongoing feminist influence on policymaking, service delivery, clinical decision-making, and therapeutic intervention, however, gone was the feminist community action out of which these services evolved.

Trauma and complex trauma reinforced the feminist focus on relational issues (and connection, as discussed below), because, in trauma-informed practice, the relationship between therapist and service user was the site for healing and recovery. Badenoch (2018) explained that the brain and body system had the 'ongoing capacity of attaching … the many significant connections we have throughout our lives … [and] shape and reshape our relational circuitry and experience' (p. 242). The idea that the therapeutic relationship assisted in changing brain circuitry lent support to the argument that male counsellors could establish safe, appropriate, and respectful relationships with female survivors. If counsellors, male and female, were able to provide a 'safe and responsive' therapeutic space, in which to build 'trust in the possibility of having safe relationships' (Badenoch, 2018, p. 279), this would, in turn, assist in building trusting relationships with men in and outside the therapeutic environment.

Apart from feminist and trauma-informed practice, none of the counsellors referred to other therapeutic approaches, reflecting the generalist approach used in SASs. Service users, however, mentioned several therapies, including DBT and exposure therapy, since they had consulted male counsellors with specialist expertise in private practice. This was also indicative of an organisational culture, where managers on the ground supported generalist ideologically based feminist and trauma-informed practice rather than the specialist clinical approaches and

evidence-based therapies advocated in policy. This might also explain why the counsellors described management as 'out of touch' and why resources for training and clinical intervention did not match increased cases of complex trauma. Managers were constrained by the neoliberal ethos of doing more with less, while engaging in evidence-based effectiveness discourse, rather than a sound understanding of the complexity of trauma work and effective clinical responses. The counsellors felt unsupported by managers out-of-date with expanding research and literature on clinically proven trauma therapies. This, in turn, limited the scope for counsellors to provide up-to-date effective and efficient clinical services and resulted in a disservice to clients and the community at large.

This finding attested the researcher's struggle to obtain management support for training in EMDR therapy for the clinical team of which she was a part. As stated earlier, EMDR therapy was a well-researched primary therapeutic intervention with a strong evidence base for effective trauma therapy in the sexual assault field. Many counsellors in this study identified the need for management to increase training budgets to allow opportunities to expand and enhance their clinical skills with the most current and informative knowledge through conferences and international speakers. Training budgets had stagnated while conference and training fees had continued to rise putting them further out of reach for SAS counsellors.

Threats from medical, forensic, and judicial influences

Legal scholars have taken a great deal of interest in sexual assault though, as one counsellor in this study proclaimed, 'the legal system is *so not feminist*' (C3). Chapters 4 and 5 highlighted the fight for legal and policy reform, and the ongoing struggle to have a criminal and judicial system educated about sexual assault and sympathetic to women's vulnerability in these male-dominated systems. Given the importance of the burden of proof in the judicial process, the field of forensic medicine had grown along with the focus on forensic evidence to obtain rare

legal convictions of the perpetrators of sexual assault. Some counsellors also pointed to the increased training and focus on forensic medical examinations following a sexual assault as one of the foremost changes to SAS delivery in recent years. As discussed in Chapter 2, sexual assault had 'the lowest rates of reporting, investigation, prosecution, and conviction of any violent crime' (Ting & Palmer, 2020, n.p.). Only one in three cases reported to the police resulted in legal action and three in five remained unsolved or incomplete; only 3% of sexual assault cases resulted in guilty verdicts and only 1% in a conviction, while false complaints of sexual assault were rare at between 2% and 8% (Gilmore, 2019). Dyer (2019) believed men's misperceptions of sexual intentions that the legal system often used to support the accused (perpetrator) in court, where the issue of consent was central, had a lot to do with this poor legal outcome, while C2 and C5 attributed it to the gender imbalance in the legal system. Thus, medical forensic advances had yet to bring justice to sexual assault victims. It was, therefore, unsurprising that 87% of women chose not to contact the police (ABS, 2017a) and approximately 85% of sexual assault offences went unreported (Fileborn, 2011). Similarly, years of feminist activism and consciousness raising had not succeeded in alleviating the distress women experienced in the legal system following sexual assault charges. Carmody and Carrington (2000) argued that extensive NSW law reform on sexual violence, though necessary and welcome, had not acted as a deterrent: 'The law reform approach embodies virtually negligible preventative value, as it represents an intervention after, not before the incident' (p. 345). Further, research continued to show that attempts to be more sensitive (via law reform) to the needs of victims (as witnesses in the legal process) had also been largely unsuccessful in the ultimate aim of alleviating the focus on the victim. As some counsellors noted, there had been some positive changes with law reform (such as the option of closed-circuit television rooms to avoid contact with the defendant and the option of support workers), but there was still the sense that it was the victim on trial. The ordeal continued for the survivor as the legal

system remained imbued with cultural myths surrounding sexual assault that led, intentionally or not, to acquittals or non-guilty verdicts.

RQ 3: Service users' experiences of therapy and perceived impacts of having a male counsellor

There were two main findings relating to service-users' experiences of male counsellors:

1. They were less concerned about male counsellors than the counsellor participants were.
2. A relational connection was more important than the counsellor's gender.

Service users were less concerned about male counsellors than the counsellor participants

Feminists have long supported female employee-dominated SASs and feminist practices with arguments about safety. This did not seem to be an issue for the service users in this study; only one had felt unsafe with a male counsellor. As found in the literature, some service users felt more comfortable talking to female counsellors about intimacy and sexual issues. Otherwise, though they were concerned about gender issues, they did not see male counsellors as problematic. For them, gender was an important issue in sexual assault, not whether the counsellor employed a feminist approach. They wanted a strong relational connection with the counsellor, and this was more important than whether the counsellor was male or female. The service users believed that not all women felt comfortable with the approach of female counsellors.

A relational connection was more important than gender

As found in the literature, the service users believed that the relational connection with the counsellor – and quality of this relationship – was more important than his or her gender. The service users saw connection as primary and the gender of the counsellor as less important than the quality (comfort, trust, and safety) of the therapeutic relationship. Beyond the counselling relationship, service users also gained support from their social networks and connections with family and friends, face to face or in online chat groups. Jackie said sharing her story in this way had paved the way for opening up and expressing her feelings to a male counsellor. These relational fora also helped their progress after therapy.

Restricted choice in rural and remote areas

Some service users identified the severe restrictions on the survivor's ability to choose a counsellor, let alone his or her gender, in rural and remote areas. They had to consult the closest therapist regardless of gender or compatibility. Generally, the clinician's community standing prompted their engagement rather than other considerations like relational connection. For rural service users, practicalities, such as the cost of travelling to appropriate counselling services and the distance this entailed, determined referral avenues rather than choice and other feminist considerations.

RQ 4: Elements of feminist practice, if any, service users experienced

The researcher wanted to know whether service users valued the choice of having a male counsellor. She questioned whether it was important to them that the male counsellor adhered to a feminist stance and developed therapeutic relationships that facilitated and promoted healing. The service users did not relate 'choice of counsellor' to 'choice in feminist practice' and seemed more enthusiastic about comfort, trust, and safety within the therapeutic

relationship than with it having feminist grounding. All psychotherapeutic approaches rested on strong therapist-client relationships.

The service users, nevertheless, made constant references to power dynamics, choice and control, and a non-expert approach, and feminist techniques, such as use of power, shifting self-blame, and working between individuals and structures; and valuing feminist principles of relational connection, avoiding retraumatisation, and respecting culture. They talked about their male counsellors collaborating with them and giving them time to share their stories at their own pace. As Brown (2008) noted, 'collaboration requires careful attention to client's level of readiness and willingness to approach any topic or problem and places the definition of the problem into the collaborative space' (p. 293). However, overall, whether the counsellor employed an articulated feminist approach was not a major issue for them, but therapy imbued with feminist principles appeared favourable.

Conclusions

This feminist qualitative study captured women's subjective perspectives and experiences and provided a snapshot of their reflections, thoughts, and opinions at a certain time and place. In summary, these were the main conclusions to this study:

- Generally positive about the inclusion of male counsellors
- Feminism continued to inform practice
- Feminism remained relevant within trauma-informed practice
- A strong relational connection trumped gender or feminism
- Restricted access for rural and remote service users

Generally positive about the inclusion of male counsellors

Albeit with many concerns and provisos, most counsellors and all the service-user participants in the study perceived benefits in the inclusion of male counsellors in the therapeutic space, organisation, and community. Positive therapeutic experiences with male counsellors would challenge myths and stereotypes about men and reinforce that *not all men were perpetrators*. The counsellors believed positive male counsellor-female client relationships would model healthy gender relations. They saw value in gaining a male perspective and having a male voice in the agency and community advocating for women's rights and protecting against sexual violence. The male presence signalled inclusive feminist practice. There were reservations, however, about altered power balances within the organisational hierarchy with men reducing women's chances of promotion, threatening fair work distribution, and changing the nature of their work.

Feminism continued to inform practice

The study concluded that feminism continued to inform practice, due to an enduring stance on sexual assault as a gendered crime, centrality of choice and empowerment, primacy of safety issues, and focus on power imbalances and male privilege. Although the counsellors were often unclear about what feminist practice entailed, these second-wave feminist claims underlay much of their work with female service users. They continued to see sexual assault as evidence of male dominance and women's oppression. As such, they continued to embrace the structural-feminist discourse and lamented the loss of foundational elements of second-wave radical feminist practice, including community advocacy, dynamic interagency relationships, and political activism. They attributed this loss to changes in workplace culture and management that brought increased workloads, limited resources, and an increasing focus on

individual trauma. In this environment, there was a lack of managerial support for the continued evolution of feminist practice and up-to-date specialist clinical interventions.

Feminism remained relevant within trauma-informed practice

The counsellors believed that the feminist philosophy was compatible with the socio-ecological, trauma-informed perspective now dominating NSW SASs. Driven by policy regulating SASs, feminist and trauma therapy intertwined in sexual assault counselling, continuing long-established links between feminism, trauma, and mental health. However, developments in psychology and neuroscience, rather than feminism, provided impetus for this. The counsellors' embrace of the trauma focus was due, in large part, to the feminist perspective on sexual assault and abuse as a traumatic experience, along with understanding PTSD and advances in psychotherapeutic techniques to treat trauma-related conditions. As Egan (2016) found, the counsellors understood trauma within a feminist framework in which survivors' symptoms were a 'normal' result of trauma (often in childhood). She noticed that a trauma focus made 'sense' (Egan, 2016, p. 107) to practitioners because it externalised the problem. By dealing with trauma, survivors could exercise choice and regain power and control. Only a few found it difficult to reconcile trauma and feminist therapy, seeing them as distinct approaches. The service users valued the counsellor's ability to tolerate emotional discomfort and distress, and to provide a genuine and authentic response of reassurance in a bounded and respectful manner, both of which were important to feminist and trauma-informed counselling.

A strong relational connection trumped gender or feminism

For service users, a positive relationship with the counsellor overrode issues of counsellor gender and feminist practice. Nevertheless, many of the elements of practice they valued were feminist, including the therapist's use of power, taking a non-expert role, allowing them to exercise choice and control, shifting self-blame, working between individuals and structures,

building trust, safety, and comfort, understanding triggering events, and respecting culture. Most had had positive experiences and found male counsellors direct and less emotional and judgmental than female counsellors. They would consult a male in the future and did not share the counsellors' concerns about threats to feminist practice and workplace cultures. They had experienced a variety of therapeutic approaches which suggested male counsellors had specialist skills not necessarily valued by managers within generic SASs. Nevertheless, some service users found it difficult to discuss sexual matters with male counsellors and a few had issues with termination of the therapeutic relationship.

Restricted access for rural and remote service users

This study provided confirmation of NSW Health's (2020) claims regarding barriers to disclosure and service provision for female sexual assault survivors in rural, regional, and remote locations regarding:

- Limited or non-existent service provision and opportunities for medical, legal, or emotional support.
- Economic factors and geographic isolation limiting options to disclose sexual assault and gain access to support services.
- Strong community ties in rural areas meant survivors were less likely to report sexual assault because they were more likely to know their perpetrators than survivors in urban locations.
- There was an increased likelihood that people who had experienced violence would have personal relationships or connections with service providers, which placed additional barriers to service access, due to shame and confidentiality concerns.

NSW Health workers had to be mindful of these barriers and the practical issues surrounding geographic location and access to service provision when working with vulnerable rural and

remote clients (NSW Health, 2020). Both counsellors and service users pointed to these difficulties for survivors in rural and remote areas.

Recommendations for policy and practice

The inclusion of male counsellors and focus of feminist interventions needed to be a part of a comprehensive policy approach to enable targeted campaigns and interagency work to tackle the structural issue of violence against women within the broader community. NSW Health claimed its policy and procedures applied at all levels of intervention, yet, to a large extent, the focus of SASs was individualistic and trauma-oriented. For SASs to remain active and responsive to broader structural issues, while offering efficient client-based services, there needed to be a return to well-resourced community development and interagency work.

For any change to occur, the most relevant agencies needed to be able to respond effectively, compassionately, and comprehensively, alongside NSW Health. Governments and government services needed to stand up and take responsibility in their role for ending violence against women. Within SASs, frontline workers should not be the only ones holding the flag. They needed the backing of all levels of the organisation led by vocal, supportive, and active managers. Change depended on the combined knowledge, skills, and expertise of all involved. Further, there needed to be commensurate funding and resources for informed and robust services and evidence-based interventions. As has also been demonstrated, managers needed to equip themselves with sharpened knowledge of the complex needs of men, women, and children caught in the trauma of sexual assault.

This study demonstrated the need to consider the cessation of female-only employee advertisements for SASs in the interests of greater inclusivity. The counsellors and service users saw value in the inclusion of male counsellors in this NSW Health service provided their entry was managed appropriately with service-user well-being paramount. They saw

inclusivity as an avenue to show the community at large that Health was at the forefront of tackling challenging systemic issues relating to sexual violence.

It was clear from both service users and counsellors that the best role for male counsellors lay in responding to the needs of survivors of past sexual abuse with female counsellors also responding to the acute phase. To provide the element of choice of the counsellor's gender was not only a feminist principle of practice but also could influence a service-user's view of their therapy and so result in effective and positive outcomes. Such practice change was profound and appeared to contrast with some literature reports on the choice of the counsellor's gender. However, unique to this conversation and requiring full consideration was the service-users' voice sending a strong and clear message regarding these changes to service delivery, echoed by counsellors and epitomised in C15's statement that 'just having a male in the service is a powerful message in itself'.

Finally, the study's conclusions regarding access in rural and remote areas suggest that future policies need to:

- Tackle the barriers to equitable access to SASs hampering effective service delivery and preventing consistent healing and recovery journeys for all service users regardless of their location.
- Consider how male counsellors could fit within a culturally appropriate, sensitive, and respectful service response to survivor communities, particularly Aboriginal communities in rural and remote areas.

Suggestions for future research

NSW Health (2020) noted that, 'with more Aboriginal people living in NSW than in any other Australian state or territory, improving the health and wellbeing of Aboriginal communities is a key focus for the NSW Government' (p. 14). The NSW Health (2020) policy highlighted that

Aboriginal women were three times more likely to experience sexual assault than non-Indigenous women were. With Aboriginal women most at risk of sexual assault, Hill (2019) noted the importance of hearing their views, recording their experiences, and ensuring their stories were told and not minimised or excluded, as has been done to them in the past. Therefore, it is important for future research to focus on the voice of Aboriginal women, especially in NSW.

This study pointed to the difficulties and barriers faced by women living in rural, remote, and regional areas, who had limited choice, due to a shortage of counsellors, lack of privacy and confidentiality arising from life in close-knit communities, having to travel long distances to access counselling, and cultural beliefs that prioritised women's business. It is, therefore, important to hear Aboriginal and rural and remote women's views on male counsellors and increased choice, as they might raise culturally specific concerns and issues (NSW Health, 2019). The fact that this study had a very low representation of women from non-English speaking backgrounds indicated a need for future research to include the voices of women from diverse backgrounds. It would also be vital to hear from the LGBTQI+ community on how these service changes would affect them. Connecting this to the criticisms of feminism in the past being centred on the needs and issues of white Western women, it is essential to hear the experience and wisdom of all women. Failing that, 'the "grand-narrative" of feminism becomes the story of western endeavour, and relegates the experience of non-western women to the margins of feminist discourse' (Gamble, 2001, p. 66). In this study, the researcher interviewed a small sample of service users. Further research might extend to a larger number of participants from diverse backgrounds to generate further evidence to inform policy and practice on male counsellors with adult female survivors in this therapeutic field.

A future study could focus on counsellors from metropolitan and remote SASs, as this study did not include them, as already explained. It would be informative to compare the

experiences and insights of counsellors in metropolitan and remote areas to those in rural and regional areas, as this researcher initially had hoped to do. In addition, further research could explore the views of male counsellors who provide sexual assault therapy to ascertain their views on inclusion in NSW SASs and how this could occur, as this researcher, again, had hoped initially to do.

Research could explore how counsellors envisage the introduction and establishment of such profound service changes to allow for a smooth, acceptable transition. One counsellor had pointed to the fact that the consultative process for changes in service delivery generally overlooked frontline clinicians' views. Incorporating all voices on this multidimensional issue would indeed be inclusive. As Gates (2019) observed:

> Overcoming the need to create outsiders is our greatest challenge as human beings. It is the key to ending deep inequality … we invent excuses for our need to exclude. We say it's about merit or tradition when it's really just protecting our privilege and our pride (p. 52).

To achieve greater inclusivity, this research has demonstrated that male sexual assault counsellors could help with the resultant change to a structural response their inclusion would entail. Their presence would highlight that it is not only a women's issue, it is an issue for all; male voices were imperative in the fight to end sexual violence against women. The findings showed that the inclusion of male counsellors, therefore, meets the challenge to address the issue at the ecological levels of micro, mezzo, and macro service provision: At the personal level with the service user, at the mezzo level with the service structure, and the macro level with the political and community players. This study has also highlighted that such service-delivery change could assist not only female survivors, but also male survivors. Overall, the research concluded that, while such change might be an important but challenging transition, the benefits outweighed the negatives. Nevertheless, anxieties surrounding challenges to

historical notions, philosophies, and practices needed to be carefully and sensitively managed if a smooth transition were to eventuate.

Further, the study highlighted the need to consider the cultural complexities for Aboriginal people given their unique needs and values, especially since NSW Health (2020) has noted this is a 'key focus for the NSW Government' (p. 14), as already discussed.

Finally, accompanying greater inclusivity is the important question of whose responsibility it is to ensure perpetrators take responsibility for their sexually violent behaviour. This could be an area for further study. In terms of contemporary practice, this was likely to be a legal justice matter with treatment services provided in gaols for convicted perpetrators. It is unlikely that adult offenders would admit to a crime of sexual assault outside the judicial and correctional spheres and independently seek personal counselling through the private sector. These assumptions require further testing in future research addressing service-sector responsibility regarding perpetrator accountability.

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Appendices

Appendix I: NSW Sexual Assault Services

1. Albury Sexual Assault Service	2. Armidale Sexual Assault Service
3. Bankstown Sexual Assault Service	4. Bathurst Sexual Assault Service
5. Bega Valley Sexual Assault Service	6. Blacktown/Mt Druitt Sexual Assault Service
7. Bourke Sexual Assault Service	8. Broken Hill Sexual Assault Service
9. Coffs Harbour Sexual Assault Service	10. Clarence Valley (Grafton) Sexual Assault Service
11. Coonamble Sexual Assault Service	12. Coonabarabran Sexual Assault Service
13. Cooma Sexual Assault Service	14. Cowra Sexual Assault Service
15. Deniliquin Sexual Assault Service	16. Dubbo Sexual Assault Service
17. Eastern & Central Sydney Sexual Assault Service	18. Eurobodalla Sexual Assault Service
19. Forbes Sexual Assault Service	20. Glen Innes Sexual Assault Service
21. Gosford Sexual Assault Service (Biala Cottage)	22. Goulburn Sexual Assault Service
23. Griffith Sexual Assault Service	24. Gunnedah Sexual Assault Service
25. Illawarra VAN - Sexual Assault Service	26. Inverell Sexual Assault Service
27. Kempsey Sexual Assault Service	28. Lightning Ridge Sexual Assault Service
29. Lithgow Sexual Assault Service	30. Liverpool/Fairfield Sexual Assault Service
31. Macarthur/Bowral Sexual Assault Service	32. Maitland Sexual Assault Service (Lower Hunter)
33. Moree Sexual Assault Service	34. Mudgee Sexual Assault Service
35. Muswellbrook Sexual Assault Service (Upper Hunter)	36. Narrabri Sexual Assault Service
37. Newcastle Sexual Assault Service	38. Northern Sydney Sexual Assault Service
39. Orange Sexual Assault Service	40. Parkes Sexual Assault Service
41. Penrith Sexual Assault Service (Springfield Cottage)	42. Port Macquarie Sexual Assault Service
43. Queanbeyan Sexual Assault Service	44. Richmond Sexual Assault Service, Lismore
45. Shoalhaven VAN - Sexual Assault Service	46. Southern Sydney Sexual Assault Service
47. Tamworth Sexual Assault Service	48. Taree Sexual Assault Service
49. Toomelah / Boggabilla Sexual Assault Service	50. Tweed Valley Sexual Assault Service
51. Wagga Wagga Sexual Assault Service	52. Westmead Sexual Assault Service
53. Yass Sexual Assault Service	54. Young Sexual Assault Service

Source: NSW Health (2018). ` Regional and rural SASs (n=45)

Appendix II: HNE ethics approval

9 May 2017

Professor Mel Gray
Faculty of Education & Arts
University of Newcastle

Dear Professor Gray,

Re: Male counsellors in sexual assault services: Perspectives of service users and counsellors (17/03/15/4.03)

HNEHREC Reference No: 17/03/15/4.03
NSW HREC Reference No: HREC/17/HNE/71

Thank you for submitting the above application for single ethical review for a multi-centre study. This project was first considered by the Hunter New England Human Research Ethics Committee at its meeting held on **15 March 2017.** This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (2007)* (National Statement) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. Further, this Committee has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review. The Committee's Terms of Reference are available from the Hunter New England Local Health District website.

I am pleased to advise, the Hunter New England Human Research Ethics Committee has determined that the above protocol meets the requirements of the *National Statement on Ethical Conduct in Human Research* and following acceptance of the requested clarifications and revised Information Statements and Consent Forms by Dr Nicole Gerrand Manager, Research Ethics & Governance, under delegated authority from the Committee, grants ethical approval of the above project.

The *National Statement on Ethical Conduct in Human Research (2007),* which the Committee is obliged to adhere to, include the requirement that the Committee monitors the research protocols it has approved. Ethics Approval will be ongoing subject to the following conditions:

- A report on the progress of the above protocol is to be submitted at 12 monthly intervals. A proforma for the annual report will be sent at the beginning of the month of the anniversary of approval. Your review date is **May 2018.**
- All variations or amendments to this protocol must be forwarded to, and approved by, the Hunter New England Human Research Ethics Committee prior to their implementation.
- A final report must be submitted at the completion of the above protocol, that is, after data analysis has been completed and a final report compiled.
- The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:

Hunter New England Research Ethics & Governance Office
Locked Bag No 1
New Lambton NSW 2305
Telephone: (02) 49214950
Email: HNELHD-HREC@hnehealth.nsw.gov.au
http://www.hnehealth.nsw.gov.au/ethics/Pages/Research-Ethics-and-Governance-Unit.aspx

- Notify the reviewing HREC of any adverse events that have a material impact on the conduct of the research in accordance with the NHMRC Position Statement: *Monitoring and reporting of safety for clinical trials involving therapeutic products May 2009* https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e112_nhmrc_position_statement_monitoring_reporting_safety_clinical_trials.pdf
- Unforeseen events that might affect continued ethical acceptability of the project.

➢ If for some reason the above protocol does not commence (for example it does not receive funding); is suspended or discontinued, please inform Dr Nicole Gerrand as soon as possible.

The following documentation has been reviewed and approved by the Hunter New England Human Research Ethics Committee:

Document	Version	Date
NEAF [Submission Code: AU/1/E78B23]		
Flyer	Version 1	13 February 2017
Information Statement and Consent Form – Service Users	Version 2	13 April 2017
Information Statement and Consent Form – Counsellors	Version 2	13 April 2017
Interview Schedule for Service Users	Version 1	13 February 2017
Interview Schedule for Female Counsellors	Version 1	13 February 2017

Approval has been granted for this study to take place at the following sites:

- **Regional, Metropolitan and Country NSW Health Sexual Assault Services**
- **Port Macquarie, Central Coast, Sydney, Western Sydney, and Central West New South Wales**

It is noted: *Other sites NGO's that receive funding from NSW Health but are not NSW PHO's will be approved by the University of Newcastle.*

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorisation from the Chief Executive or delegate of that site has been obtained.

A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

Should you have any concerns or questions about your research, please contact Dr Gerrand as per the details at the bottom of the page. The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Please quote **17/03/15/4.03** in all correspondence.

The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Yours faithfully

For: Ms M Hunter
Chair
Hunter New England Human Research Ethics Committee

Hunter New England Research Ethics & Governance Office
Locked Bag No 1
New Lambton NSW 2305
Telephone: (02) 49214950
Email: HNELHD-HREC@hnehealth.nsw.gov.au
http://www.hnehealth.nsw.gov.au/ethics/Pages/Research-Ethics-and-Governance-Unit.aspx

Appendix III: UON external HREC approval

RESEARCH INTEGRITY UNIT

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Registration of External HREC Approval

To Chief Investigator or Project Supervisor:	**Professor Mel Gray**
Cc Co-investigators / Research Students:	**Ms Julie Hopkins**
Re Protocol:	**Male counsellors in sexual assault services: perspective of service users and counsellors**
Date:	**06-Jun-2017**
Reference No:	**H-2017-0172**
External HREC Reference No:	**17/03/15/4.03**

Thank you for your **Initial Application** submission to the Research Integrity Unit (RIU) seeking to register an External HREC Approval in relation to the above protocol.

Your submission was considered under an **Administrative Review** by the Ethics Administrator.

I am pleased to advise that the decision on your submission is **External HREC Approval Noted** effective **06-Jun-2017**.

As the approval of an External HREC has been noted, this registration is valid for the approval period determined by that HREC.

Your reference number is **H-2017-0172**.

PLEASE NOTE:
As the RIU has "noted" the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University's RIU, via RIMS.

Linkage of ethics approval to a new Grant

Registered External HREC approvals cannot be assigned to a new grant or award (ie those that were not identified in the initial registration submission) without confirmation from the RIU.

Best wishes for a successful project.

Mr Alan Hales
Manager, Research Compliance, Integrity and Policy

For communications and enquiries:
Human Research Ethics Administration

Research & Innovation Services
Research Integrity Unit
NIER, Block C

The University of Newcastle
Callaghan NSW 2308
T +61 2 492 17894
Human-Ethics@newcastle.edu.au

RIMS website - https://RIMS.newcastle.edu.au/login.asp

Linked University of Newcastle administered funding:

Funding body	Funding project title	First named investigator	Grant Ref
		,	

Appendix IV: HNE ethics variation

16 August 2017

Professor Mel Gray
Faculty of Education & Arts
University of Newcastle

Dear Professor Gray

Re: Male counsellors in sexual assault services: Perspectives of service users and counsellors (17/03/15/4.03)

HNEHREC Reference No: 17/03/15/4.03
NSW HREC Reference No: HREC/17/HNE/71

Thank you for submitting a request for an amendment to the above project. This amendment was reviewed by the Hunter New England Human Research Ethics Committee. This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (2007)* (National Statement) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. Further, this Committee has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review.

I am pleased to advise that the Hunter New England Human Research Ethics Committee has determined the variation meets the requirements of the National Statement on Ethical Conduct in Human Research and has granted ethical approval for the following amendment requests:

- For the addition of Illawarra/Shoalhaven and Hunter New England Local Health Districts as study sites

Approval has been granted for this study to take place at the following sites:

Regional, Metropolitan and Country NSW Health Sexual Assault Services:
- **Port Macquarie, Central Coast, Sydney, Western Sydney, Central West New South Wales, Illawarra/Shoalhaven and Hunter New England LHD's**

The *National Statement on Ethical Conduct in Human Research (2007),* which the Committee is obliged to adhere to, include the requirement that the committee monitors the research protocols it has approved. Ethics Approval will be ongoing subject to the following conditions:

- A report on the progress of the above protocol is to be submitted at 12 monthly intervals. A proforma for the annual report will be sent at the beginning of the month of the anniversary of approval. Your review date is **May 2018.**
- All variations or amendments to this protocol must be forwarded to and approved by the Hunter New England Human Research Ethics Committee prior to their implementation.

Hunter New England Research Ethics & Governance Office
Locked Bag No 1
New Lambton NSW 2305
Telephone: (02) 49214950
Email: HNELHD-HREC@hnehealth.nsw.gov.au
http://www.hnehealth.nsw.gov.au/ethics/Pages/Research-Ethics-and-Governance-Unit.aspx

- A final report must be submitted at the completion of the above protocol, that is, after data analysis has been completed and a final report compiled.
- The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
  - Notify the reviewing HREC of any adverse events that have a material impact on the conduct of the research in accordance with the NHMRC Position Statement: *Monitoring and reporting of safety for clinical trials involving therapeutic products May 2009* https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e112_nhmrc_position_statement_monitoring_reporting_safety_clinical_trials.pdf
  - Unforeseen events that might affect continued ethical acceptability of the project.
- If for some reason the above protocol does not commence (for example it does not receive funding); is suspended or discontinued, please inform Dr Nicole Gerrand as soon as possible.

The Hunter New England Human Research Ethics Committee also has delegated authority to approve the commencement of this research on behalf of the Hunter New England Local Health District. This research may therefore commence.

Should you have any queries about your project please contact Dr Nicole Gerrand as per the contact details at the bottom of the page. The Hunter New England Human Research Ethics Committee Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the Hunter New England Local Health District website.

Please quote **17/03/15/4.03** in all correspondence.

The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Yours faithfully

For: Ms M Hunter
Chair
Hunter New England Human Research Ethics Committee

Hunter New England Research Ethics & Governance Office
Locked Bag No 1
New Lambton NSW 2305
Telephone: (02) 49214950
Email: HNELHD-HREC@hnehealth.nsw.gov.au
http://www.hnehealth.nsw.gov.au/ethics/Pages/Research-Ethics-and-Governance-Unit.aspx

Appendix IV: UON ethics approval

HUMAN RESEARCH ETHICS COMMITTEE

Notification of Expedited Approval

To Chief Investigator or Project Supervisor:	**Professor Mel Gray**
Cc Co-investigators / Research Students:	**Doctor Martina Zangger** **Ms Julie Hopkins**
Re Protocol:	**Male counsellors in sexual assault services: perspectives of service users and counsellors - Recruitment through non-NSW Health organisations**
Date:	**18-Dec-2018**
Reference No:	**H-2018-0367**
Date of Initial Approval:	**18-Dec-2018**

Thank you for your **Response to Conditional Approval (minor amendments)** submission to the Human Research Ethics Committee (HREC) seeking approval in relation to the above protocol.

Your submission was considered under **Expedited** review by the Ethics Administrator.

I am pleased to advise that the decision on your submission is **Approved** effective **18-Dec-2018**.

In approving this protocol, the Human Research Ethics Committee (HREC) is of the opinion that the project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research, 2007, and the requirements within this University relating to human research.

Approval will remain valid subject to the submission, and satisfactory assessment, of annual progress reports. *If the approval of an External HREC has been "noted" the approval period is as determined by that HREC.*

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal *Certificate of Approval* will be available upon request. Your approval number is **H-2018-0367**.

If the research requires the use of an Information Statement, ensure this number is inserted at the relevant point in the Complaints paragraph prior to distribution to potential participants You may then proceed with the research.

Conditions of Approval

This approval has been granted subject to you complying with the requirements for *Monitoring of Progress*, *Reporting of Adverse Events*, and *Variations to the Approved Protocol* as detailed below.

PLEASE NOTE:
In the case where the HREC has "noted" the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University's HREC.

- ***Monitoring of Progress***

Other than above, the University is obliged to monitor the progress of research projects involving human participants to ensure that they are conducted according to the protocol as approved by the HREC. A progress report is required on an annual basis. Continuation of your HREC approval for this project is conditional upon receipt, and satisfactory assessment, of annual progress reports. You will be advised when a report is due.

- ***Reporting of Adverse Events***

1. It is the responsibility of the person **first named on this Approval Advice** to report adverse events.
2. Adverse events, however minor, must be recorded by the investigator as observed by the investigator or as volunteered by a participant in the research. Full details are to be documented, whether or not the investigator, or his/her deputies, consider the event to be related to the research substance or procedure.
3. Serious or unforeseen adverse events that occur during the research or within six (6) months of completion of the research, must be reported by the person first named on the Approval Advice to the (HREC) by way of the Adverse Event Report form (via RIMS at https://rims.newcastle.edu.au/login.asp) within 72 hours of the occurrence of the event or the investigator receiving advice of the event.
4. Serious adverse events are defined as:
    - Causing death, life threatening or serious disability.
    - Causing or prolonging hospitalisation.
    - Overdoses, cancers, congenital abnormalities, tissue damage, whether or not they are judged to be caused by the investigational agent or procedure.
    - Causing psycho-social and/or financial harm. This covers everything from perceived invasion of privacy, breach of confidentiality, or the diminution of social reputation, to the creation of psychological fears and trauma.
    - Any other event which might affect the continued ethical acceptability of the project.

5. Reports of adverse events must include:
    - Participant's study identification number;
    - date of birth;
    - date of entry into the study;
    - treatment arm (if applicable);
    - date of event;
    - details of event;
    - the investigator's opinion as to whether the event is related to the research procedures; and
    - action taken in response to the event.

6. Adverse events which do not fall within the definition of serious or unexpected, including those reported from other sites involved in the research, are to be reported in detail at the time of the annual progress report to the HREC.

- ***Variations to approved protocol***

If you wish to change, or deviate from, the approved protocol, you will need to submit an *Application for Variation to Approved Human Research* (via RIMS at https://rims.newcastle.edu.au/login.asp). Variations may include, but are not limited to, changes or additions to investigators, study design, study population, number of participants, methods of recruitment, or participant information/consent documentation. **Variations must be approved by the (HREC) before they are implemented** except when Registering an approval of a variation from an external HREC which has been designated the lead HREC, in which case you may proceed as soon as you receive an acknowledgement of your Registration.

Linkage of ethics approval to a new Grant

HREC approvals cannot be assigned to a new grant or award (ie those that were not identified on the application for ethics approval) without confirmation of the approval from the Human Research Ethics Officer on behalf of the HREC.

Best wishes for a successful project.

Associate Professor Helen Warren-Forward
Chair, Human Research Ethics Committee

For communications and enquiries:
Human Research Ethics Administration

Research & Innovation Services
Research Integrity Unit
The University of Newcastle
Callaghan NSW 2308
T +61 2 492 17894
Human-Ethics@newcastle.edu.au

RIMS website - https://RIMS.newcastle.edu.au/login.asp

Linked University of Newcastle administered funding:

Funding body	Funding project title	First named investigator	Grant Ref

Appendix V: Information statement for service users

Professor Mel Gray
School of Humanities and Social Science
Faculty of Education and Arts
University of Newcastle
(02) 4921 7322
Mel.Gray@newcastle.edu.au

INFORMATION STATEMENT FOR SERVICE USERS

Male counsellors in sexual assault services: perspectives of service users and counsellors

You are invited to participate in the research identified above, which is being conducted by Professor Mel Gray, Dr Martina Zangger, and Julie Hopkins (PhD candidate) from the University of Newcastle, New South Wales. This research is being conducted as part of Julie Hopkins' PhD.

You are invited to participate, if you have consulted with a male counsellor about an experience of sexual assault or sexual abuse. Your selection is based on the researcher's intention to involve service users so as to hear their perspectives and their experiences of working with a male counsellor about these issues. At this stage, your reading of this statement is not known to the researcher's and they will only become aware of your involvement if you indicate your willingness to participate. The research also aims to explore the views of female counsellors regarding the possible inclusion of male counsellors in sexual assault services. The researcher will meet with female counsellors from sexual assault services in a focus group to ascertain their views and experiences.

Why is the research being done?
The purpose of this research is to explore service users' perspectives of consulting with a male counsellor about sexual assault or sexual abuse. The aim is to hear the voices of women service users and to have these voices and wisdoms as part of a broader conversation around the

possible inclusion or not of male counsellors in government sexual assault services. The overall aim is to provide evidence and information to enhance service delivery and promote best practice for this group of service users. Specifically, the research will ask:

1. What are the views and experiences of adult women who have consulted with male counsellors around issues of sexual assault or sexual abuse?
2. Are male counsellors able to promote and facilitate recovery and healing for adult female victims and survivors of sexual assault or sexual abuse?
3. If so, what elements of their practice enable this to occur?

This research hopes to provide insights into the experiences of adult women consulting with male counsellors about sexual assault or sexual abuse, and therefore provide insights into best service responses and clinical practices for government sexual assault services. The research is of significance because:

- It is not known of other research that has focussed on the actual experience of adult women consulting with male counsellors about sexual assault or sexual abuse.
- Historically, only female counsellors have been employed in government sexual assault services, due to the understanding of the gendered nature of this type of crime.
- It will provide an opportunity for adult women service users to share their perspectives and their wisdoms in a sensitive and respectful context.
- The results will enable a best practice and policy response from government services to this group of service users.
- It will add to information and evidence for sexual assault counsellors regarding best clinical practice.

Who can participate in the research study?
You are invited to participate if you are female, aged 18 years and over, have experienced sexual assault or sexual abuse, and have consulted with a male counsellor about that issue.

What would you be asked to do?
You will be asked to participate in a feminist research project, involving a semi-structured private interview. The research is collaborative and only involves the researcher and the participant in the interview. You will be invited to share information with the researcher about your experiences and reflections of consulting with a male counsellor about a sexual assault or sexual abuse. The interview will be audio recorded, but only with your prior consent. You have the right to stop the recording at any time, to request that it be edited, and you also have the right to review and edit the transcript of the interview.

What choice do you have?
Participation in this study is entirely your choice. Only those people who give their informed consent will participate in the interviews. If you decide you no longer want to participate at any stage, you may withdraw from the project at any time without any consequences. You will not be disadvantaged if you choose to stop participating.

How much time will it take?
If you agree to participate, you will be asked to participate in an interview. The interviews may take approximately one to two hours to complete. These will be organised at a time and place that will be suitable for you, so as to ensure a sense of safety and comfort and convenience. Interviews can be organised face to face, or by telephone, email, Skype or facetime. If you would like to have a support person with you, this is fine. If you identify as an Aboriginal or Torres Strait Islander person, you will be asked if you would like an Aboriginal worker to support you and this will be arranged if possible. For clarification purposes, the researcher may contact and arrange a follow up interview.

What are the risks and benefits of participating?
There are no anticipated risks associated with participating in this research. However, as the research is exploring your views and experiences relating to sexual assault or sexual abuse, it has the potential to raise sensitive issues and feelings. If you find any of the questions upsetting, you can withdraw at any time. If you feel distressed as a result of your participation in the research, you may also contact Rape & Domestic Violence Services Australia on 1800 737 732 (24/7) or 1800 424 017 (24/7). The researcher will discuss supports and services available to you. You are free to leave the research at any time without any repercussions on your relationship to the researcher, the counselling service where you may have first heard about this research project, or to the University of Newcastle. A significant benefit of participating in this study is that you will be consulted about your experiences and have the opportunity to share your wisdoms and perspectives. The findings will help health services and counsellors deliver best practice and service-delivery responses, and therefore also help future service users on their journey of healing and recovery.

How will your privacy be protected?
At the commencement of the interview, pseudonyms will be developed with you so as to remove identification. Information and data collected during the research will be stored securely, either in locked storage or in password protected computers. Data will be retained for a minimum of five years as per the University of Newcastle policy and requirements. All information will be treated with respect and treated as confidential. However, the researcher does have a duty of care to all participants and an obligation to report concerns of risk of safety and harm of children and young people. This will be explained to you at the beginning of your involvement in the research. You will be asked to sign a consent form to indicate your understanding of your involvement and consent to participate in the research.

How will the information collected be used?
Information collected during the interview will be recorded and gathered and analysed. Common themes and issues, and points of difference, among participants will be noted. Outcomes and recommendations will be developed into a written report for the researcher's written thesis for the Research Higher Degree at the University of Newcastle. The researcher can provide a summary of the report and discuss this with you at the completion of the research.

What do you need to do to participate?
Please read this Information Statement carefully. Be sure you understand its contents before you agree to participate. The researcher will be happy to discuss this Statement with you and answer any questions or concerns you may have. If you do wish to participate in the research, please complete the attached Consent Form, and return this to the researcher in the stamped return-addressed envelope provided. The researcher will confirm your understanding of the Statement and confirm your consent prior to the interview.

Further Information
If you would like further information, please contact Julie.Hopkins@uon.edu.au.

Thank you for reading this Information Statement and considering the invitation to participate in the research**.**

Professor Mel Gray	Dr Martina Zangger	Julie Hopkins
Chief Investigator	Co-supervisor	Researcher

Complaints about this research
This research has been approved by the Hunter New England Human Research Ethics Committee of the Hunter New England Local Health District: Reference 17/03/15/4.03

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred to:

Dr Nicole Gerrand
Manager Research Ethics and Governance
Hunter New England Local Health District
Locked Bag 1, New Lambton
NSW 2305

Tel: (02) 49214950
Email: HNELHED-HREC@hnehealth.nsw.gov.au

Appendix VI: Consent form for service users

Professor Mel Gray
School of Humanities and Social Science
Faculty of Education and Arts
University of Newcastle
(02) 4921 7322
Mel.Gray@newcastle.edu.au

CONSENT FORM FOR SERVICE USERS

Male counsellors in sexual assault services: Perspectives of service users and counsellors

I understand that participation is voluntary, and I agree to participate in the above research and give my consent freely.

I understand I can withdraw from the research at any time, I do not have to give any reason and there are no consequences for this.

I understand that the research will be conducted as described in the Participant Information Statement, of which I have a copy.

I consent to participating in an interview with the researcher that will last for approximately 1-2 hours.

I am aware that the information given to the researcher will be handled with sensitivity and respect, and will remain confidential unless required to be disclosed due to safety concerns and duty of care obligations.

I am aware that information will be recorded and stored securely by the researcher.

I understand that the interview will be audio recorded; that I have a right to stop or edit the recording, and that I can review and make any corrections necessary to the transcript of the recording.

I acknowledge that I will be provided with a summary of the results of the research if I request this.

I have had the opportunity to ask questions and raise any concerns or issues to the researcher.

Print Name: _____

Phone: _____

Email (if preferred): _____

Signature: _____

Date: _____

Professor Mel Gray	Dr Martina Zangger	Julie Hopkins
Chief Investigator	Co-supervisor	Researcher

Appendix VII: Information statement for counsellors

Professor Mel Gray
School of Humanities and Social Science
Faculty of Education and Arts
University of Newcastle
(02) 4921 7322
Mel.Gray@newcastle.edu.au

INFORMATION STATEMENT FOR COUNSELLORS

Male counsellors in sexual assault services: Perspectives of service users and counsellors

You are invited to participate in the research identified above which is being conducted by Professor Mel Gray, Dr Martina Zangger and Julie Hopkins (PhD candidate) from the University of Newcastle, New South Wales. This research is being conducted as part of Julie Hopkins' PhD. You are invited to participate because you are a female counsellor working in a sexual assault service. Your selection is based on the researcher's intention to involve participants so as to hear their perspectives of male counsellors in sexual assault services. The research also aims to explore the views of service users, i.e., of adult women who have consulted with a male counsellor regarding a sexual assault or sexual abuse. The researcher will meet with service users and explore their experiences and perspectives in a semi-structured and confidential interview.

Why is the research being done?

The purpose of this research is to explore counsellor's perspectives around the possible inclusion or not of male counsellors in government sexual assault services. The overall aim is to provide evidence and information to enhance service delivery and promote best practice for this group of service users. Specifically, the research will ask:

1. What are the views of counsellors regarding the possible inclusion of male counsellors working with adult women in government sexual assault services?
2. Are male counsellors able to promote and facilitate recovery and healing for adult female victims and survivors of sexual assault or sexual abuse?
3. If so, what elements of male counsellors' practice enable this to occur?
4. Is feminist practice and philosophy still current in government sexual assault services?

This research hopes to provide insights into the experiences and perspectives of counsellors working in the field of sexual assault counselling, and therefore provide insights into best service responses and clinical practices for government sexual assault services. The research is of significance because:

- It is not known of other research that has focussed on the actual experience of adult women consulting with male counsellors about sexual assault or sexual abuse
- Historically, only female counsellors have been employed in government sexual assault services, due to the understanding of the gendered nature of this type of crime
- It will provide an opportunity for adult women service users to share their perspectives and their wisdoms in a sensitive and respectful context
- It will provide an opportunity for counsellors to share their perspectives and their wisdoms in a sensitive and respectful context
- The results will enable a best practice and policy response from government services to this group of service users
- It will add to information and evidence for sexual assault counsellors regarding best clinical practice.

Who can participate in the research study?

You are invited to participate if you are a female sexual assault counsellor in a government sexual assault service.

What would you be asked to do?

You will be asked to participate in a feminist research project, involving participation in a focus group. The research is collaborative and respects the wisdoms and experiences brought by all counsellors and invites shared and varied opinions. You will be invited to share information with the researcher about your perspectives of male counsellors working with adult women in sexual assault services.

What choice do you have?

Participation in this study is entirely your choice. Only those people who give their informed consent will participate in the focus groups. If you decide you no longer want to participate at

any stage, you may withdraw from the project at any time without any consequences. You will not be disadvantaged if you choose to stop participating.

How much time will it take?

Female counsellors will be asked to participate in a focus group Follow up contact may be required for clarification purposes. The initial focus groups may take approximately one to two hours to complete, at a venue of your choice e.g. workplace.

What are the risks and benefits of participating?

There are no anticipated risks associated with participating in this research. However, as the research is exploring your views and experiences as well as that of other counsellors, it has the potential to raise differences of opinions. If you find any of the questions or discussion upsetting, you can withdraw at any time. If you feel distressed as a result of your participation in the research, you may also contact EAP, or Rape & Domestic Violence Services Australia on 1800 737 732 (24/7) or 1800 424 017 (24/7). You are free to leave the research at any time without any repercussions on your relationship to the researcher or to the University of Newcastle. A significant benefit of participating in this study is that you will be consulted about your experiences and have the opportunity to share your wisdoms and perspectives. The findings will help health services and counsellors deliver best practice and service-delivery responses, and therefore also help future service users on their journey of healing and recovery.

How will your privacy be protected?

Information and data collected during the research will be stored securely, either in locked storage or in password protected computers. Data will be retained for a minimum of five years as per the University of Newcastle policy and requirements. All information will be treated with respect and treated as confidential. However, the researcher does have a duty of care to all participants and an obligation to report concerns of risk of safety and harm of children and young people. This will be explained to you at the beginning of your involvement in the research. You will be asked to sign a consent form to indicate your understanding of your involvement and consent to participate in the research.

How will the information collected be used?

Information collected during the focus groups will be recorded and gathered and analysed. Common themes and issues, and points of difference, amongst participants will be noted. Outcomes and recommendations will be developed into a written report for the researcher's written thesis for the PhD at the University of Newcastle. The researcher can provide a summary of the report and discuss this with you at the completion of the research.

What do you need to do to participate?

Please read this Information Statement carefully. Be sure you understand its contents before you agree to participate. The researcher will be happy to discuss this Statement with you and answer any questions or concerns you may have. If you do wish to participate in the research, please complete the attached Consent Form, and return this to the researcher. The researcher will confirm your understanding of the Statement and confirm your consent prior to the focus group.

Further Information

If you would like further information, please contact Julie.Hopkins@uon.edu.au.

Thank you for reading this Information Statement and considering the invitation to participate in the research.

Professor Mel Gray	Dr Martina Zangger	Julie Hopkins
Chief Investigator	Co-supervisor	Researcher

Complaints about this research

This research has been approved by the Hunter New England Human Research Ethics Committee of the Hunter New England Local Health District: Reference 17/03/15/4.03

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred to:

Dr Nicole Gerrand, Manager
Research Ethics and Governance
Hunter New England Local Health District
Locked Bag 1, New Lambton
NSW 2305

Tel: (02) 49214950
Email: HNELHED-HREC@hnehealth.nsw.gov.au

Appendix VIII: Consent form for counsellors

Professor Mel Gray
School of Humanities and Social Science
Faculty of Education and Arts
University of Newcastle
(02) 4921 7322
Mel.Gray@newcastle.edu.au

CONSENT FORM FOR COUNSELLORS

Male counsellors in sexual assault services: Perspectives of service users and counsellors

I understand that participation is voluntary, and I agree to participate in the above research and give my consent freely.

I understand I can withdraw from the research at any time, I do not have to give any reason and there are no consequences for this.

I understand that the research will be conducted as described in the Participant Information Statement, of which I have a copy.

I consent to participating in a focus group / interview with the researcher that will last for approximately 1-2 hours.

I am aware that the information given to the researcher will be handled with sensitivity and respect and will remain confidential unless required to be disclosed due to safety concerns and duty of care obligations.

I am aware that information will be recorded and stored securely by the researcher.

I understand that the interview will be audio recorded and that I can review and make any corrections necessary to the transcript of the recording.

I acknowledge that I will be provided with a summary of the results of the research if I request this.

I have had the opportunity to ask questions and raise any concerns or issues to the researcher**.**

Print Name: _____

Phone: _____

Email (if preferred) :_____

Signature: _____

Date: _____

Professor Mel Gray	Dr Martina Zangger	Julie Hopkins
Chief Investigator	Co-supervisor	Researcher

Appendix IX: HNE flyer

Professor Mel Gray
School of Humanities and Social Science
Faculty of Education and Arts
University of Newcastle, Callaghan NSW 2308
(02) 4921 7322
Mel.Gray@newcastle.edu.au

RESEARCH STUDY

www.newcastle.edu.au

Sexual assault or abuse and counselling

Would you like to participate in a confidential and respectful interview?
Historically, only female counsellors have been employed in government sexual assault services. This is because of the gendered nature of this type of crime (i.e., majority of victims are women and majority of offenders are male). Is it time for change in government sexual assault services?

If you are female, aged 18 years or over, and have consulted with a male counsellor about sexual assault or sexual abuse, you are invited to participate in this research.

If you would like to share your experiences, views, and wisdom in a confidential and respectful interview, please contact Julie Hopkins at Julie.Hopkins@uon.edu.au or Mel Gray on 02-4921 7322.

I hope to hear from you - your views are important so that together we can work to make counselling services the best they can be.

Thank you

This project has been approved by Hunter New England Health Human Research Ethics Committee Approval No 17/03/15/4.03

Appendix X: UON flyer

Professor Mel Gray
School of Humanities and Social Science
Faculty of Education and Arts
University of Newcastle, Callaghan NSW 2308
(02) 4921 7322
Mel.Gray@newcastle.edu.au

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Sexual assault or abuse and counselling

Would you like to participate in a confidential and respectful interview?

Historically, only female counsellors have been employed in government sexual assault services. This is because of the gendered nature of this type of crime (i.e., majority of victims are women and majority of offenders are male). Is it time for change in government sexual assault services?

If you are female, aged 18 years or over, and have consulted with a male counsellor about sexual assault or sexual abuse, you are invited to participate in this research.

If you would like to share your experiences, views, and wisdom in a confidential and respectful interview, please contact Julie Hopkins at: Julie.Hopkins@uon.edu.au or Mel Gray on 02-4921 7322.

I hope to hear from you - your views are important so that together we can work to make counselling services the best they can be.

Thank you

RESEARCH STUDY

www.newcastle.edu.au

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2018-0367.

Appendix XI: Interview guide for service users

INTERVIEW GUIDE FOR SERVICE USERS

Male counsellors in sexual assault services: perspectives of service users and counsellors

Age: 18-25, 26-30, 31-40, 41-50, 50-60, 61-70, 70+

Childhood sexual abuse ☐ Adult assault ☐

Familial ☐ Non familial ☐

Supports Formal ☐

Informal ☐

History of counselling:

NGO ☐ Government service ☐

1. How many times have you been to counselling about the issue of sexual assault or abuse?
2. When did you see a male counsellor regarding this and for how long?
3. How did it happen that you consulted with a male counsellor?

   Your Choice Not your choice

4. Further information /reason:

_____

_____

_____

_____

Reflections:

1. What was this experience like for you?
2. What three words would you use to describe this experience?
3. What was it like talking with a male counsellor about the assault/abuse?
4. Could you tell me about how trust in the counsellor developed?
5. Could you tell me about how rapport in the counsellor developed?
6. Could you tell me about how confidence in the counsellor developed?
7. Could you tell me about how safety in the relationship developed?
8. Do you think/feel that the gender of the counsellor had any influence on the counselling experience in any way?
9. What was helpful?
10. What was unhelpful?
11. For you, what were the positives of this experience?
12. What were the negatives?
13. How did the counselling experience end?
14. How did the counselling experience compare with seeing a female counsellor?
15. Would you consider consulting with a male counsellor again in the future regarding sexual abuse or assault?
16. What advice would you like to share with other women in similar situation to you, considering counselling?

Elements of feminist practice described:

_____

_____

_____

_____

Appendix XII: Interview guide for counsellors

INTERVIEW GUIDE FOR FEMALE COUNSELLORS

Male counsellors in sexual assault services: perspectives of service users and counsellors

.

Social Worker ☐ Psychologist ☐ Clinical Psychologist ☐ Other ☐

Length of experience as Sexual Assault Counsellor:

Length of clinical practice in general:

Activity-oriented question - Warm up – what words come to mind when you think of male counsellors working in government SAS with adult women survivors? Could you rank these according to what you consider most important to least important?

1. What are your thoughts/views of male counsellors working in Sexual Assault Services (SAS)?
2. Have you any experience of working with male counsellors in SAS?
3. What was this like?
4. What do you think could be possible benefits? – for counsellors, service users, service/organisation, crime of sexual assault/abuse and community perception.
5. What do you think could be possible drawbacks? - for counsellors, service users, service/organisation, crime of sexual assault/abuse and community perception.
6. What do you think would be some challenges, if any, e.g., team dynamics, male presence in 'safe' environment?

7. What changes do you think might need to be made to service delivery and organisation (e.g., waiting areas, intake workers)?
8. What is your view on the thought that service-user choice of gender of counsellor could be a positive element to effective therapy?
9. Is this a feminist way of practising? Yes or No
10. If yes, how is it a feminist way of practising?
11. If no, why is it not a feminist way of practising?
12. Do you think SAS still operate under a feminist framework/philosophy?
13. How do you see this?
14. Is a feminist framework still relevant to current SAS?
15. Why/Why not? Please explain.
16. What do you no longer see now that used to be a part of SAS in the past?
17. Is this positive or negative?
18. Why? Please explain.
19. Activity-oriented question: show stick figure picture labelled with male counsellor and female service user, ask group to add words or phrases of what each person would probably be thinking, feeling, communicating.