Online Counselling for Survivors of Sexual Abuse

e-book

What is Online Counselling?

Counselling or psychotherapy is when the counsellor and client are engaging in a professional therapeutic relationship having a balance of trust and openness with the relationship and exploring issues that the individual client might find hard to deal with.

Online Counselling is the interaction between the counsellor and the client through the use of the internet. Counselling is communicated through the use of a messenger program so the counsellor and client are able to directly chat.

Online counselling is defined as professional relationship between the professional mental health practitioner and client that uses the internet. The terms used in defining online counselling are new and recent with the counselling arena. For example, a counsellor or mental health practitioner can use various methods of counselling online practice. These methods can include text based, email or video based communication via the internet.

Power of Mind private online counselling is an established service that offers a convenient and suitable way of being able to log on to counselling sessions with an experienced counsellor through online communication. Power of Mind is a confidential online service to help individuals with a variety of issues including: sexual abuse and long term sexual abuse issues, grief and loss, domestic violence, depression, family difficulties, children and adolescent issues, drug and alcohol issues etc.

What are the advantages of Online Counselling?

There is no travelling time - you can be at home and have counselling at your own convenience, when you feel ready and comfortable to do so. You can access the internet anywhere at a time that best suits you.

You can reflect / Re read communication - The process of writing down thoughts and feelings can be particularly powerful. For some, this can help to focus thoughts and concerns. Online interaction also gives you the option to reflect or re read your communication with the counsellor.

There is an increased level of Comfort - online counselling provides support with great ease through text based chat with a counsellor and eliminates feelings of embarrassment and demotivation that comes with face to face counselling. Online counselling is a simple and cost effective way of seeking counselling with a professional.

Online counselling also offers a suitable and convenient service to those individual clients who are not able to access face to face counselling or if they are not able to get to a counselling office in any time that is suitable for them. This could be due to limited area access to services, having a particular mental health issue that is limiting for the client to feel comfortable and able to seek face to face counselling.

Whether it is text based counselling or email counselling each mental health practitioner and client has a record of their counselling session and are able to read and re read their feeling and thoughts from time to time to be able to get a clear indication of the stage they are at.

Through the online counselling experience clients are able to comfortably gather their thoughts in a non-confronting way and be able to feel relaxed

while writing in their counselling session. Writing and can be a great way to communicate their concerns in a private and therapeutic manner.

There can be an easier level of comfort regarding the stigma associated with online counselling. In a private and professional setting the client can feel safe and secure. The online counselling session and directly between the mental health practitioner and the client. So there is a level of privacy for the client and it is strictly a therapeutic relationship where no other individual is involved.

Power of Mind Private Online Counselling is a confidential service providing one on one counselling for individuals of all ages who may need support and assistance. Power of Mind offers a private, secure and confidential counselling service, through the use of an instant messenger program, that can be accessed online at home, in the workplace or anywhere in particular the client would like to access the internet.

The services that are provided are Online Counselling, Skype Counselling and Email Counselling.

Why are individuals afraid to seek counselling?

There are many individuals who are afraid to seek counselling. This could be for a number of reasons for example they may be unfamiliar with the counselling process, they may feel reluctant to talk about the current issues they are facing. They may feel uncomfortable talking to a complete stranger. They may be embarrassed about the current issues they may be facing. It is important for the individual to look at the things they may be afraid of in seeking counselling and be able to try a counselling session and see if the issues they have been afraid of are there.

What are the stigmas attached to counselling in general?

There are many stigmas attached to counselling and the counselling process. For example one of the stigmas may be that mental health issues may be looked at as not a normal person, am I going crazy if I need to see a counsellor or therapist for help. There is at times a negative theme for people seeking counselling treatment in today's society and as an international stigma attached to mental health treatment in general. You may hear a lot of stigmas attached to the therapeutic process but it is an individual's choice to seek counselling treatment and be brave enough to step and take charge of your life.

Many people experience a sense of stigma or shame around issues for example having an addiction surrounding alcohol, drugs or gambling. The opportunity for anonymous and confidential online counselling support can help more people feel comfortable and in control when they communicate their concerns instead of physically going to seek face to face counselling.

There can also be difficulty for males to seek help and get counselling face to face. Online counselling may be a better choice for those males in particular who feel stigma or shame associated with seeking help.

Benefits of Counselling:

Explore those issues you feel difficult to communicate face to face. Be able to open up and talk about the feelings you find hard to express in person.

Online Counselling is inexpensive in comparison to face to face counselling. It will save you time and cost and is very convenient. You don't have to wait long

for an appointment and a counsellor will contact you within 24 hours from the time you book an appointment.

What is sexual abuse and long term sexual abuse?

Sexual assault takes many forms including attacks such as rape or attempted rape, as well as any unwanted sexual contact or threats. Usually a sexual assault occurs when someone touches any part of another person's body in a sexual way, even through clothes, without that person's consent. Some types of sexual acts which fall under the category of sexual assault include forced sexual intercourse (rape), sodomy (oral or anal sexual acts), child molestation, incest, fondling and attempted rape. Sexual assault in any form is often a devastating crime. Assailants can be strangers, acquaintances, friends, or family members. Assailants commit sexual assault by way of violence, threats, coercion, manipulation, pressure or tricks. Whatever the circumstances, no one asks or deserves to be sexually assaulted.

Sexual abuse is any sort of non-consensual sexual contact. Sexual abuse can happen to any individual of any age at any given time or place. Sexual abuse can include any physical inappropriate touching to the genital area and can include insulting name calling, intentionally causing unwanted physical pain during sex, deliberately passing on sexual diseases or infections and using objects, toys, or other items (e.g. baby oil or lubricants) without consent and to cause pain or humiliation to the individual person.

Defining sexual abuse is a complicated task. Although some behaviours are considered sexually abusive by almost everyone (e.g., the rape of a 10-year-old child by a parent), other behaviours are much more equivocal (e.g., consensual

sex between a 19-year-old and a 15-year-old), and judging whether or not they constitute abuse requires a sensitive understanding of a number of definitional issues specific to child sexual abuse.

A very general definition of child sexual abuse has been proposed by Tomison (1995): "the use of a child for sexual gratification by an adult or significantly older child/adolescent" (p. 2). Similarly, Broadbent & Bentley (1997) defined child sexual abuse as: "any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards" (p. 14). Sexually abusive behaviours can include the fondling of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, fondling of breasts, voyeurism, exhibitionism and exposing the child to or involving the child in pornography (Bromfield, 2005; US National Research Council, 1993).

However, unlike the other maltreatment types, the definition of child sexual abuse varies depending on the relationship between the victim and the perpetrator. For example, any sexual behaviour between a child and a member of their family (e.g., parent, uncle) would always be considered abusive, while sexual behaviour between two adolescents may or may not be considered abusive, depending on whether the behaviour was consensual, whether any coercion was present, or whether the relationship between the two young people was equal (Ryan, 1997).

Sexual abuse of children and teenagers often has painful and long-lasting effects on the victim, the family, and the community in which it occurs. If wounds heal and recovery does take place, the process takes a long period of time and some emotional scars are inevitable. Members of the Georgia

Association of Physicians for Human Rights are aware that many of their patients have been victims of sexual abuse or have concerns about sexual abuse. We offer the following set of questions and answers to promote a better understanding regarding sexual abuse.

Common myths about Sexual Abuse

Myth: Most child molester were once victims themselves (or conversely, most victims grow up to be child molesters).

Myth: If the victim was a willing participant and enjoyed the experience, it was either the victim's fault or it was not abuse.

Myth: Boys are less traumatized by the abuse than girls.

Myth: Boys abused by males will grow up to be gay.

Myth: Most child molesters of boys are gay.

Myth: There are no female sexual abusers.

Long-term effects of childhood sexual abuse:

The effects of any type of trauma can vary greatly depending on the environment, the coping skills, and age of the survivor. Not all survivors experience severe long-term effects, yet some may experience one or more of the following symptoms:

Depression and anxiety

Confusion about sexual orientation

Confusion about sexual orientation

Problems with intimacy

Alcohol and drug addictions

Sexual addiction or oversexualization of relationships

Sexual addiction or oversexualization of relationships

Treatment available for the effects of sexual abuse:

There have been many studies of the effects of childhood abuse in the last decade. There are several recent studies that indicate that psychotherapy is the best form of treatment for relationship difficulties, problems with self-image, depression, and anxiety. Psychiatric medications can be an important part of treatment, given that the current array of psychotropic medications (e.g., Prozac, Zoloft, Wellbutrin, etc.) has proven useful in alleviating anxiety, and some of the symptoms of depression. Medications may allow some people to enter into psychotherapy and make better use of it. Psychotherapy and psychiatric services should be sought from a psychiatrist, psychologist, counsellor or social worker with expertise in working with sexual abuse survivors. It is also important to choose a physician and psychotherapist who is gay/bi/lesbian friendly. A referral to a trained professional can be made by contacting a mental health professional.

Methods of counselling used to treat survivors of sexual abuse:

There are various method of counselling treatment for survivors of sexual abuse.

An important approach is the Client centred counselling. Where the counsellor is able to Listen and try to understand how things are from the client's point of view. The counsellor is able to be there for the client and have understanding when the client is unsure. The counsellor is able to treat the client with the utmost respect and regard. There is also a directive for the therapist to be "congruent", or "transparent" - which means being self-aware, self-accepting, and having no mask between oneself and the client. The therapist knows themselves and is willing to be known.

Cognitive behavioural therapy (CBT) is a counselling technique that is used by many clinical psychologists, psychiatrists and counsellors. Some therapists will specialise in this form of therapy while others will use some of the techniques to help you work through particular difficulties. The therapy is based around helping you understand, manage and change your thoughts (cognitions) and actions (behaviour). This form of therapy has been shown to be very effective for a whole range of things but is particularly effective if you have depression or anxiety and it is also be known to be effective for sexual abuse and long term sexual abuse survivors.

Cognitive therapies include cognitive behaviour therapy, rational emotive therapy and cognitive processing therapy. All share the assumption that psychological distress and behavioural dysfunction can be produced by inaccurate and dysfunctional thinking. The goal of therapy therefore, is to change psychological distress by challenging and changing the distorted cognitions which give rise to it. Clients are taught, in a variety of ways to "recognize, observe, and monitor their own thoughts and assumptions, especially their negative automatic thoughts" (Corey, 2005, p. 285).

involves a number of different techniques, such as exposure to traumatic Cognitive behavioural therapy memories, cognitive restructuring and eye movement desensitisation and reprocessing (Bradley, Greene, Russ, Duttra, & Westen, 2005).

Prolonged exposure therapy: Under the cognitive behavioural framework, Foa and Rauch (2004) evaluated the outcomes of prolonged exposure therapy on its own as well as the combination of prolonged exposure and cognitive restructuring therapies. Prolonged exposure requires the client to confront traumatic memories repeatedly (through imaginal exposure) as well as confronting trauma related situations which are usually avoided (in vivo exposure) (Foa & Rauch, 2004). The goal of this type of therapy is to present the client with information that invalidates PTSD-related cognitions.

Cognitive restructuring therapy*:* Cognitive-restructuring targets the negative cognitions associated with a traumatic event. The aim of this therapy is to actively engage the client in challenging negative automatic thoughts in order to alter PTSD related cognitions. Foa and Rauch (2004) found that prolonged exposure therapy was effective in reducing PTSD related symptoms in victims of sexual assault; however the addition of cognitive restructuring did not enhance the outcome of therapy.

Other therapeutic services that address PTSD: Therapeutic services to prevent sexual assault victims from experiencing chronic symptoms of PTSD and depression have also been explored. Resick and Schnicke (1992) used cognitive processing therapy involving education, exposure and cognitive components in a 12-week program using a pre-test post-test design. Women who received the program compared with a wait list (control) group showed significant

improvement on measures of PTSD and depression and this improvement was maintained for six months. Foa, Hearst-Ikeda, and Perry (1995) developed a brief cognitive behavioural program for recent victims of sexual assault. The program involved education about common reactions to sexual assault, breathing and relaxation training, prolonged exposure therapy and cognitive restructuring therapy. Immediately following the program, women who received the brief therapy were less likely to meet the criteria for PTSD than those who did not receive the therapy. Five and a half months after the end of treatment, women who had experienced the therapy maintained low levels of PTSD symptomatology and were also significantly less depressed than those who had not.

The efficacy of cognitive-behavioural techniques in comparison to solution-focused counselling was investigated by Foa et al. (1991) for the treatment of PTSD in victims of rape. Participants were assigned to either stress inoculation training, prolonged exposure therapy, supportive counselling or a waiting list group (control group). Stress inoculation training involved education about coping strategies, breathing and relaxation exercises, cognitive restructuring and role playing to prescribe new models of behaviour. Prolonged exposure involved asking the client to imagine the rape event repeatedly within the session, and outside the session to expose herself to feared or avoided situations that were judged by both the client and the therapist to be safe. Supportive counselling was governed by a solution-focused framework in which the client was asked to report and generate strategies to deal with problems in a highly supportive environment.

Each of the therapeutic procedures was effective in reducing PTSD symptoms, immediately after the treatment and at follow up. However, the timing of the

effect differed between the two therapeutic approaches. The clients who received stress inoculation training showed more improvement in PTSD symptoms immediately after treatment than those receiving supportive counselling or those on the waiting list. By contrast the clients who received prolonged exposure therapy showed the lowest levels of PTSD symptoms at follow up more than three months later.

Interventions that address victim blaming and feelings of guilt. Victim blaming and feelings of guilt are commonly reported by sexual assault survivors and have become a focus of psychotherapeutic intervention in their own right (Campbell et al., 1999). Trauma-related guilt has been associated with the etiology of depression in victims of sexual assault (Andrews, 1995; Gladstone et al., 2004). Nishith et al. (2005) compared the effectiveness of cognitive processing therapy and prolonged exposure on female rape victims. Cognitive processing therapy was equally effective in treating women with 'pure' PTSD or PTSD together with major depressive disorder and significantly more effective than prolonged exposure in reducing guilt cognitions related to the trauma.

Interventions that address sleep difficulties. As noted earlier, chronic nightmares and other sleep difficulties occur frequently in clients with PTSD but have not been a major focus of treatment to date. Krakow et al. (2001) treated chronic nightmares in female sexual assault victims using imagery rehearsal therapy and cognitive restructuring. This treatment decreased chronic nightmares, improved sleep quality and decreased PTSD symptom severity. Another positive outcome was that the clients' experiences in therapy were generalised to and helpful with other areas of maladaptive functioning such as negative and obsessive thinking.

Eye movement desensitisation and reprocessing therapy: Eye Movement Desensitisation and Reprocessing (EMDR) is another component of cognitive behavioural therapy that has been used quite extensively in traumatised populations (Shapiro, 1989). During EMDR the client is asked to move their eyes rapidly from side to side while imagining an aspect of their trauma experience; such as a visual image, negative cognition, negative emotion or physical sensation (Wilson, Becker, & Tinker, 1995). This process is repeated until the client has altered self-cognitions in a positive manner and has become desensitised to disturbing aspects of their trauma experience. Wilson et al. (1995) found that psychologically traumatised individuals, including sexual assault victims, showed reductions in their trauma related issues and anxiety and increases in positive self-cognitions. These results were maintained at three-month follow-up and EMDR was shown to be effective regardless of type of trauma experienced by the client.

As the counsellor it is important within the early stage of therapy with adult survivors of childhood sexual abuse focuses on building up trust between the counsellor and the client and preparing the survivor for the healing process. During this phase of therapy the client is encouraged to tell their story which allows the counsellor to assess which therapeutic techniques may be the most beneficial.

Telling their story is difficult for many survivors. To be able to open up and express their feelings is one of the hardest things to do for survivors of sexual abuse and long term sexual abuse. There can be many memories and incidents that client may find had to talk about. It is the role of the counsellor to be there for the client and allow them to process the trauma in a safe and caring manner.

The treatment of adult survivors of childhood sexual assault incorporates a number of therapeutic approaches which reflect major the theoretical schools of therapy, emotional, cognitive and behavioural. Experiential or exploratory techniques focus on accessing emotions, re-experiencing the trauma and integrating these with the adult self. Cognitive therapy aims to identify the survivor's distorted cognitions of themselves, others and the world and attempts to replace these with more accurate and realistic cognitions. Behavioural therapies focus on enhancing the survivor's behavioural repertoire through the acquisition of more adaptive behavioural responses, coping strategies and learning new skills.

To normalise the issues of sexual abuse the survivor’s reactions to the abuse experience and the effects this has had on their psychological functioning, both historically and currently, is a key factor with the therapeutic process and It's important to point out that the coping strategies they evolved allowed them to survive at the time and adapt to their experiencing. In that way, these strategies served them well. However, these responses have become maladaptive in adulthood and limit their ability to live a full life, limit their interpersonal relationships and their psychological functioning.

What are the difficulties in seeking counselling treatment for sexual abuse survivors?

There are a number of different sexual abuse issues that are related to seeking counselling treatment. Each and every individual client can feel and think differently according to the issues of sexual abuse they are facing and having to deal with on a day to day basis. It is important to consider the many ways that sexual and long term sexual abuse can impact on each individual client. For example self-blame, self-perception, trust issues, relationships, self-confidence and self-esteem, boundaries due to these negative issues that can affect each client differently

If the child is sexually abused by a family member, or someone very close to the family, it can be even more difficult to reach out and seek counselling treatment due to difficulties faced.

An adolescent or adult, who is sexually assaulted, can experience a completely different and unique set of responses and perceptions.

Some of the effects that we have seen include: panic attacks nightmares, strong sense of paranoia and generalized fear, physical damage to the client, body crying spells, self-blame, guilt and shame, problems with intimacy, profound impact on trust, significant problems with loved ones following the assault.

Lack of community awareness within the issues suffered by sexual abuse survivors

There is an overall lack of community awareness in our society for victims of sexual and long term sexual abuse. It is complex for members in the community to understand the social and psychological effects for individual clients. It is vital to recognise that Sexual assault affects not only the victim, but the loved ones and family of the survivor, as well as the community. Family

members and friends many times not only have to help their loved one manage the aftereffects of the assault but also have to deal with their own feelings about the victimization of someone they care about. Those that live with the survivor may become concerned about their security and may have similar feelings and responses as those the survivor experiences. Family members in some communities can find support groups for loved ones of those who have been victims of sexual assault. The immediate neighbourhood as well may be affected by the victimization of their neighbour and become more concerned about their personal safety.

There are important factors to consider when supporting and assisting the individual survivor.

To be able to listen without judging, Let them know the assault was not their fault; Let them know they did what was necessary to prevent further harm; Reassure the survivor that he or she is cared for and loved; Encourage the sexual assault victim to seek medical attention; and to Encourage the survivor to talk about the assault with an advocate, mental health professional or someone they trust.

Stigma attached to seeking counselling/psychotherapy

There are many stigmas attached to seeking counselling/psychotherapy. Each client faces challenging issues that most of us face as challenges in our lifetime that cause anxiety, depression and/or self-doubt that negatively impact some aspect of our life such as work or our relationships. There still seems to be an underlying assumption that a person is “weak” if they admit these feelings or seek help when one feels overwhelmed or unsure of what direction to take in life or how to solve a problem. Many individuals seek answers from family and

friends, but when the support network is unable to provide the assistance or guidance necessary, the person feels alone, isolated and confused.

Issues suffered by sexual abuse survivors

- Shock/Denial
- Irritability/anger
- Anxiety
- Complex PTSD
- Psychosis
- Dissociation
- Depression
- Eating disorders
- Interpersonal and parenting difficulties
- Memory impairment
- Personality disorder
- Posttraumatic Stress Disorder (PTSD)
- Victimization
- Self-blame
- Self-harm and suicidal behaviour
- Sexual difficulties
- Substance abuse
- Self-blame issues
- Guilty feelings associated
- Fear
- Suicidal thoughts
- Helplessness
- Social withdrawal

- Numbing/apathy (detachment, loss of caring)
- Restricted affect (reduced ability to express emotions)
- Nightmares/flashbacks
- Difficulty concentrating
- Diminished interest in activities or sex
- Loss of self-esteem
- Loss of security/loss of trust in others
- Guilt/shame/embarrassment
- Loss of appetite

Online counselling is an alternative to face to face counselling/psychotherapy

Online Counselling can be safer than speaking for some individual clients. Some clients feel it is easier to communicate by text based communication or email as an alternative to face to face counselling. Some clients can explore some of their feelings and thoughts by writing which may be

An easier alterative than speaking and the anonymity of the internet seems to be helpful for clients. Some clients may respond and open up easier using a less confronting approach without observations from the counsellor directly using face to face counselling.

The online counselling method which writing as a therapeutic process writing about your own feelings can also separate thoughts out, making them safer to deal and easier to deal within a smaller amount of words written as oppose to communication in sentences form face to face. The action of putting thoughts into words via the computer keyboard is a powerful step towards standing back and examining things more closely, from a new perspective. You can also read and re read your feelings and thoughts and keep a copy of your online

counselling sessions

Some individual clients find writing to be an easier format than talking out your feelings and thoughts in a comfortable and less challenging way to write about your issues.

Another issue that can be seen to some clients is that the counselling relationship is equal and some clients find an online counsellor is to be less of an authority figure than they expected and this allows them to take an equal share of responsibility for the work.

Other difficulties might be experienced for the client is term of being homebound, having a particular disability, loving in a rural or remote area having less access to counselling services.

Long term survivors are made to keep silent

Reporting and disclosure of sexual violence represents an important opportunity for victim/survivors to receive assistance from service providers and begin the process of recovery. However, numerous barriers to reporting and disclosure operate at both the personal level and at the level of the criminal justice system. Furthermore, victims who have been sexually assaulted by someone they know well, particularly an intimate partner, may not even name what has happened to them as a crime and are far less likely to report than victims who have been sexually assaulted by a stranger. Barriers to reporting and disclosure thus may also be barriers to victim/survivors accessing the specialist services they might require.

Lievore (2005) argued that the process of silencing women about sexual violence occurs from the macro level of social discourses and representations, including discourses around women's lack of entitlement to sexual autonomy or stereotypical media representations of 'real rape', through to the micro level of interpersonal interactions. Her study of women's help-seeking decisions and service responses to sexual assault found that a quarter of the women interviewed either did not or could not name what they had experienced as sexual assault. Yet, even if an experience is unnamed it can still exert a profound impact. All these women experienced psychological and physical consequences, ranging from depression and suicide attempts to poor health and eating disorders. At the same time, when an experience of sexual violence remains unnamed, delays in accessing services may occur and victim/survivors may not link negative personal, health and social outcomes that appear over time with past violence.

Lievore (2003) cited a number of personal barriers to disclosure including:

- shame, embarrassment;
- regarding it as a private matter;
- not thinking what has happened is a crime or not thinking it is serious enough to report to police;
- not wanting anyone else to know;
- self-blame or fearing blame by others for the attack;
- dealing with it themselves; and
- Wanting to protect the perpetrator, the relationship or children.

Barriers at the level of the justice system include:

- Believing that the police would not or could not do anything or would not think it was serious enough;
- Fear of not being believed or being treated with hostility;
- Fear of the police and/or the legal process;
- Lack of proof that the incident occurred;
- Not knowing how to report; and
- Doubt that the justice system will provide redress.

The barriers identified by Lievore (2005) have a personal and social dimension and provide a map of the psychological terrain likely to be inhabited by many survivors. All are capable of engendering emotional distress in addition to that generated by the sexual assault. In this way, these barriers may complicate and compound the psychosocial burden already carried by survivors. This burden is the one with which service providers must grapple when they work with victim/survivors and develop interventions to meet their needs.

In addition to these matters, sexual violence is associated with both immediate and long-term effects. Service providers must be able to identify and respond appropriately to these effects if victim/survivors are to receive meaningful assistance. Most research on these effects has been conducted in the US: a brief review follows.

'No longer silent'

The main source of evidence on service users decision making around help seeking and survivors perceptions, views, and experiences of sexual assault services, is Denise Lievore's (2005) study *No longer silent: A study of women's help seeking decisions and service responses to sexual assault*.

This qualitative study focused on service users who had experienced adult sexual assault and consisted of two components. The first examined social and personal factors that influenced victim/survivors' decisions to seek help from a variety of sources including sexual assault services. It involved semi-structured interviews with 36 female survivors recruited through sexual assault services across Australia. Service users' views were complemented by 65 sexual assault counsellors representing 23 services. The second component involved consulting with 55 sexual assault workers regarding their perceptions of the efficacy of coordinated service provision, their experiences of collaborating with criminal justice and forensic medical personnel and their recommendations for improving service delivery. We discuss the findings of this study here, including the context of other research on service provision from overseas.

Victims made to believe they are the problem

Immediate effects include shock, fear and feelings of helplessness. Illusions regarding personal safety and being invulnerable in the world are shattered, and levels of psychological distress are very high in the first few weeks after the sexual assault but abate over the longer term (Koss et al., 1994). Victims can experience a range of physical injuries and damage to the urethra, vagina and anus and are at increased risk of contracting sexually transmissible infections including HIV/AIDS. Fears of contracting HIV and/or becoming pregnant as a result of sexual assault are pervasive (Holmes, Resnick, Kilpatrick, & Best, 1996; Resnick, Acierno, & Kilpatrick, 1997).

Long term effects of survivors

Sexual violence, whether this occurs in childhood or adult life, is associated with a plethora of poor, long-term, physical health outcomes. These physical

health problems include sexual and reproductive health problems, pain syndromes, eating disorders (especially bulimia nervosa), and gastro intestinal problems (Krakow et al., 2002; Leserman, Li, Drossman, & Hu, 1998).

Mental health problems such as major depression, generalised anxiety, panic, phobias, symptoms of traumatic stress and suicidal thoughts and actions are common. These can co-occur with reduced self-esteem and a damaged sense of gender identity.

Relationships can also suffer depending on how well or badly those closest to the victim such as a partner, family or friends are able to understand the impact of the sexual assault and how they respond to its disclosure (Coker et al., 2002; Fleming, Mullen, Sibthorpe, & Bammer, 1999; Koss, 1993; McMahon, Goodwin, & Stringer, 2000; Resnick et al., 1997). Being better informed about the psychological effects of sexual violence would greatly assist family and friends of survivors to feel more confident in providing support and understanding.

Women who have been sexually victimised as children face increased risks of subsequent rape and domestic violence in adult life and experience even higher rates of adverse health outcomes (Fleming et al., 1999).

Post-traumatic stress disorder

Of all the traumatic stressors researched so far including natural disasters such as earthquakes, hurricanes and tsunamis, it is the 'man made' trauma of sexual violence that most strongly predicts the subsequent development of post-traumatic stress disorder (PTSD) (Bruce et al., 2001; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Women who have experienced sexual violence

constitute the single largest group of people suffering from PTSD (Calhoun & Resnick, 1993). Rape victims are six times more likely to develop PTSD at some point in their lives than non victimised women (Kessler et al., 1995; Kilpatrick, Edmunds, & Seymour, 1992). Women's risk of developing PTSD following exposure to trauma has been found to be approximately two-fold higher than men's. Women's PTSD also tends to last longer. This parallels the gender difference found for depression, with which PTSD frequently co-occurs (Breslau et al. 1998).

Feminist researchers have criticised the use of the psychiatric diagnosis of PTSD as the main way of understanding and responding to the psychological distress and the meaning of sexual violence for women. Both Edna Foa and her colleagues (Foa, Cashman, Jaycox, & Perry, 1997) and Judith Herman (1992) have argued that the assumptions and the symptoms that define the diagnosis of PTSD do not accurately reflect the range of traumatic experiences and traumatic effects experienced by survivors of sexual violence and whose PTSD is of a more complex type than that experienced by survivors of discrete traumatic events.

Like all psychiatric diagnoses, PTSD relies on the individualising and pathologising language of 'psychiatric symptoms' and represents the victim of sexual violence as the bearer of a psychiatric disorder. By focusing on the victim/survivors as a person with a mental illness needing treatment, attention is deflected from the social causation of rape and the generalised oppression of women. Moreover, the concentration on a set of decontextualised and medicalised set of problematic symptoms inherent in the diagnosis of PTSD also shifts attention from survivors' psychological concerns including the impact of sexual violence on their sense of themselves, their lives, their

relationships, their sense of safety in the world and their overall health and wellbeing.

Sexually victimised women who develop PTSD are significantly more likely than those who do not, to have to contend with a number of other co-occurring or co-morbid psychological difficulties that may persist for many years (Kessler et al., 1995). Survivors who develop PTSD can be impacted by this both during the day when they experience intrusive thoughts and distressing recollections of the violence, and at night when nightmares and other sleep disturbances may be the norm rather than the exception (Choquet, Darves-Bornoz, Ledoux, Manfredi, & Hassler, 1997; Krakow et al., 2000; Krakow et al., 2002; Roberts, 1996). A number of the women interviewed in Lievore's (2005) study commented on being unable to sleep, not sleeping properly and having nightmares.

Nightmares are listed within the symptom cluster describing 're-experiencing symptoms' and difficulty getting to sleep and staying asleep are listed within the symptom cluster describing 'arousal symptoms'. One US study found that survivors with PTSD recalled having more than five nightmares per week on average (Krakow et al., 2002). Sleep problems affect the daytime functioning of those who experience them and impair functioning at work, diminish quality of life and are associated with a higher risk of accidents and increased health care costs (Roth, 2005). Prescribed medications for sleep problems include anxiolytics and hypnotics but over-the-counter medications, alcohol or other drugs are often used to self-treat (Roth, 2005).

Health providers have a unique opportunity to identify a history of sexual violence, diagnose psychological disorders and provide accurate and

meaningful responses to survivors' sleep and other violence related health problems. Research to date suggests that few take this opportunity. A study of more than 3000 women attending general practitioners in Victoria found that only 9% of women who had experienced sexual abuse had ever disclosed this to their general practitioner, primarily because the practitioner had never asked about a history of victimisation (Mazza, Dennerstein, & Ryan, 1996). Yet recent Australian research (Vos et al., 2006) demonstrates that intimate partner violence including sexual violence is the single largest risk factor for ill health (primarily poor mental health) for Victorian women aged between 15 and 45 years.

Psychological effects of Sexual Abuse Survivors

Fear. The offender may swear the child to secrecy and say that if they tell something bad will happen. Sexual abuse is usually accompanied by coercion, bribery or threats. The child is afraid to tell because of what the consequences might be. e.g. punishment, blame, abandonment or not being believed.

Helplessness/powerlessness. Children in this situation often feel that they have no control over their own lives or even over their own bodies. They feel that they have no choices available to them.

Guilt and Shame. The child knows something is wrong and blames him or herself not others. The offender will often encourage the child to feel that the abuse is his or her fault and sometimes s/he will feel that s/he is a "bad" person.

Responsibility. The offender often makes the child feel responsible for keeping the abuse a secret. Sometimes the child also feels responsible for keeping the

family together and the burden of this responsibility interferes with experiencing a normal childhood.

Isolation. Incest victims feel different from other children. They must usually be secretive. This even isolates them from non-offending parents and brothers and sisters.

Betrayal. Children feel betrayed because they are dependent upon adults for nurturing and protection and the offender is someone who they should be able to love and trust. They may also feel betrayed by a non-offending parent who they feel has failed to protect them.

Anger**.** Not surprisingly this is one of the strongest feelings which many children have about their sexual assault. Children may feel anger against the perpetrator and also against others who they feel failed to protect them.

Sadness**.** Children may feel grief due to a sense of loss, especially if the perpetrator was loved and trusted by the child.

Flashbacks**.** These can be like nightmares which happen while the child is awake. They are a re-experience of the sexual assault and the child may experience all the feelings a gain which they felt at the time.
http://www.secasa.com.au/

Recovered Repressed memories

Myth: It is a fact that victims of long-term, violent childhood abuse commonly repress the memory of each and every incident from conscious awareness after it occurs so that they have no awareness the rest of the time of having been abused, and then recall the abuse only years or decades later.

Reality: This is a theory, not a fact; if a mental health provider states this is a fact, they have committed malpractice and the client will have an open-and-shut case if he or she takes legal action as a result. Moreover, "Despite widespread clinical support and popular belief that memories can be 'blocked out' by the mind, no empirical evidence exists to support either repression or dissociation." -- Sydney Brandon, M.D., et al, "Recovered memories of childhood sexual abuse: implications for clinical practice," *British Journal of Psychiatry,* April 98, p. 302

Myth: "The ordinary response to atrocities is to banish them from consciousness." -- Judith Herman, M.D., *Trauma and Recovery*

Reality: "Numerous studies in children (Terr, 1983; Malmquist, 1986; Pynoos & Nader, 1989) and adults (Leopold & Dillon, 1963) have shown that psychologically traumatic events are vividly though not always accurately recalled and are frequently followed by intrusive recollections in one form or another. The problem following most forms of trauma is an inability to forget, rather than a complete expulsion from awareness, and amnesia for violent events is rare." -- Sydney Brandon, M.D., et al, "Recovered memories of childhood sexual abuse: implications for clinical practice," *British Journal of Psychiatry,* April 98, p. 300

Myth: Memory operates like a videotape. Everything is stored permanently in the "unconscious mind" and can be accurately replayed.

Reality: "The assumption, however, that a process analogous to a multichannel videotape recorder inside the head records all sensory impressions and stores them in their pristine form indefinitely is not consistent with research findings or with current theories of memory." American Medical Association Council on

Scientific Affairs, "Scientific Status of Refreshing Recollection by the Use of Hypnosis" (Journal of the American Medical Association, 5 April 1985, Vol. 253, No. 13, pp. 1918-1923)

Myth: "Something in the neighborhood of 60 percent of all incest victims don't remember the sexual abuse for many years after the fact."-- John Bradshaw, "Incest: When You Wonder If It Happened To You," *Lear's,* Aug. 92, p. 43

Reality: "Most people who were sexually abused as children remember all or part of what happened to them." Interim Report of the American Psychological Association Working Group on Investigation of Memories of Childhood Abuse

Myth: Reliving abuse in detail ("abreaction") is a required step on the path to healing.

Reality: "Loftus (1997) reviewed 30 cases selected at random from 670 claims submitted to the Washington Victims Compensation Program. Twenty-six had 'recovered' a memory of abuse through therapy. All 30 were still in therapy after three years, 18 for more than five years. After treatment 20 were suicidal compared with three before treatment began, 11 were hospitalised (cf. two before treatment), eight engaged in self-mutilation (cf. one before) and marriage break-up occurred in almost all. It appears that in these cases, recovery and abreaction had serious adverse effects." -- Sydney Brandon, M.D., et al, "Recovered memories of childhood sexual abuse: implications for clinical practice," *British Journal of Psychiatry,* April 98, p. 303

Myth: There is evidence for the spontaneous, complete "massive repression" of traumatic memories from conscious awareness followed by accurate delayed recall.

Reality: "No evidence exists for the repression and recovery of verified, severely traumatic events, and their role in symptom formation has yet to be proved. There is also a striking absence in the literature of well-corroborated cases of such repressed memories recovered through psychotherapy. Given the prevalence of childhood sexual abuse, even if only a small proportion are repressed and only some of them are subsequently recovered, there should be a significant number of corroborated cases. In fact there is none (Pope & Hudson, 1995; Pendergrast, 1996)." Sydney Brandon, M.D., et al, "Recovered memories of childhood sexual abuse: Implications for clinical practice", p. 303

Myth: Hypnosis can "reverse amnesia" or "recover memories."

Reality: "Contrary to what is generally believed by the public, recollections obtained during hypnosis not only fail to be more accurate but actually appear to be generally less reliable than nonhypnotic recall." "Scientific Status of Refreshing Recollection by the Use of Hypnosis," American Medical Association's Council on Scientific Affairs, 1985. "There is no evidence that the use of consciousness-altering techniques, such as drug-mediated interviews or hypnosis, can reveal or accurately elaborate factual information about any past experiences including childhood sexual abuse." Royal College of Psychiatrists, U.K., 1997

Myth: There are checklists which can be used to diagnose previous sexual abuse.

Reality: "In children and adolescents, symptoms and behaviour patterns may alert the clinician to the possibility of current sexual abuse, but these are no more than indicators for suspicion. Previous sexual abuse in the absence of memories of these events cannot be diagnosed through a checklist of symptoms." Royal College of Psychiatrists, U.K., 1997

Myth: Adults are normally capable of remembering abuse or other events from early infancy.

Reality: "Few people seem able to remember events which took place before about the age of three years. This 'infantile amnesia' (Campbell & Speak, 1972; Campbell *et al*, 1974; Coulter *et al*, 1976) depends on delayed maturation of the brain, which has been demonstrated in other species of mammal. Episodic memory does not develop until after age four years and most people have limited memories before about five or six years of age (Hudston & Nelson, 1986)." Sydney Brandon, M.D., et al, "Recovered memories of childhood sexual abuse: implications for clinical practice," *British Journal of Psychiatry,* April 98, p. 298

Myth: Techniques such as sodium amytal interviews, hypnosis, age regression, guided imagery, dream interpretation, journaling, or the diagnosis of 'body memories' can be used to accurately recover forgotten or "repressed" memories.

Reality: "Psychiatrists are advised to avoid engaging in any 'memory recovery techniques' which are based upon the expectation of past sexual abuse of

which the patient has no memory. Such 'memory recovery techniques' may include drug-mediated interviews, hypnosis, regression therapies, guided imagery, 'body memories', literal dream interpretation and journaling. There is no evidence that the use of consciousness-altering techniques, such as drug-mediated interviews or hypnosis, can reveal or accurately elaborate factual information about any past experiences including childhood sexual abuse. Techniques of regression therapy including 'age regression' and hypnotic regression are of unproven effectiveness." Royal College of Psychiatrists, U.K., 1997

Myth: "You must believe that your client was sexually abused, even if she sometimes doubts it herself .... Joining a client in doubt would be like joining a suicidal client in her belief that suicide is the best way out." *The Courage to Heal*, First Edition, p.347

Reality: "The psychiatrist should normally explore his or her doubts with the patient about the accuracy of recovered memories of previously totally forgotten sexual abuse. " Royal College of Psychiatrists, U.K., 1997. "Psychiatrists should maintain an empathic, non-judgmental, neutral stance towards reported memories of sexual abuse. As in the treatment of all patients, care must be taken to avoid prejudging the cause of the patient's difficulties, or the veracity of the patient's reports. A strong prior belief by the psychiatrist that sexual abuse, or other factors, are or are not the cause of the patient's problems is likely to interfere with appropriate assessment and treatment." The American Psychiatric Association Board Statement On Memories Of Sexual Abuse

Myth: Whether a memory is "historical truth" does not matter; only a client's "narrative truth" is important.

Reality: "Some clinicians believe, as did Freud, that historical truth is not important to therapy. It may be the case that abreaction of an imagined but believed-in event is effective in relieving symptoms, and clinical examples of 'reincarnation therapy' have been described. However the effects of distorted truth should not be overlooked. The damage done to families if the accusations are untrue is immense. Moreover, it is not only families that are damaged by mistakes in this area. Patients who are mistakenly diagnosed as having been abused, frequently end as mental health casualties (Loftus, 1997). Where apparent improvement is based upon a false belief, there seems a serious possibility of further mental distress." Sydney Brandon, M.D., et al, "Recovered memories of childhood sexual abuse: implications for clinical practice," *British Journal of Psychiatry,* April 98, p. 304

Myth: A therapist could never suggest a false memory without intending to.

Reality: "Doctors should be aware that patients are susceptible to subtle suggestions and reinforcements whether these communications are intended or unintended." Royal College of Psychiatrists, U.K., 1997

Myth: The great detail of "recovered memories" is evidence for their historical accuracy.

Reality: People who claim they were abducted by aliens have detailed "memories" of the aliens, the ships, and the experiments which were supposedly performed by the aliens. Is this evidence that aliens are actually kidnapping people?

Myth: The emotional intensity of "recovered memories" is evidence for their historical accuracy.

Reality: "Memories, however emotionally intense and significant to the individual, do not necessarily reflect actual events." Royal College of Psychiatrists, U.K., 1997

Myth: The intensity of a person's belief in their memories is evidence for their historical accuracy.

Reality: "The evidence shows that memories of events which did not in fact occur may develop and be held with total conviction." Royal College of Psychiatrists, U.K., 1997

Myth: Many people claim to have been violently abused for many years during childhood but to have repressed all memory of the abuse after each and every incident so that neither they nor anyone else was aware of it the rest of the time, then to have recovered the memories years or decades later, so massive repression and recovery of memories of chronic, violent abuse must really happen.

Reality: Many people claim to have been abducted by aliens; does this mean that alien abduction really happens? Clearly, the fact that many people believe something doesn't prove that it actually happened to them.

Myth: "Age regression," with or without the use of hypnosis, enables people to accurately relive past events as they happened.

Reality: "It is the consensus of the Panel that hypnotic age regression is the subjective reliving of earlier experiences as though they were real--which does not necessarily replicate earlier events." American Medical Association Council on Scientific Affairs, "Scientific Status of Refreshing Recollection by the Use of Hypnosis" (Journal of the American Medical Association, 5 April 1985, Vol. 253, No. 13, pp. 1918-1923) "Techniques of regression therapy including 'age regression' and hypnotic regression are of unproven effectiveness." Royal College of Psychiatrists, U.K., 1997

Myth: False memories don't exist.

Reality: "The evidence shows that memories of events which did not in fact occur may develop and be held with total conviction." Royal College of Psychiatrists, U.K., 1997

Interactions that can trigger memories of sexual abuse

A sexual Abuse Survivor can have triggers occur when some aspect of counselling treatment causes a recall (flashbacks or vague body memories) or overwhelming feelings as a result of past abuse.

Although many survivors may have many similar triggering experiences, there is no complete predictable list of triggers for all survivors. Some client survivors may be able to identify their triggers while others may be unaware of them.

A trigger can be anything that causes the release of emotions or memories of sexual abuse including certain colours, smells, sounds, situations, words, time of day or even seasons

Who is going to be my counsellor?

My Name is Lisa Sarkis - I'm a Social Worker, Counsellor and Psychotherapist. I have a Bachelor of Social Science Majoring in Applied Psychology Counselling and a Bachelor of Social Work. I'm a Member of the Australian Association of Social Workers. I am the owner of Power of Mind – Private Online Counselling.

I am a qualified counsellor exploring various issues including:

Addiction, Eating Disorders, Grief & Loss, Bereavement, Domestic Violence, Drug and Alcohol Issues, Sexual Abuse, Long Term Sexual Abuse, Adult Survivors of Sexual Abuse, Depression, Home Bound Depression, Anxiety, Self Esteem, Sexuality, Family and Relationship difficulties, Children and Adolescent problems, Financial & Gambling issues, Adoption, Pregnancy Issues, Trauma & Post Traumatic Stress Disorder, immigration issues.

I am unsure and undecided about starting counselling.

Starting counselling or psychotherapy is never an easy thing but it is important that you consider the advantages of counselling and the benefit you will gain in deciding to start the therapeutic process.

The initial step is difficult but once you make the decision to seek counselling or psychotherapy you will begin to see positive changes in your life within your feelings and thoughts and be able to think more clearly about your future and the goals you would like to achieve.

I have never had counselling or online counselling before, what do I do?

In order to start online counselling clients need to read the informed consent form and counselling contract.

Power of Mind will email each individual client an informed consent/counselling contract form to sign before online counselling takes place. Clients are asked to fax back the form to Fax Number: (Country Area Code) +61 02 8209 4887 or scan and email the form to private_counselling@yahoo.com.au. Online counselling will begin after the form has been signed and sent back to Power of Mind.

How to start Counselling Online

Step 1 – Sign Informed Consent Form & Counselling Contract

Step 2 – Sign up with Windows Live/Msn Messenger www.webmessenger.msn.com/

Step 3 - Sign up with Pay Pal www.paypal.com.au/au

Click on Informed Consent Form and send form back to us by fax +610282094887 or

Step 4 - Email us an Appointment time - private_counselling@yahoo.com.au

Step 5 - P*ower of Mind will reply to confirm your appointment time*

Step 6 - Sign in to Windows Live/MSN, Skype or Email & Start Counselling instantly online!

Power of Mind Privacy Principles:

Fair Collection use of personal information

Before Online counselling Sessions begin, the client's personal information is collected, for example client name, email address and client's signature for

informed consent. Power of Mind may collect personal information about the client which may be relevant to online counselling.

Power of Mind will only collect information that is considered necessary for the effectiveness of online counselling. The counsellor will keep information stored in computer file to keep a record of the session. Power of Mind may also ask the client during the online counselling session for information about themselves regarding age, gender, and issues they would like to discuss.

Use and Disclosure

Power of Mind may ask for and collect information that is necessary for the outcome of a positive online counselling session. The use of information is to provide the best possible service to the client, to be there as a support, to protect the safety and well-being of the individual client.

Power of Mind will only disclose personal information if necessary; if the person either counsellor or client is at risk of harm; if there is a suspected case of child abuse or alleged child abuse, known or suspected case of adult or elder abuse, or if there is a threat to self-harm.

Confidentiality

Power of Mind keeps all client personal information confidential. When possible Power of Mind will always advise clients of confidentiality and the importance it has on the individual counselling sessions.

Data Quality

Power of Mind will always ensure personal information is gathered accurately. Power of Mind will only use your email address for the purpose of online counselling. Your email address will be used as a form of contact in order to book an appointment.

Security

Power of Mind uses a secure system for online counselling, protecting the information that is collected by the client both in paper format and stored in the computer file. Power of Mind will always ensure that information is transferred securely and log in passwords by PayPal and MSN Messenger are used in order to protect the individual client.

Openness and Access

Power of Mind will always be open about counselling practices regarding management of personal information. If you require access to your individual online counselling sessions. Power of Mind can provide you with this information; the individual client will have to write a request in writing and have a valid reason for having this information.

Anonymity

Power of Mind will provide an anonymous service where you will have the option of being able to use another name for the purpose of online counselling, you may use a name you feel comfortable with, and the choice is up to the individual client.

Sensitive Information

Talking to a counsellor about issues affecting you through online counselling may be very difficult. Power of Mind is aware that the information in the

counselling session may be sensitive and the counsellor at all times will provide the best possible professional help, support and guidance to cater to each individual client.

More information about Privacy law and National privacy principles can be found at www.privacy.gov.au./

Will I be judged?

The counsellor's role is to guide and support the individual client is a professional manner to reflect the principles and values in the counselling profession and to always uphold a non-judgemental and respectful empathic role at all times with the therapeutic relationship.

Do I need a referral to make an appointment?

For Power of Mind Private Online Counselling you do not need a referral.

How long do I have to wait to book an appointment?

You are able to book in an appointment time within 24 hours.

How long will counselling treatment take?

The number of counselling sessions is up to the individual client. Depending on the issues at hand it varies for each client.

What are the Terms and Conditions for this online counselling service?

1. **Counselling Consent/Contract**

In order to start online counselling clients need to read the informed consent form and counselling contract.

Power of Mind will email each individual client an informed consent/counselling contract form to sign before online counselling takes

place. Clients are asked to fax back the form to Fax Number: (Country Area Code) +61 02 8209 4887 or scan and email the form to private_counselling@yahoo.com.au. Online counselling will begin after the form has been signed and sent back to Power of Mind.

2. **Disclaimer**

This website is provided by Power of Mind for the purpose of providing online counselling to individual clients. The service is for anybody who would like to receive counselling as long as the individual client is able to understand and acknowledge what is involved in this service and are willing to cooperate and follow terms and conditions. This website contains information and links to other websites which are external to Power of Mind. Power of Mind takes careful consideration when adding links to the website. It is the user's responsibility to acknowledge the necessary appropriateness of information contained in other external sites.

3. **Liability**

Power of Mind holds no liability if the connection with the website becomes unavailable. Power of Mind does not accept any liability for any injury, loss, costs, damage or false information given to receive counselling from this website. Power of Mind holds no responsibility to a user's computer system, software and data technical difficulty occurring in connection to this website. Power of Mind holds no responsibility and holds no liability in regard to any computer viruses, computer corruption to any individual client's computer.

4. **Payment**

Payment is to be made through PayPal at a fee of $60.00 per 60 minutes. Payment may also be made through direct deposit. Payment is needed to be

made before counselling (any or a) session begins. If by any chance you are having difficulty connecting to the internet at the appointment time scheduled, please email Power of Mind private_counselling@yahoo.com.au within 24 hours to arrange another appointment time.

5. **Copyright**

The material on this website is copyright to Power of Mind.

Privacy Policy - Protection of your Privacy

Power of Mind Private Online Counselling acknowledges that your privacy protection is very important. Power of Mind follows the Privacy Act 1988 (Cth) and the Privacy Amendment (Private Sector Act) 2000. Personal information such as your name, email and signature are collected to give the client the best possible service.

Case Study

Child abuse issues can affect individuals for many years. It is important to consider the issues, symptoms and difficulties clients experience throughout their adult life.

Child abuse has crucial effects on individuals such as emotional, psychological issues of anger, hatred, guilt, betrayal, commitment and relationship hardship. Power of Mind gives you the opportunity to discuss issues with a counsellor and be supported, listened to and provide an understanding that it is necessary to continue and function in everyday life.

The client needs to feel the counsellor is there as a support to help through the past issues and be helped to gradually overcome the painful struggle they have experienced. Counselling is important to any individual who has experienced

sexual abuse at any age and any culture. The cycle of sexual abuse can be so difficult and the individual will find it hard to feel accepted and to feel loved.

Karen* was a victim of sexual abuse for many years. Karen did not seek any counselling and felt very ashamed and embarrassed by what had happening to her. Karen was afraid that nobody would believe her and what she was experiencing. Karen failed to tell anyone out of her family and friends what had happened to her throughout many years.

Due to Karen feeling the symptoms, difficulties and struggling to cope with everyday activities Karen decided to eventually seek help from a professional counsellor and gained the support , counselling and help she needed to continue with her life she was able to feel better, she felt relieve in being able to tell someone. Karen was able to finally talk about her feelings, the anger, hurt, sadness and the emptiness she felt for a long time and Karen felt more at ease being able to be comforted and supported by a counsellor. As Karen also had a low self-esteem she was not comfortable in seeing a counsellor face to face Karen heard about a private online counselling service and found it helped.

Issues of child abuse are very painful, it is very hard to be able to open up and talk about your experiences and deal with such horrific issues. It is important to note that help and support is always out there, there are counsellors that can help, support and encourage clients to feel better and feel at ease knowing that importance of effective professional counsellors are here to acknowledge the painful experience and be there to provide assistance, support and be there for the client.

If you feel you know anyone who could benefit from online counselling, tell

them about Power of Mind. Please feel free to contact Power of Mind Private Online Counselling Service at www.powerofmind.com.au and please feel free to email private_counselling@yahoo.com.au at any time for any further queries.

Testimonials

"I work long hours, 6 days a week... counselling online works for me. It's convenient, low cost and most importantly comfortable!" S.

"I was hesitant to try it, but after I thought what do I have to lose? I would definitely recommend it." Y.

"I don't have to travel anywhere. I get support online at home... and it is cheap too!" J.

"I have always felt embarrassed to see a counsellor face to face. When my friend told me about this service, I wanted to give it a try. I wish I discovered Power of Mind earlier... I didn't even know counselling online existed." A.

"I live in a rural town, counselling services are too far away. Online counselling helped me as I was able to get support through the internet at home. Power of Mind is a service that is needed, especially in the country areas." P.

"I was seeing a counsellor for many years, but I just couldn't afford the high fees anymore. I found Power of Mind online and I was relieved as I could get help for half the price!" M.

“I was in need of help and found Power of Mind through Google search. I found my counsellor Lisa, to be dedicated, understanding and guiding. Sometimes we are so occupied in the rush of life and it can be difficult to control. However, online counselling gives you the opportunity to be in control, to stay positive and to find a way to deal with such issues in the best possible way.” T.

“I have been a long term survivor of sexual abuse. I found it really difficult to open up and talk to a counsellor face to face. I felt ashamed and embarrassed; it was very confronting. After having a few sessions with Lisa through Power of Mind, I felt more comfortable in seeking counselling and being assisted through online sessions. I felt safe and secure because I knew it was highly confidential.” M.

“I have seen many counsellors for years and I couldn’t find a counsellor who could help me in a professional, caring and understanding manner. I believe online counselling sessions have helped me connect with my feelings and thoughts in a private, anonymous way being able to get a good professional service and great counselling skills online. I strongly recommend Power of Mind Online Counselling.” P.

"I live in regional NSW, counselling services are too far away. Online counselling helped me as I was able to get support through the internet at home. Power of Mind is a service that is needed, especially in the country areas." P.

Resources:

http://www.powerofmind.com.au

http://www.sydneycounseling.com

http://privatecounselling.org/

http://onlinecounselling.biz/

http://livecounselling.biz/

http://cheapcounselling.com/

http://privatetherapy.biz/

http://onlinecounsellor.biz/

http://counselloronline.biz/

http://privatecounselling.webs.com/

http://www.goodtherapy.com.au/lisa_laba_sarkis

http://www.twitter.com/counsellor881

http://www.naturaltherapypages.com.au/therapist/29771

http://liveperson.com/lisa-laba/

referralkey.com/privatecounselling

http://www.choosehelp.com/profile/Counsellor881

http://www.mentalhelp.net/

http://powerofmind-privateonlinecounselling.blogspot.com

http://blog.mens-sexual-health.org/2011/05/mens-power-of-mind-

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