ASKING THE QUESTION

CHILDHOOD SEXUAL ABUSE AND TRAUMA

ENQUIRY AND RESPONSE

A WORKBOOK FOR MENTAL HEALTH CARE WORKERS

PAUL HAMMERSLEY, PROFESSOR JOHN READ AND PETER BULLIMORE

Acknowledgement:
This workbook is based on a training manual developed by Auckland Rape Crisis and the Department of Psychology at Auckland University, New Zealand. Permission has been granted to use this material from Dr John Read, Professor of Psychology

CONTENTS PAGE

DEFINITIONS

Child abuse and neglect is sometimes referred to as **child maltreatment**, and is defined in the World Report on Violence and Health as:

'All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust, or power' (WHO 1999, 2002). Childhood maltreatment can be divided into five main areas:

- **Sexual abuse**
- **Physical abuse**
- **Emotional/Psychological abuse**
- **Neglect and neglectful treatment**
- **Commercial abuse**

In the UK 'harm' is defined in Section 31 of the Children's Act (1989) and remains unchanged in the Protection of Children's Act (1999). Harm is defined by the Act as "ill treatment or the impairment of health or development".

- "Development" is taken to mean physical, intellectual, emotional, social or behavioural development
- "Health" is taken to mean physical or mental health
- "Ill treatment" includes sexual abuse and forms of ill treatment that are not physical

1. Childhood Sexual Abuse

Childhood sexual abuse is the involvement of a child in sexual activity. Childhood sexual abuse is an activity between a child and an adult or another child, who, by age or development is in a relationship of trust or power. The activity being intended to gratify or satisfy the needs of the other person (WHO, 1999). In the UK a child from 13 and below cannot consent legally to sexual contact or intercourse.

Sexual abuse may include:

- Non-contact abuse - exhibitionism, voyeurism, exposure to pornography
- Contact abuse - touching breasts, genital/anal fondling, masturbation, oral sex, object or finger penetration of the anus or vagina, penile penetration of the anus or vagina, encouraging the child or young person to perform such acts on the perpetrator
- Involvement of a child or young person in sexual activities for the purposes of pornography or prostitution.

2. Childhood Physical Abuse

Physical abuse of a child is that which results in actual or potential physical harm from an interaction or lack of interaction, which is reasonably within the control of a parent or person in a position of responsibility, power, or trust. There may be single or repeated incidents (WHO, 1999). This includes:

- Bruises and welts
- Cuts and abrasions
- Fractures or sprains
- Abdominal injuries
- Head injuries
- Injuries to internal organs
- Strangulation or suffocation
- Poisoning
- Burns or scalds

3. Childhood Emotional/Psychological Abuse

Emotional abuse includes the failure to provide a developmentally appropriate, supportive environment, including the availability of a primary attachment figure, so that the child can develop a stable and full range of emotional and social competencies. These acts must be reasonably within the control of the parent or person in a relationship of responsibility, trust or power.

It may include:

- Inappropriate and continued criticism, threats, humiliation, accusations
- Exposure to family violence
- Severe isolation enforced by another person
- Corruption of the child or young person through exposure to, or involvement in illegal or anti-social activities
- The negative impact of the mental or emotional state of the parent or carer
- The negative impact of substance abuse by anyone living in the same residence as the child or young person

4. Childhood Neglect and Negligent Treatment

This is the inattention or omission on the part of the carer to provide for the development of the child in all contexts. It includes the failure to properly supervise and protect children from harm as much as is feasible (WHO, 1999). Some examples are:

- Neglect (especially as a child) - including physical neglect, neglectful supervision, medical neglect, abandonment and refusal to resume parental responsibility
- Deliberate or unintentional starvation
- Lack of essential provision such as clothing and basic comfort.

5. Childhood Commercial or Other Exploitation of a Child

This refers to use of the child in work or other activities for the benefit of others. It includes, but is not limited to, child labour and child prostitution. These activities are to the detriment of the child's physical or mental health, education, moral or social-emotional development (WHO, 1999). Some examples are:

- Hiring out the child for work of a physical or sexual nature
- Any other aspect of exploitation that is harmful to the child

6. Summary

Childhood sexual abuse is an international public health problem both at an individual and societal level. Definitions and examples of different types of child maltreatment have been given. A child can experience a combination of these. The greater the trauma dose, the greater the likelihood of psychological dysfunction in adulthood.

Since the recognition of childhood abuse as a social problem in the 1970's, organizations such as schools have developed educational programmes to promote a greater awareness. Professionals are now more aware of childhood abuse. Unfortunately, they rarely ask adults about childhood abuse histories. There is a wealth of evidence that health professionals rarely ask about bad things that may have happened to their clients as children (Lampshire, 2000; Lothian and Read, 2002). A recent review (Warne & McAndrew, 2005) highlighted how ill prepared, in terms of knowledge and attitudes, mental health nurses are to work with service users who have had such experiences. Both pragmatic and emotional reasons were explored. Other frontline mental health care professionals including psychiatrists and social workers are equally ill equipped (Read & Fraser, 1998).

FRAMEWORK FOR ASKING. STOP-THINK-ACT

Confidentiality issues

Local and government policy

Caldicott guardian's advice

Contextual considerations

1-1 interpersonal issues

Relationship meshing

Common language

Cultural, personal demographic equity

Semi-structured documentation

Psychosocial framework

Language refinement

Reduction of shame

Immediacy - Being there

Leading questions - Polarised comparisons

Evaluate information and person responsiveness

Check out verbally 'How are you feeling right now?'

Prepare to ASK

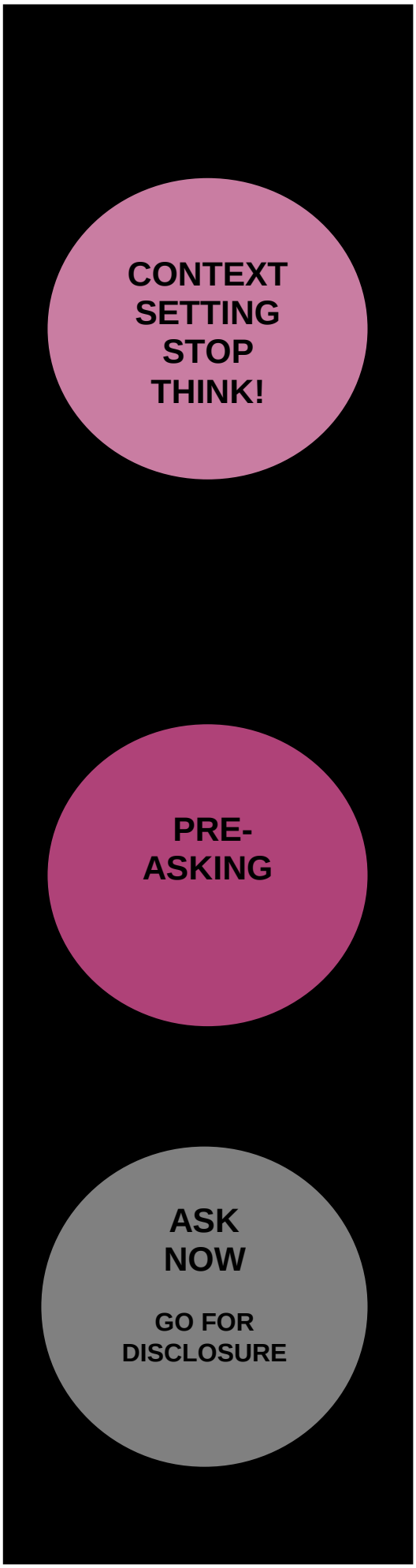
Record reasons for not asking and next opportunity to ask

Ask specifics about childhood trauma experiences

Has it stopped?

Thoughts now?

Disclosure considerations



Source: K P Kennedy: Psychosexual Therapist

ASKING ABOUT ABUSE

This workbook is adapted from one utilised in New Zealand and has been contextualised for a UK audience. The workbook was used as a manual to deliver training to Mental Health Professionals into 'Sexual abuse inquiry and response'. Eighty-five Mental Health Professionals took part in a research programme examining the effects of the delivery of training into sexual abuse inquiry. This training was found to be highly valued (Cavanagh et al, 2004). The study found that the workbook and interactive nature of role-playing between facilitators and students was highly effective in improving confidence and knowledge in this area.

This workbook is provided for mental health care workers working with adults. The primary focus is childhood sexual abuse/assault, it may also be utilised for working with other types of childhood maltreatment.

ASKING ABOUT ABUSE

The Guiding Principle

It is important for mental health care workers to know whether a service user has been abused to facilitate proper formulations regarding the origins of their current problems and to be able to offer appropriate support and treatment (for example, abuse focussed counselling/psychotherapy). Not all service users will need or want this, the key thing is that they feel listened to and believed (Hammersley et al 2003). Therefore, it is recommended that mental health care workers routinely ask about the service user's trauma history, especially trauma which occurred during childhood. It is recommended that questions regarding the service user's trauma history should not be asked if this information has been previously shared by the service user and they have stated that the effects of that abuse have either been dealt with to their satisfaction, that they do not wish to deal with them, or that they do not feel the abuse had any adverse effects. There are some situations where survivors may also have abused another person and/or still be abusing. In this situation, it is important for the mental health care worker to access professional advice to reduce the risk to others.

1. Confidentiality

It is important for the service user to know what happens to the information they give (during assessment and treatment). The mental health care worker should be aware of the specific confidentiality policy of their local area. A service user should know what happens to the information they are giving, who will see it, where it goes after disclosure and what it is used for. Information about confidentiality should be given at the initial assessment and repeated at anytime the service user asks about the confidentiality of any information they have given.

2. The Pre-asking Context

Enquiry about abuse should take place in the context of a general psychosocial history. It should not be asked 'out of the blue'. It is also advised that, where possible, the staff member establishes a relationship with the service user before asking about trauma history. The mental health care worker should ensure that they have enough time to ensure the service user has appropriate support immediately after disclosure, if support is required.

***Please note*:**
The following pages include suggestions for ways of asking and receiving disclosures about abuse. The examples should be used as a guideline only. It is important to acknowledge and validate how the survivor is feeling on an individual basis and to respond appropriately.

When taking a psychosocial/sexual history, questions about trauma history can be introduced with questions such as:

- Think back to when you were a child: *Tell me a little bit about your parents: Did they show affection openly to each other?*
- Can you tell me a bit about your childhood?
- Can you tell me what your childhood was like?

This might be followed with slightly more specific questions such as:

- What was the best thing about your childhood?
- What was the worst thing?
- What was the worst thing that ever happened to you as a child?
- Which person in your childhood did you feel most comfortable with?
- Which person, if any, in your childhood was it uncomfortable to be with?

Note:
Consider expanding on the above with **'why was this?'** This filters information from the 'general' to 'specific'. This is known as a '**continuation response'** and elicits further engagement and information.

These questions can send clear messages to the person. Messages that tell the person they are being listened to actively. Some examples are as follows:

- **'***Tell me a little more about …'*
- *'Okay…I see'*
- *'Do you feel okay to continue?'*

3. The Asking Context

If these questions do not elicit information about abuse, it is necessary to ask specific questions such as:

- Did a parent or another adult ever hurt or punish you in a way that left a bruise, cut, scratches, or made you bleed? (This question evaluates for possible childhood physical abuse)
- Have you had any unwanted sexual experiences?
- Did anyone ever do something sexual with you or to you that made you feel uncomfortable as a child? (This question evaluates for possible childhood sexual abuse).

Note:
The reason for including **uncomfortable** is that some people who were sexually abused as children may have felt confused at the time about whether or not they wanted the event to happen but might nevertheless have felt uncomfortable.

- Did anyone **older** or **younger** than you ever do anything sexual to you that was against your will?

- Has anyone ever done something sexual to you against your will, or that you didn't feel comfortable about? (This question evaluates for possible adult sexual assault).

- Have you ever been beaten, hit or battered in a sexual or marital relationship? (This question checks for possible spouse or partner abuse).

- Have you ever been physically attacked or assaulted by someone who wasn't a sex partner or spouse? (This question evaluates for possible non-domestic assault).

- Have you ever been in a situation, where you thought you were going to die?

Note:
It is advisable **not** to ask '*Were you sexually, emotionally or physically abused?'* because many people who were abused will not have used this term to describe their experience.

If the person responds with *"No I haven't been abused",* the mental health care worker may like to respond in a way that lets the service user know that support is available in the future if they wish to revisit this topic at a later date; eg. *"That's fine" – 'the reason we ask is that we like to offer people the opportunity to get some support if they want it. If anything, uncomfortable happened to you in the future would you know how to get help?'*

4. Recording if Questions Not Asked

There are occasionally good reasons for not asking about abuse at a specific time, but if this is the case it should be recorded that abuse enquiry has not occurred and a plan made as to when this will be done and by whom.

For example: The service user, where possible, should be asked in a culturally appropriate assessment by a gender appropriate worker. Level of rapport should already be established. Ideally, there should be a strong likelihood of an ongoing working relationship with the service user and time available to attend to this responsively.

5. Documentation

It is recommended that information as to whether or not the person has been asked about abuse/trauma history is recorded in an easy to access form, to avoid repeat questioning by multiple agencies. Where possible, collaborative note taking is advised. It is suggested that every file (computerised or hard copy) include a section as below:

Has the person been asked about abuse/trauma history?

YES **NO**

RESPONDING TO DISCLOSURES OF ABUSE

1. Guiding Principle

It is **not** necessary, or desirable, on first being told by a service user that they have been abused, to immediately gather details of that abuse. It **is** important that the service user feels that the health care worker has understood the importance of what has been disclosed and that this will, if the service user wishes, be returned to later.

2. Positive Affirmation of the Disclosure and Acknowledgment

Service users will have a range of responses to disclosing abuse. They might feel and show anger, shame, self-blame, fear, relief, a lack of connection with their feelings, appear numb or ambivalent about the abuse. What is important is that they are believed and that the fact they have disclosed is met with an immediate and positive response from the health care worker. Here are some '**do**' and '**don't**' statements:

Helpful 'do' statements

- *I believe you (or showing acceptance of what the person says)*
- *Thank you for telling me*
- *It's not your fault*
- *I will help you*
- *That is an important thing you have told us*
- *It is OK to have said this and we believe what you have said*

Unhelpful 'don't' statements

- *Why didn't you tell anyone before?*
- *I can't believe it!*
- *Are you sure that this is true?*
- *Why? Who? When? Where? How?*

Never make false promises

3. Responding to a Person Making an Allegation of Abuse

- Stay calm, listen carefully to what is being said
- Find an appropriate early opportunity to explain that it is likely that the information will need to be shared with others

- Do not promise to keep secrets
- Allow the service user to continue at his/her own pace
- Ask questions for clarification only, and at all times avoid asking questions that suggest a particular answer
- Reassure the person that they have done the right thing in telling you
- Tell them what you will do next and with whom the information will be shared
- Record in writing what was said using the service user's own words as soon as possible. Note the date, time, any names mentioned, to whom the information was given and ensure that the record is signed and dated by the mental health care worker.

Acknowledge that abuse can sometimes be difficult to talk about, but that it is a positive thing to talk about. It is also important to gauge from the person how they feel about disclosing rather than making judgements. It is also important to normalise the disclosure by using statements such as:

- In my experience of talking with people about this, people often find that although it is difficult, it is often really helpful to talk about it. How has it been/is it for you talking about this now?
- Often this can have a real effect on someone's life and often it can be quite difficult to talk about

Acknowledge how the person is reacting:

- *I can see you are really upset*

Survivors of abuse often experience much self-blame. If self-blame does occur it is important to affirm that self-blame is a common reaction, and, if appropriate, to state that any abuse they have experienced is not their fault. Some people may feel ambivalent about the abuse. In this case it is important not to frame the abuse as either positive or negative. Mental health care workers may, in this case, also offer support to the service user.

4. Empowerment/Support

This section focuses on initiating discussion around treatment/support for symptoms and effects of the disclosed abuse.

Ask about previous disclosure and support/treatment:

- Have you had the opportunity to talk to anyone about this before?
- Have you had any support or help to deal with your feelings about what happened?

Ways of asking if the person wishes to have counselling:

- Do you have any support for how you feel about what has happened? Some people find talking to a counsellor to be very supportive. If you are interested I can help you find someone to support you.

- There are people trained in counselling in these issues – would you like to think about seeing someone? I am willing to assist you to find some support for yourself.

- Would you like to talk to someone about how you feel about it all now?

If you are trained and able to offer counselling yourself:

- Would you like to talk with me about that at some point?

Sometimes service users have concerns about their physical/sexual health resulting from the abuse. (See Appendix 1 on the website for more information on available services).

5. Current Safety of Person

If the service user discloses that they are being abused currently, confidentiality may need to be waived to guarantee safety. The mental health care worker will first counsel the service user to contact the appropriate statutory agency. However, if he or she is not responsive to this or is unable to act, the mental health care worker may, in conjunction with the team, report the situation to maintain person safety.

Note:
If the adult person has disclosed historical abuse and now not at risk there is no mandatory reporting although the person has the right to report the assault to the Police when and if they wish to.

Ways to establish safety of the service user:

- Do you feel safe now?

- Is anything like that still going on?

- Are you safe to leave?

- Is anyone treating you like that at the moment?

- I need to check if you are now safe.

6. Others Currently at Risk from Service User

If the service user discloses that they are currently abusing another person, confidentiality may need to be waived to guarantee the safety of others. The mental health care worker will first counsel the person to contact the appropriate statutory agency. However, if he or she is not responsive to this or is unable to act, the mental health care worker may, in conjunction with the team, report the person to the appropriate agency.

Note:
It may be useful to inquire about the safety of others especially children *"As part of this I need to check if people around you are safe".*

7. Others Still at Risk from Abuser

If the service user discloses that somebody they know is currently at risk from an abuser, confidentiality may need to be waived to guarantee safety. The mental health care worker will first counsel the service user to contact the appropriate statutory agency. However, if he or she is not responsive to this or is unable to act, the mental health care worker may, in conjunction with the team, report to the relevant agency.

I need to check if you or the people around you are safe.

- Is anything like that still going on?

8. Establish Feelings and Respond to Possible Upset

Before ending the session, the mental health care worker should establish with the service user how they feel after talking about their abuse:

- Telling someone about what happened can sometimes bring up many feelings. I am just wondering how you are feeling about what you have just told me?

- If you feel upset later about what we have talked about today you can talk to (staff member's name) about how you are feeling. (Tell (staff member) that the service user may approach them regarding the disclosure of abuse so they are aware of the service user's needs during their shift).

- Sometimes people have a lot of feelings after they have told someone something like this. What will you do if you find yourself getting upset later today or over the next few days?

If the service user is in crisis over the disclosure, health care workers should respond to the crisis and remain with the service user/access available resources to help stabilise them. It may be important to assist the service user to identify his or her own support systems.

- Do you have someone who is a real support person that you could talk to or call if you need to?

Establish support and offer some if there is nobody the service user could talk to. The health care worker can offer the names of support people from inside the agency as well as offer telephone numbers of sexual assault support groups outside the agency.

9. Follow Up

Establish at the time whether the service user wishes to be seen again to discuss what they have disclosed. Arrange a time that suits you both so that the service user is aware of when this will take place.

PHYSICAL EFFECTS OF TRAUMA

- Physical health effects of psychological effects, e.g. binge eating or starvation, depression, self-injury
- Drink/drug use to cope with trauma
- Effects of pregnancy, abortions etc at early age
- Escaping abuse: many risks to health when homeless
- Fear & avoidance of dental checks
- Side-effects of prolonged psychiatric medication
- Injuries & infections from repeated assaults
- Possible cause of cancer onset
- A weaker Immune system
- Irritable bowel syndrome & other GI complaints
- Chronic pelvic pain/severe premenstrual pain
- Fibromyalgia & musculoskeletal pain; arthritic-type
- Respiratory conditions, wheezing, throat problems
- Chronic fatigue

Symptoms are often across several organ systems

WRITING LETTERS TO YOUR INNER CHILD

Aim: To communicate with the child you were and to support and comfort him or her.

1. Think of an incident or a time as a child when you were unhappy. This does not have to be during the time you were abused. Write a letter to yourself as the child you were then from the adult you are now. Try to make contact with him or her. Tell the child you are an adult who will listen and believe and will try to understand what is happening. Write your letter in simple language, the sort of language a child could understand. If you had a nickname as a child you may want to use it in your letter.

Dear_____

2. Write a reply to yourself as you are now from this child. Try to remember how you felt as a child and what you would have liked from an adult. You may want to write about how you were feeling, what was happening to you, the things you didn't understand.

Dear _____

3. Continue writing letters to and from yourself as a child so the adult part of yourself is able to support and accept the child you were and the child feels comforted.

   As an adult, you could try to explain to the child how she or he was not to blame for the abuse and did not deserve to be abused. The adult may be able to help the child understand his or her moods, feelings and behaviours. As you continue writing letters you may be able to get closer to the child who felt unloved and alone and offer the child love and support. You can help the child realize he or she is no longer alone. Comforting the child could take some time, so keep repeating the letter-writing exercise over the following months.

Examples

Lucy's Letters

Dear Little Lucy,

I am so sorry for all the bad things that happened. None of them were your fault and you didn't deserve to be treated like that. I am sorry that I didn't like you before and thought you were a nuisance. That was wrong of me and I will try to make up for it now. When I look at your photograph I see a beautiful tiny child with lovely brown eyes and dimples cheeks. I just want to pick you up and hold you, take care of you, have fun with you. We will do all of these things together. We will walk hand in hand and I will show you how lovable you are and always were.

You are not alone now.

I love you,

Big Lucy

Dear Big Lucy,

Thank you very much for your letter. It means everything to me to know you care about me. I felt ugly and unwanted before. It is so lovely to be told I am beautiful and that you want to be with me. I cannot believe it yet, though, so you will have to go slowly as I am not used to trusting people.

Little Lucy

TALKING TO A CHAIR

Aim: To help you express your feelings to your abuser and to feel more empowered.

Sit on a chair and pick another chair to represent your abuser. Place this chair opposite you at whatever feels the most comfortable distance. Imagine this chair is your abuser. You are able to talk to your abuser but he or she is not able to speak back to you. Talk to your abuser and tell him or her whatever you want to. Start by telling your abuser what he or she has done to you and how it has affected your life. Be aware of how you are feeling. You may experience one type of emotion most strongly – anger, love, fear, hate, upset, pity, distaste – or many different emotions mixed together. Accept whatever feeling come up and express these feelings to your abuser.

Make a note below of any feelings that came up when you were talking to your abuser.

……

……

……..

……

ROLE PLAY CONFRONTATION

Aim: To role-play a confrontation with your abuser as a way of feeling more empowered in relation to him or her and of challenging negative reactions to yourself.

Chair role-play

- Get two chairs, one to represent yourself and one to represent your abuser as you did in the previous exercise. Place them at a comfortable distance apart.
- Sit in the chair that represents you and talk to your abuser. Say the things you would like to say if you could.
- Swop chairs and talk back to yourself as if you are your abuser, using your abusers reactions.

- Return to your own chair and reply to your abuser as yourself.

- Continue swapping chairs and confronting your abuser until you feel ready to stop.

Remember, you are in charge of this conversation and can stop it whenever you want to.

HELPING WITH BODY FLASHBACKS

Childhood trauma increases the risk of future trauma

Many people experience tactile experiences, that is, a feeling that someone or something is actually touching you. In some cases, this touching can seem to be of a sexual nature and can be extremely distressing.

When childhood trauma is not resolved, this fundamental sense of fear and helplessness carries over into adulthood, setting the stage for further trauma. During an experience of feeling frightened or overwhelmed the person can experience what is known as a body flashback, they experience being touched or they can feel things like spiders crawling on or under their skin. This can occur when you are discussing the past trauma or just after discussing it or if you are under any form of stress. These experiences are perfectly normal for people who have had severe trauma in their life especially people who have been sexually abused, their bodies are still in a state of trauma and reminding them of unresolved issues in their lives this usually occurs when the person has been sexually or physically abused in childhood.

Ways of helping with body flashbacks

Keep your sleeping area relaxed and calm. Open the window during the daytime; close it at night to stop you getting cold and if it feels like a relaxed atmosphere you have a better chance of dozing off.

Stick to a daily routine, with regular times for walking, sleeping, eating, working and exercise. Make sure to schedule time for relaxing and social activities, too.

Break large jobs into small manageable tasks. Take pleasure from the accomplishment of achieving something, even if it's a small thing.

Find activities that make you feel better. Keep your mind occupied (reading, cooking playing with a pet) so you're not dedicating all your energy and attention to focusing on the traumatic experience

Staying grounded: A trauma self-help exercise

If you are feeling disorientated, confused or upset, you can do the following exercise.

Sit on a chair. Feel your feet on the ground. Press on your thighs. Feel your behind on the seat and your back against the chair.

Look around you and pick six objects that have red or blue. This should allow you to feel in the present, more grounded, and in your body. Notice how your breath gets deeper and calmer.

You may want to go outdoors and find a peaceful place to sit on the grass. As you do, feel how your body can be held and supported by the ground. The more you get in touch with your body the more control you will have over the flashbacks.

Try to get plenty of sleep and take regular exercise, eating a balanced diet can be helpful. The body flashbacks are related to stress and anxiety the more you reduce these experiences the less frequent the flashbacks should be.

Importantly don't be afraid to ask for help theses experiences can be very difficult to cope with alone.

POSITIVE WAYS OF DEALING WITH RELAPSES

Aim: To look at ways of dealing with relapses and add any others you can think of.

Read through the list below of positive ways of dealing with relapses and add any others you can think of.

Positive ways of dealing with relapses

- Tell myself it's normal to have relapses occasionally and that I can get through it.
- Remember I have felt this bad before and it will pass.
- Remind yourself of the progress you have made and that this is a temporary setback – I am not back to square one.
- Write down how you are feeling.
- Try to use your positive coping strategies

- Talk to a friend.
- Contact someone you trust
- Contact your GP
- Phone the Samaritans or another telephone helpline.
- Get some professional support or therapy.
- Think about how far you have come and how your going to persevere with the journey.

Solution-focused questions

This approach assumes that solution-focused behavior already exists for people.

It is based on solution-building rather than problem-solving. It focuses on the desired future rather than on past problems or current conflicts. People are encouraged to increase the frequency of current useful behaviors. No problem happens all the time. There are exceptions – that is, times when the problem could have happened but didn't – that can be used to co-construct solutions. Small increments of change lead to large increments of change. The goal is to co-construct a vision of a preferred future and draw on the persons past successes, strengths, and resources to make that vision a reality.

- So, what has been helping you to survive?
- How have you been getting through?
- How come you have not given up hope?
- So how come you have managed to get here today?
- How do you cope?
- That situation sounds pretty overwhelming: how do you get by?
- What is it that even gives you the strength to get up in the morning?
- So what have you been doing to stop things getting even worse?
- When are the times when that doesn't happen?
- When are the times that it seems less intense?
- When you have faced this sort of problem in the past how did you resolve it?
- What other tough situations have you handled?
- If you read about a woman/man who had been through what you have been through, what do you imagine you would think of them?

- What does this teach you about yourself?
- What have you learned from this experience?
- Have you always been a survivor or did you learn the hard way?
- How did you manage to keep your sense of humour/kindness/sense of justice - is this one of your qualities which has kept you going?