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# A Capacity Building Process for Women with a History of Child Sexual Abuse

Antonia van Loon<sup>1</sup> and Debbie Kralik<sup>2</sup>

*Royal District Nursing Service Research Unit, Flinders University<sup>1</sup>  
Royal District Nursing Service Research Unit, University of Adelaide<sup>2</sup>*

*We report the research process used to promote the capacity of women made homeless by the consequences of addictions to alcohol, drugs or gambling, that are considered the result of being sexually abused as children. We aimed to improve the capacity of service providers working with this client group. We used the participatory action research (PAR) process “Look, Think, Act”, employed by Stringer (1999; Stringer & Genet, 2004). “Looking” involved building a picture of the issue based on available information. Participants described what was going on so a clear picture of the context emerged. “Thinking” was the clarification phase where meanings and feelings generated by the experience were explored. It involved sense-making questions such as, “What is happening and why? How am I feeling about this?” The aim was to understand the when, what, where and how of the experience. After describing the issues the women were invited to think about what they could do about the issue. “Acting” (a difficult phase), involved effecting change. Action required involvement with the situation. It was a new skill for many women as they had become disengaged with their lives. They were encouraged to choose actions that moved them towards chosen goals. Many women had become so disempowered they ignored their needs and had few hopes or aspirations. We encouraged them to take the smallest and most easily managed actions likely to have the most benefit for their wellbeing. The process and the outcomes are described in this paper.*

**Key words:** *Participatory action research, Child sexual abuse, Capacity building, Community health*

The purpose of this paper is to report the processes developed to promote capacity for marginalised women who have become homeless adults due to addictions to alcohol, drugs or gambling. These women were all sexually abused as children. Catherine House Inc. in South Australia offers emergency and transitional supported accommodation, and a range of services, to women with complex needs who are homeless. Over 93% of the women who use the service were sexually abused as children. As a result, many use drugs, alcohol and gambling to try to manage their emotional and physical suffering and this contributes to their homelessness (Van Loon & Kralik, 2005a). Catherine House partnered with the Royal District Nursing Service (RDNS:SA) Research Unit and Centacare to address these issues, seeking to move the women towards a healthier, independent and addiction-free life that enabled increased social and community function for the women. The project was funded by the Alcohol Education and Rehabilitation Foundation Ltd. (AER), commenced in August 2003 and concluded September 2005.

This inquiry was grounded in the experiences of women who had been sexually abused during childhood and had continued to live with disruption and adversity throughout their lives. Women shared the events and experiences that shaped and disrupted their lives. The topics discussed and the processes used to surface deep and emotional life experiences have been captured in two companion books that are the key products of this research project. A self-help resource book for women Child Sexual Abuse (CSA) survivors titled *Reclaiming Myself After Child Sexual Abuse* (Van Loon & Kralik, 2005b) and a companion volume for helping service providers when working with women titled *Facilitating Transition After Child Sexual Abuse* (Van Loon & Kralik, 2005c). The resources can be downloaded electronically from [www.rdns.org.au](http://www.rdns.org.au)

## **Literature**

It is difficult to be accurate about prevalence of CSA due to under-reporting, social silence and shame surrounding discussions about the sexual abuse of children. Caught in this vortex of confusion and

denial are as many as 1:3-5 girls and 1:8-12 boys (James, 2000; Layton, 2003; Mullighan, 2005). It is not possible to estimate how many of these children will suffer adverse impacts from their experience. CSA is correlated with a wide variety of short- and long-term impacts (Beitchman, Zucker, Hood, da Costa, & Akman, 1991; Beitchman et al., 1992; Briere, 1992; Bushnell, Wells, & Oakley-Browne, 1992; ). CSA has been directly linked to an increase in the prevalence of mental illness (Bifulco, Brown, & Adler, 1991; Elliot & Briere, 1995; Fergusson, Horwood, & Lynskey, 1996; Fergusson, Lynskey, & Horwood, 1996; Kendler et al., 2000; Macmillan et al., 2001; Mullen, Martin, Anderson, Romans, & Herbison, 1993), addiction (Berry & Sellman, 2001; Kingree, Thompson, & Kaslow, 1999; Langeland & van den Brink, 2004; Manhal-Baugus, 1998; Miller, 2000; Walton-Moss & Becker, 2000), physical illness (Eonseca & Booth, 1997; Mayer, 1995), experiencing violence (Astbury et al., 2000; Attorney General's Department, 2001; Cook & Grant, 2001; Department of Indigenous Affairs, 2002; Gladstone et al., 2004; Romans, 1997; Sadoff, 2004; homelessness (Australian Institute of Health and Welfare, 2005; Anderson & Chiochio, 1997; Boyle, 2001; Chung, Kennedy, O'Brien, & Wendt, 2000; Martin, 2003; The NSW Women's Refuge Movement and the Victorian Council to Homeless Persons, 2001; Tyler, Whitbeck, Hoyt, & Johnson, 2003) early and/or undesirable sexual experiences (Brown, Cohen, Chen, Smailes, & Johnson, 2004; Einbender & Friedrich, 1989; Fergusson, Horwood, & Lynskey, 1997; Hickie, 1996), to name a few of the adverse sequelae. The cost to our society is enormous in terms of health, social and economic expenditure, but worse is the loss of aptitude for so many people with considerable gifts, who are not employed or developing their full potential.

### **Defining child sexual abuse**

The literature is replete with various definitions of CSA. There is no universally accepted definition of what constitutes "sexual assault". Definitions vary between jurisdictions, agencies and research reports throughout Australia and internationally. The most recent definition of sexual abuse laid down in the current "Children in State Care: Commission of Inquiry in South Australia" is:

*Conduct which would, if proven, constitute a sexual offence, where a sexual offence is defined within the meaning of section 4 of the "Evidence Act*

*1929". In that section, a "sexual offence" means, rape, indecent assault, any offence involving unlawful sexual intercourse or an act of gross indecency, incest, any offence involving sexual exploitation or abuse of a child, or abuse of a child as an object of prurient interest, or any attempt to commit, or assault with intent to commit, any of these offences. (<http://www.statecareinquiry.sa.gov.au/Reports.htm>: pp. 5-6. [Mullighan, 2005])*

One key issue defining sexual abuse is the lack of consent:

*a physical assault of a sexual nature, directed toward another person where that person: does not give consent; or gives consent as a result of intimidation or fraud; or is legally deemed incapable of giving consent because of youth or temporary/permanent incapacity. (<http://www.abs.gov.au/Ausstats/abs@.nsf/Lookup/6A5AC4F1840B41B9CA256EA00079BD78>: p.40)*

The child's consent to sexual activity seems to be a contentious point because the power and control always lie with the adult perpetrator, who can readily coerce the child into sexual compliance (Rokvic, 2003). Definitions are notoriously problematic as there are controversies and anomalies in Australian law around each term, such as the legal age of a child, what the term "sexual" means, and what constitutes abuse. Defining assault/abuse involves notions of intention of the behaviour, as it relates to generally accepted social values and practices, and the issue of truly informed consent (Haugaard, 2000).

For the purposes of this project the participants were asked to describe their sexual abuse experience. From these descriptions we constructed this working definition: "CSA is any form of sexual activity or behaviour that an adult or adolescent exerts upon a child without her/him being able to control that situation". The women participating in this project unanimously agreed the end result was a betrayal of trust and a misuse of adult power over the child.

CSA is a major contributing factor to: youth and adults becoming homeless, experiencing family and intimate partner violence, misusing alcohol, gambling and drugs; mental illness; self-harm and difficulty managing anger. These all contribute to interpersonal conflict, which is a key catalyst for homelessness (Brown et al., 2004; Chung et al., 2000; Martin, 2003; The NSW Women's Refuge Movement and the Victorian Council to Homeless Persons, 2001; Tyler et al., 2003).

**Language**

The language used in the literature to describe the person who has been sexually abused during childhood varies with descriptors such as “victims”, “survivors”, “thrivers” and “over-comers”. The real victims are those who have lost their lives because of their CSA experiences, either through suicide, self-harm or murder (Davis, 1990). At the commencement of the research, many women in this study also perceived they were victims. When the group work progressed they began to identify themselves as “survivors”. None had arrived at the point of considering themselves to be thriving, but were hoping that this would be the case one day.

In this study we considered that the victim of CSA is a person who has experienced unwanted and/or uninvited sexual abuse/assault as a child (Saxe, 1993). The victim feels unable to take personal control of her life. She may feel hopeless, confused, in pain, tired, isolated and disconnected. She may be overwhelmed with emotions such as anger, fear, sadness and feelings of rage, depression, anxiety, guilt and shame. Her life feels out of her personal control.

The survivor is a woman who has recognised she can have a say in her own life (Davis, 1990; Holden, 2002). Rather than being impassive she consciously decides to regain some control of her life. She thinks through responses to her thoughts, feelings and emotions, and in so doing, becomes empowered to change her situation (King, 1998). The thriver is the woman who has addressed her past and made sense of her situation. Some survivors refer to this woman as the overcomer—one who has learnt to overcome the impacts of abuse and move forward with life (Brown, 2003).

**The Study**

**Aim**

To promote the capacity of women who were sexually abused as children by generating personal resources that would enable them to move into a healthier and more life affirming future.

**Participants**

Ethics approval was obtained prior to commencement of recruitment. Two groups of women were recruited through a flyer that was circulated among

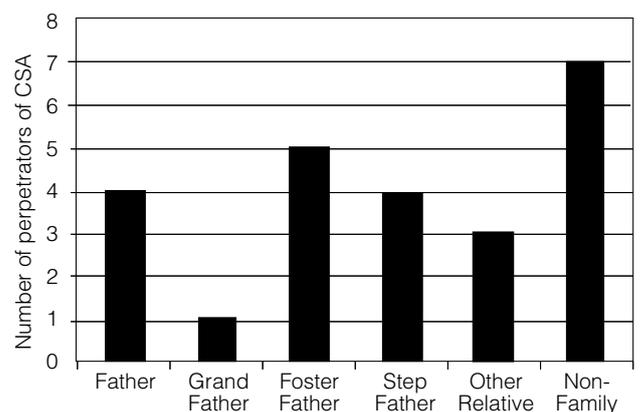
women in accommodation at Catherine House. The age of women participants (*n*=16) varied with the youngest being 22 years of age and the oldest 54 years of age. The women participants in Group 1 were mostly aged over 40 years and in Group 2 they were under 40 years. Eighty per cent of the women had been sexually abused by more than one person during childhood. Of the 13 women who could recall the age at which the abuse started, most were between the ages of 6-8 years.

Six women stated they had multiple suicide attempts requiring periods of hospitalisation. All the women practised at least one or more of the following risky health behaviours: drinking excessive alcohol; using illicit drugs or substances; self-harm; and gambling.

Four women did not have children, two had one child, five had two children, four had three children and one had seven children. At least four said they had worked within the sex industry and 11 described themselves as having been very sexually active during adolescence.

Two participants were born overseas, and two were Indigenous Australians. The remaining women were Australian-born Caucasian. Nine women had spent their childhood in rural and remote areas.

**Figure 1: The family role of the perpetrator**



Most women reported having had more than one CSA perpetrator during their childhood years. Of those perpetrators, 22 were identified as male and two were female. The first CSA perpetrator was most often a family member, and most commonly a biological, step, or foster father (refer Figure 1). Additional perpetrators were extended family members, step-brothers, uncles and grandparents. There were three women who were sexually abused while in the care of the State. Only three

women had proceeded to court to prosecute the offender/s and, of these, only one secured a conviction after which the offender was imprisoned for their criminal action.

We also worked with two groups of 12 service providers ( $n=24$ ). We fed back to them the findings from the women’s groups about the survivor’s needs, desires, hopes and concerns, regarding the care they wanted and had found helpful over time. We discussed issues affecting and effecting service provision and considered actions to address some of the issues raised.

### Method

This project utilised the principles and processes of Participatory Action Research (PAR) because of its known emancipatory capacity and problem-solving ability when utilised by individuals and communities to meet their needs. The challenge of PAR is facilitating collaborations that demonstrate principles and values that are democratic, empowering and participatory at every step of the inquiry (Stringer & Genet, 2004; Stringer, 1999). Participants are stakeholders whose lives were affected by the issue under study. They were engaged in the data generation, analysis and theorising, to gain understanding about the nature of CSA, alcohol misuse, homelessness and transition. In using PAR we sought a viable, sustainable and effective intervention to the problems faced by this client group.

### Guiding principles of PAR

While a participatory action approach to working with people may appear to be fundamental, it is a complex undertaking. Assisting the process is an understanding of the working principles of PAR, which are based on building relationships, open communication, equal participation and inclusion of all people (Stringer, 1999).

Relationships need to be developed in a way that reflects equality, harmony, acceptance, cooperation and sensitivity. Communication must be attentive, comprehensible, truthful, sincere, appropriate and accepting of the other person or people. Participation in PAR involves all people, is authentic and personal and demonstrates action, support and success. Inclusion accounts for all individuals, all groups and all issues, and demonstrates cooperation and benefit to all people involved.

### Research process

We worked with two groups of eight women CSA survivors, and met fortnightly to discuss issues pertinent to their daily lives. PAR is based in a process of meaning-making, identified by its ability to be democratic, equitable, liberating and life enhancing (Stringer, 1999). Democracy is recognised by action that enables the participation of all people. Equity is seen when people’s equality of worth is acknowledged. Liberating participation provides freedom from oppressive, debilitating conditions and life-enhancing practice enables the expression of people’s full human potential.

To ensure these principles are demonstrated, all stakeholders whose lives are affected by the issue under study are engaged in the process. This includes all aspects of the process such as collecting data, analysing and reflecting on the data collected, theorising to gain greater understanding about the nature of the issue, taking action by making plans to resolve the issue and evaluating how the action is working.

The primary purpose of PAR is to be “a practical tool for solving problems experienced by people in their professional, community, or private lives” (Stringer, 1999, p.11). Stringer developed a model of PAR that simplified the planning, implementation, evaluation, reflection of earlier theorists, into a simple process termed “Look, Think, Act”, which is summarised in Table 1.

**Table 1: Stringer’s Model of the Three Components of the PAR Method**

PAR component	Focus
LOOK	Gather relevant information (gather data) Build a picture to describe the situation (define and describe) The aim is to define and describe the problem to be investigated and the general context within which it is set
THINK	Explore and analyse: What is happening here? Interpret and explain: How/why are things as they are? (theorise) The aim is to analyse and interpret the situation to extend understanding of the nature and context of the problem
ACT	Plan Implement: Act to formulate solutions to the problem Evaluate

This approach results in a continual cyclical set of activities where change and understanding are simultaneously pursued. Critical reflection

enables review of prior actions and the planning of new ways to solve problems. PAR is a process of planning, action, observation and reflection that develops over time.

Participatory Action Research:

- Helps to answer the questions that are easily missed by busy service providers.
- Gives a focus to the things people may be doing anyway without critical reflection.
- Is a useful way to increase organisational and individual efficiency.
- Helps to improve professional and personal practice.
- Makes evaluation easier and more enjoyable.
- Values “hunches” and helps people to explore them in ways that are relevant and useful to their daily lives (Stringer & Genet, 2004; Stringer, 1999).

Participatory action research aims to demonstrate a culturally sensitive way of working with people and seeks to change the social and personal dynamics of the research situation.

### ***The philosophical perspective underpinning the project***

The project was underpinned by a critical, feminist perspective where what women say has validity and truth. We began from the basis that each woman was the expert on her own experience and knew what she needed to facilitate her healing. We sought to validate each woman and her experiences, empowering her to work with her strengths to move forward.

Each woman was encouraged to reflect on her experiences and the issues in her life that she wanted to action. We did not engineer discussion to a prefixed agenda, although we did seek clarification on some issues that surfaced. This was done to facilitate mutual understanding. We recognised the women’s strengths and courage, and encouraged movement to a preferred future, while reflecting and validating the past. We did not psycho-pathologise the woman’s addiction/s, or any other behaviour she may have been used to cope with her life situation. Instead we saw these as responses that enabled survival at that time. As a group, we discussed the issues for each woman, based on their feedback notes from each meeting. We listened for what was being said and what was

not being said, but we paid particular attention to choices and what sustained those choices. We looked carefully for barriers and enablers that impacted upon each woman’s capacity to act. This was their story, so we tried to faithfully represent their issues to the service providers for their reflection and action.

We found the women spent a lot of time looking and thinking, and often became trapped in this process because they could not give clear expression to their thoughts. With encouragement they found their voice and began to examine personal issues. They gained insights from hearing their own story. They received valuable perspectives from others in the group, and, in so doing, situations and experiences took on multi-dimensional views which created a very different viewpoint than that the women could see on their own. The group became a valued part of life for the women, because it was a safe forum to practise what was becoming a new life skill.

### ***Narrative***

In the group we used a narrative approach (Russell & Carey, 2004; White & Denborough, 1998) to describe and explore the impacts of child sexual abuse. The women were interviewed individually in the first instance. They were asked to share what they believed were the impacts the CSA had on their lives, from their earliest memories. This was distilled into a succinct “common story” that pulled together several important themes present in each woman’s story relating to the adverse impacts of CSA on her sense of identity, her health and her wellbeing. In the group we talked about the many emotions and feelings they felt in the ongoing struggle with who they were. The most common emotions and feelings to surface were shame, blame, guilt, anger, fear and love.

During discussions we tried a less structured way to define such problematic feelings, so they could be explored. The aim was to focus on how these feelings were continuing to shape their lives and the way each woman viewed herself. For many women this perspective revealed a life script where the woman felt “different somehow”. This welled up emotions, feelings and thoughts that the women termed “that package of feelings”. In the group we used narrative processes to explore those feelings and unpack the power dimensions and socio-cultural influences of this package of

feelings. We explored the women's reactions to the "package", which we discovered was often a trigger for addiction responses.

### ***The "Package of Feelings" put into a common story***

The individual accounts generated with each woman had diverse personal detail, but together there was a readily identifiable common story which included the package of feelings that contributed to their addictions. We presented this simple summative story as the starting point for our group work. The women were immediately aware they were with other women who knew and understood. They then began the process of sense-making that is facilitated by the process, as this woman's comment demonstrates:

*I've read the transcripts and I actually got upset, because I think, "Oh my God, these things have happened to me too! I'm not alone any more. There are other people who've been through this too!" It was really in my face and in the front of my mind, but none of it was clearly thought out. I've given it more thought now and I'm making some sense of how it's affected my life.*

They wanted this common story to be available to professionals (their own words are in quotation marks), to alert them to the experience of CSA and the need for sensitive intervention, appropriate referral and compassionate support (Van Loon, Koch, & Kralik, 2004):

*We were told throughout our lives that we were "useless", "good for nothing" and "deserving of everything we got". This was reinforced by "betrayal" from our family and "manipulation" from the perpetrator/s who "dominated" us from their position of power and trust, making us feel "powerless", "worthless", "ashamed", "guilty" and "to blame somehow". We were "used" and treated as "objects" or "meat". When other children were developing "the building blocks for a strong identity" and understanding that they were unique and worthwhile, "able and OK"; we were "stuck" in a world that taught us "we would never amount to anything". But worse, we still carry the burden of "shame" and "guilt", "confusion" and "sadness", which continually diminishes our "self-worth" and "shatters our identity".*

*We spent our childhood maintaining a shroud of "silence and secrecy" around our perverse experiences of child sexual abuse. We coped by "suppressing memories", "learning to forget", "disengaging", "disassociating", "isolating ourselves emotionally and relationally", "trying to please everyone", "trying to adapt" and*

*accommodate our "weird situation", because there was "no escape anyway". This allowed us to survive our childhood. But as we became teenagers we came "unstuck". We knew we "didn't fit in". So we "numbed our rotten feelings" by using alcohol, drugs, gambling, and sex.*

*For some of us self-harm and re-victimisation continued. Weak "boundaries" made us "an easy target" for "predatory people", increasing our "hopelessness and sadness". We no longer trusted easily because "everyone seemed to want something from us", so we chose to become "disconnected" to protect ourselves from further "hurt". We had "few dreams or hopes for the future", using addictions to "escape", "cope" and even "survive". We recognise these became "toxic life patterns".*

*When we encounter health professionals we would like them to help us with "sensitivity", "understanding", "respect" and "support", so we can "heal and grow" toward the future that was "taken from us during childhood". We were "victims", but we have become "survivors", and with help we are daring to hope and believe we will eventually "thrive". (Van Loon & Kralik, 2005c, p.51)*

### ***Using the "Look, Think, Act" process***

We used the practical PAR process of "Look, Think, Act" (Stringer & Genet, 2004; Stringer, 1999). "Looking" was the phase in which the woman, or the service provider, built a picture based on information available to them about the issues confronting them. The woman located the areas she wanted to work on to move forward. She was encouraged to take some time to describe what was going on. What were her circumstances and her responses to what was happening? She was aiming to gather information to build a picture that described the context of her situation. When "Thinking" she aimed to clarify the meaning of her experiences and feelings to make sense of what was happening and increase her understanding of the why, when, what, where, how of her life experiences. After describing the issues she could think about what she might like to do with/about them. When "Actioning", the woman began to move from just thinking about change to actually doing something to effect change. Actioning required her involvement with her current situation. She was encouraged to choose actions that took her towards her chosen goals. Sometimes we had to work together to find a goal the woman wanted to work towards. Many women had become so used to having their needs ignored that they no longer had many hopes or aspirations. We would encourage her to take the

smallest and most easily managed action that would have the most benefit for her wellbeing.

Through dialogue and negotiation we spoke of past CSA and how these adverse experiences during the women's formative years related to ongoing responses behaviours, reaction that kept impacting on the women in the present. We discussed drug and alcohol use and abuse, and a range of compounding health, social and spiritual issues. These included the disclosure process, memories, flashbacks, childhood family dynamics, mental illness, domestic violence, grief, loss, identity, emotions and other topics of significance to the women's healing. The topics discussed at each fortnightly meeting were initiated by the participants. As facilitators we had questions and insights from the analysis that we could see were major concerns for the women. Some of these had not been adequately described or clarified, so we would raise them in the group to engender further looking and thinking. We would then encourage the women to take action to achieve the outcome they wanted.

The women's descriptions are used to illustrate:

### **Looking**

During this phase the woman builds a picture based on information available to her about the issues confronting her. From here she locates the areas she wants/needs to work on to move forward. She is encouraged to take some time to:

- Describe:  
What is going on? The circumstances.  
What's happening inside of her? Her responses.
- Gather information to build a picture:  
Who? The people involved.  
Where? The place.  
When? The time of the situation.
- Record the information from her experiences:  
Try to get other people's views.
- Describe the context of what is happening:  
What thoughts are going on in her head?  
How long is she mulling over an event afterwards?  
As Jana got in touch with the thoughts inside her head she said the process had brought her release:

*I have been here for six months and in that time*

*I kind of believe the hardened shell I had around me about talking about these things has cracked a bit. It was really hard at first, but since the shell cracked it has been a real release of a lot of pain and pressure within me (Van Loon & Kralik, 2005c, p. 39).*

### **Thinking**

The woman aims to clarify meaning and increase her understanding of the why, when, what, where, how of her experiences. Describe the issues and think about what she needs to do with/about them. She can ask herself questions like:

- What is the main issue?
- Why is this happening?
- What was the trigger or cause (e.g., attitudes, beliefs, past experiences)?
- What are the consequences?
- How is she behaving (e.g., are her responses defensive, grounded in her past)?
- Which area/s can she move forward with? How might moving forward look?
- When should she begin? What order?
- How should she do it?

Raelene recalled her experiences of being involved in the research process:

*Some weeks everything seems like just a big mess in my head and the group helps me find some peace. I can sort things out in my head. I can listen to how others do things and work things out, and I can talk it through. At other times it's nice to just sit back and watch, and listen to other people (Van Loon & Kralik, 2005c, p. 31).*

### **Actioning**

Thinking about change does not effect change. The women spent a lot of time thinking about how they "wished" things would be, without actually taking any steps towards making change happen. Many were so disempowered they did not believe they could influence their lives. Actioning required each woman to become involved with her current situation and choose actions. Many had learnt to disengage from their situation and used only reactive responses that were necessary for survival. We encouraged each woman to take the smallest steps that would take her towards her chosen goals. This was very slow progress and took a long time. There was usually little choice about the need to change, and the woman could only choose how

she would change, yet most believed they had no choice. Through narrative group work some of the women began to detach themselves from their problems, so they could see the issue as separate to their identity. In this way the problem became more manageable. When they believed they had some influence over their situation, actioning became achievable. A good place to start was to think about what would be a desirable outcome for the situation. Then the woman began to think of steps to achieve that. Finally, she would be encouraged to take the smallest and most easily managed action that would have the most benefit for her personal happiness and wellbeing.

Most women began to set simple personal goals, working out what action they had to take for the changes they wanted to make. Some questions to facilitate this planning include:

- What area/s does she want to act on first?
- What is most important to her right now?
- What is the most achievable thing she can act on right now?
- What is the likely outcome of the action?
- What places will help her achieve her goal?
- Which people can help her?
- Where can she get support if she needs it?

Janice recalled the difficulty in learning to take action in her life:

*The hardest part is starting. It's like riding a bike, you have to get on first and then you fall a few times, but you get back on again until you get a feel for the balance, so you know how to correct yourself, keep upright and move forward (Van Loon & Kralik, 2005b, p. 31).*

## Conclusion

Using the PAR process of “Look, Think, Act” provides the researcher with authentic co-generated data that are steeped in the lived experience of the research participants. This enables those reading the research outcomes to understand the experiences from an insider perspective. It provides outcomes that have great utility. The PAR process engages participants in an emancipatory journey and they benefit from their participation as this woman clearly illustrates:

*It was like my life was a big fruit salad and it had been thrown all over the floor. I had nothing — empty. Then I began the picking up process...grapes, cherries, the bits of me I liked, if you know what I mean. The talking spread it all out in front of me and then I began to choose what I wanted to pick up. I picked up the best bits and consciously left others behind. What I've done wrong was through circumstances beyond my control, or when I was out of control, but that was then and this is now. I think what I've done wisely is to take the little bits of wisdom that are the treasures and made myself again. (Van Loon & Kralik 2005b, p. 176)*

The “Look, Think, Act” process can be a useful method to build the capacity of disenfranchised persons in our community.

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Antonia van Loon  
Royal District Nursing Service Research Unit  
Flinders University  
GPO Box 247  
Glenside South Australia 5065  
AUSTRALIA

Debbie Kralik  
Royal District Nursing Service Research Unit  
University of Adelaide  
GPO Box 247  
Glenside South Australia 5065  
AUSTRALIA

Correspondence to Antonia van Loon