

**Balancing Recognition and Disrespect:
Recovery as the Process of Identity Formation**

A New Zealand Study of How Services Shape Recovery from Sexual Abuse

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ATTESTATION OF AUTHORSHIP

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

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Gudrun Frerichs

Date: 26 August 2007

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ABSTRACT

This study explored how the recovery of victims of sexual abuse is shaped by services available. Using the philosophical underpinnings of critical theory within the framework of Honneth's recognition theory this study provides an understanding of participants' experiences and views of recovery from sexual abuse. The study was conducted with ten adult survivors of sexual abuse using semi-structured individual interviews and two focus groups with eight service providers.

The analysis identified that the recovery from sexual abuse is the development of a positive sense of identity reflected by participants' self-confidence, self-respect, and self-esteem. In this study this is described as the process of identity formation. Services shaped recovery from sexual abuse by providing experiences of recognition and disrespect. Recognition was given in the form of emotional support and care, cognitive respect, and social esteem that led to an improvement of participants' functioning. Disrespect was perceived by participants as they struggled with the invisibility of sexual abuse, with inequality, and with the lack of understanding, through which their overall functioning deteriorated.

Recovery emerged as a dynamic process that, most of all, required from services that they provide experiences of recognition and from survivors that they accurately perceive that recognition was given to them. For recovery to occur, participants needed to balance experiences of recognition and disrespect, a process in which they needed to surrender the longing for the entirely good and benign caregiver and accept that both 'good' and 'bad' qualities reside in each caregiver, agency, therapist, or generally the 'other'. This balancing resulted in the development of self-confidence, self-respect, and self-esteem.

Recovery was experienced by participants when they were able to resist disrespect and either engaged in fighting for their rights or removing themselves from situations in which their rights could be violated. Only by having a practical experience of being able to protect their physical and psychological integrity did participants become aware that they had recovered from the legacies of sexual abuse and could proceed with their lives without professional assistance.

CHAPTER ONE

RECOVERING FROM SEXUAL ABUSE: REFLECTIONS FROM MY CLINICAL PRACTICE

In my sixteen years of experience as psychotherapist in private practice I have assisted many survivors of sexual abuse on their journey towards recovery. For many, therapy became the safe haven where they felt safe enough to talk about their past experiences of sexual abuse. Here they shared their hurt feelings from not being loved and cared for in the way they needed, about being betrayed and losing trust in people, and about feeling responsible for the abuse. They talked about feeling out of control and not trusting themselves, about their shame and guilt, about their hopelessness, and about their sense of powerlessness and victimisation.

Although survivors of sexual abuse battle with intrusive post traumatic symptoms, depression, anxiety attacks, obsessive compulsive behaviours, addictions, or urges to harm themselves, I learnt that how well they coped depended to a large extent on factors other than therapeutic interventions. I found these observations supported by Lambert's (1992) seminal meta-analysis of over 40 years of psychotherapy outcome research. He identified the main factors accounting for therapy outcome as: extra therapeutic factors (client, client's life) 40%, factors common across all therapeutic disciplines (e.g. therapeutic alliance and empathy) 30%, therapeutic models and techniques 15%, and the remaining 15% are attributed to placebo factors (hopes and beliefs).

I concluded from that research that only 15% of therapeutic outcome is attributed to therapeutic models and techniques. The remaining 85% are attributed to life circumstances and relationships survivors have that can either be discouraging and detrimental or supportive and facilitative of recovery. Ever since I learnt about Lambert's (1992) research I have been interested to explore how service providers can draw on the 85%, maximise the effectiveness of treatment, and thereby accelerate recovery.

My experiences in practice taught me how significant relationships in general were for survivors' recovery. The breakdown of relationships with significant persons in their lives was often the catalyst that brought them into therapy. Relationship

conflicts and the sense of injustice, disrespect, and victimisation survivors reported in a variety of contexts often remained as the dominant theme during therapy. These conflicts seemed to evoke feelings of immense distress and reminded survivors of abuse experiences from their past. The focus of therapy sessions thus had to be on helping survivors to cope with the emotional distress they experienced in their interactions with others. It was not unusual that survivors not only received psychotherapy, they might also require psychiatric treatment, crisis care, medical care, support from social services, or occupational assistance and support. I learnt in my work with survivors that the more they struggled with the legacies of sexual abuse, the more services were likely to be involved in their treatment, and the more opportunities arose for interactions that were perceived as unhelpful.

At times survivors experienced distress with me for not being supportive enough, making mistakes, or not being compassionate enough. At other times their distress was due to interactions with other providers such as public mental health services, social services, or the Accident Compensation Corporation (ACC). Sometimes survivors' distress was due to interactions with persons in their social environment, with family, or friends. Repeatedly survivors asked me "Do I have a sign on my forehead that says 'kick me', or why do I always meet people who treat me badly?"

There were moments when I felt survivors accurately identified acts of disrespect and I was dismayed at what appeared as the lack of compassion and understanding of some professionals in the mental health sector. At other times it seemed that survivors' perceptions were distorted by beliefs they had formed as the result of abusive experiences in their past. Frequently I wished that more of these relationship conflicts could be avoided and distress, the deterioration of survivors' functioning, their psychological de-compensation, para-suicidal behaviour, or suicide attempts could be prevented.

Many of my colleagues reported similar experiences and I wondered why unhelpful experiences with services are such a persistent theme in the recovery from sexual abuse. What are the needs of victims of sexual abuse and are services able to meet these needs? What are the assumptions and expectations of victims of sexual abuse and of service providers? Are victims' perceptions of disrespect based on actual occurrences or distorted interpretations? Are relationships indeed so pivotal for survivors' recovery, or is that just my personal experience? If they are, how can relationships between survivors and service providers be improved?

The above questions about the complexity of interactions, relationships, processes, and outcomes between survivors and service providers ultimately formed the motivation for undertaking this study.

Rationale for Undertaking the Study

This study aims to identify how services shape the recovery of victims of sexual abuse. Understanding how services impact on the mental health of survivors of sexual abuse through policies, processes, and attitudes is important for effective planning of services, service delivery, and for appropriate allocation of resources. Deeper understanding is justified because sexual abuse affects approximately one fourth of the general population and is therefore a problem of significant magnitude. Furthermore, sexual abuse is linked to exaggerated health costs and other costs such as unemployment benefit and family assistance that arise due to survivors' compromised overall functioning. Finally, there is a lack of research that explored the impact of services and health systems on the recovery of sexual abuse from a New Zealand perspective.

For that purpose ten survivors with a history of sexual abuse and eight service providers who work in the field of sexual abuse recovery have been interviewed. Their views are represented in the findings chapters and form the basis for the conclusion of this study.

Prevalence of Sexual Abuse

Knowledge about the extent of sexual abuse occurrences is important for the planning of services for the recovery of survivors of sexual abuse. That planning includes service provision, the training of health professionals, and the allocation of resources for preventative measures. Reviews of studies that investigate the prevalence of sexual abuse produced varying results. These variations are due to the use of different inclusion and exclusion criteria and to methodological shortcomings which makes it very difficult to come to a conclusive percentage. Another problem is that most studies rely on official statistics, which, as many scholars acknowledge, seriously underestimate the prevalence of sexual abuse because they do not include abuse that is not reported (Brodsky, Cloitre, & Dulit, 1995; M Cloitre, Tardiff, Marzuk, Leon, & Portera, 1996; Horen, Leichner, & Lawson, 1995; Lipschitz et al., 1996; Moncrieff, Drummond, Candy, Checinski, & Farmer, 1996; Russel, 1984). In spite of these shortcomings, widely accepted estimates suggest that 12-34% of women and 8-16% of men have

experienced sexual abuse in their lives (Finkelhor, Hotaling, Lewis, & Smith, 1990; Gorey & Leslie, 1997). “Enough credible figures cluster around or exceed 20% to suggest that the number of female victims has been at least this high” (Finkelhor, 1994, p. 37).

The Ministry of Health’s (MOH, 1998c, pp. 161-162) statistics for sexual abuse in New Zealand mirror overseas findings. A study of teenagers found that 17% of females and 6% of males experienced sexual abuse by the age of 16 (Fergusson, Horwood, & Lynskey, 1996). In contrast, an Otago study of women between the ages 18-65 reported that as many as 32% have experienced sexual abuse before the age of 16 (Romans, Martin, & Mullen, 1996). Jülich (2001) indicates in her study about restorative justice and sexual abuse in New Zealand that approximately 600,000 females and males have experienced some form of sexual abuse. The fact that there are so many persons affected by sexual abuse highlights the importance to understand their recovery needs so that services can be provided that effectively assist in survivors’ recovery.

Costs Associated with Sexual Abuse

Linking the high number of individuals who have, according to the prevalence studies, experienced sexual abuse to studies that explored the costs associated with sexual abuse underlines the considerable impact sexual abuse has on New Zealand’s expenditures for health and mental health services, social services, and correctional services.

Overseas studies (Arnow, 2004; Glaister & Abel, 2001; Walker et al., 1999) concluded that adult survivors with a history of sexual abuse have significantly higher health care costs than persons without sexual abuse in their history. Determinants for the high costs of sexual abuse include medical and psychological treatment and the indirect costs that accumulate due to victims’ compromised functioning in society; For example for child welfare, correctional services, and benefits such as invalids benefit, domestic purpose benefit, or unemployment benefit (Donato & Shanahan, 2001; Jülich, 2001; Loewenstein, 1994). Jülich’s study (2001, p. 321-323) stated that costs associated with sexual abuse in New Zealand amount to \$2,465 billion each year which have to be carried by the government and by affected individuals. Considering the financial burden of the direct and indirect costs of sexual abuse it would be economically and financially important to understand how services shape the recovery of victims of sexual abuse. Appropriate, effective, and timely interventions that lead to recovery could ease the financial burden to the government and to the affected individual.

The Research Gap

Since sexual abuse has come to the attention of health professionals in the 1970s there has been ample research and literature about the treatment of survivors of sexual abuse. Some examples of this vast literature are the publications of Briere (2002), Herman (1992), Courtois (1999), Frawley and Davies (1994), and Cloitre and colleagues (2006). They offer principles and guidelines for abuse-focused treatment of sexual abuse that consider survivors' special needs for safety and reparative relationships and are widely used by counsellors and psychotherapists.

The only studies that explored or explained the impact of services and health systems on the recovery from sexual abuse looked at the impact of negative or positive support from health care services and social services (formal support) and from family and friends (informal support). Being listened to, been given information, being able to talk about the abuse, being believed, and being validated has been mentioned as positive support in a number of studies (Campbell, 2005; Draucker, 1999; S.E. Ullman, 1996; S.E. Ullman & Siegel, 1995). Hyman, Gold and Cott's study (2003) identified that being understood and being valued as an individual was seen as supportive and helpful by survivors, whereas van Loon, Koch and Kralik's (2004) study participants highlighted that being in control of the treatment and being told what to expect from treatment has been perceived as supportive and helpful. Examples given for negative support were 'being stopped from telling the story, victim blaming, being treated harshly' (Hyman, Gold, & Cott, 2003) and 'being ridiculed and exposed, (van Loon, Koch, & Kralik, 2004). While these studies identified survivors' views of helpful or unhelpful support and linked that to the improvement or deterioration of survivors' (mental) health problems, they fell short by not investigating what specifically the function of positive or negative support is that makes it so significant in the recovery process.

This study aims to fill this gap by investigating the impact experiences with all involved service providers have on survivors' recovery from sexual abuse and by exploring what the significant function of helpful or unhelpful interaction is. There is also a lack of studies that take into account the unique position of service provision for survivors of sexual abuse in New Zealand that is addressed in this study. Referred to here is governmental funding for the treatment of the legacies from sexual abuse through the Accident Compensation Corporation (ACC) which in turn contracts privately practicing counsellors and psychotherapists to provide the treatment.

The Use of Terms

In this study I have used the term ‘survivor’ when I refer in general to discussions of literature and knowledge that has been accumulated in the field of sexual abuse. It encompasses all victims of sexual abuse and indicates that they have survived the assault and coped with its legacies to the best of their abilities.

I have used the term ‘participants’ to identify survivors of sexual abuse who have participated in this study. References made to ‘participants’ only describe the experiences of survivors of sexual abuse who participated in this study. They are not representative of all survivors of sexual abuse.

Similarly, I used the term ‘service providers’ in the general discussion of all professionals that are involved in the recovery of survivors of sexual abuse. In contrast, the term ‘participating service providers’ is used to identify the views and experiences of those service providers who participated in this study.

Recognition

The word recognition has two different meanings in the English language. One refers to experiences of identification, re-identification, or acknowledgement. This is not how recognition is used in this study. Instead, recognition is used here in the second meaning of ascribing a positive status to a person or a group of persons. Examples are a country’s recognition of another country, recognition given for achievements, such as Nobel Prize, awards, medals, titles, and distinctions, recognition of equal rights, such as women’s rights, human rights, gay rights, and the right to vote, and recognition of subjects needs, such as children’s rights and social rights. Thus, the term recognition is used in this study as an act of affirmation that acknowledges a person’s or groups’ vital need for care, equality, and appreciation which activates the person’s ability to develop a positive sense of self (Honneth, 1995b).

Disrespect

Honneth (1995b) speaks of disrespect¹ when a person’s normative expectations of recognition have been violated and due recognition has not been given. Disrespect covers not only discourteous behaviour but encompasses experiences such as physical

¹ The German word ‘Missachtung’ is poorly translated as disrespect. Disrespect is commonly interpreted with ‘no respect’ or ‘discourteous behaviour’. The German meaning of ‘Missachtung’, however, is a rather strong word and much more attacking of a person’s being. The verb ‘missachten’ means to despise, having disdain or complete disregard for the other.

and sexual abuse, neglect, rape, torture, exclusion, denial of rights, discrimination, disenfranchisement, humiliation, degradation, insults, and denigration (Honneth, 1995b). Because the word disrespect is often used in everyday circumstances in the context of lack of respect, Honneth's meaning can easily be misunderstood. For Honneth, disrespect represents the withholding of moral rights human beings have inherently by being part of humanity. These rights are for example: The right for care, food, shelter, freedom, equality, and appreciation. Disrespect means stripping a person of these basic human rights.

Structure of Study

CHAPTER TWO introduces recognition theory developed by Honneth (1995b) as the philosophical underpinning this study is based on. It provides an in-depth presentation of recognition theory and traces the influences Hegel, Mead, and Habermas had on the development of recognition theory. The chapter concludes with a rationale for using recognition theory as a framework for this study.

CHAPTER THREE explores the definition of sexual abuse and outlines the history of sexual abuse. Controversial issues of social denial and the backlash are discussed and the legacies of sexual abuse are presented. The chapter also includes a discussion of the prevalence of sexual abuse and its implications for practice.

CHAPTER FOUR provides background information for the recovery from sexual abuse by describing recovery models, key issues of formal and informal social support, main services involved in the recovery from sexual abuse, and barriers to inter-professional co-operation.

CHAPTER FIVE explains the methods applied to collect and analyse the data, introduces the researcher in her historical and cultural context, and shows in detail how the research question evolved, how the selection of the participants for this study took place, how the collection and analysis of the data proceeded, and how ethical considerations have been adhered to.

CHAPTERS SIX to ELEVEN are dedicated to the presentation of the findings starting with participants' view of recovery (Chapter Six) followed by participants' experiences of perceived misrecognition by public mental health services (Chapter Seven), experiences of perceived inequality in interactions with ACC (Chapter Eight), and experiences of perceived lack of understanding by service providers (Chapter Nine). This is followed by exploring experiences that facilitated recovery along with discussing the necessity of resisting disrespect (Chapter Ten), and finally with a presentation of service providers' view of how services shape recovery (Chapter Eleven).

CHAPTER TWELVE offers an in-depth discussion of the findings, positions them in the context of existing knowledge about recovery from sexual abuse, and presents a model of recovery based on the findings of this study. This is followed by reflecting on the problems encountered and on the suitability of the methodology used. The chapter ends by outlining the implications of this study for theory and practice and by indicating the need for further research.

The following chapter is dedicated to the discussion of the philosophical underpinnings this study is based on.

CHAPTER TWO

FINDING A PHILOSOPHICAL HOME

Understanding and representing the experiences of study participants involved finding a theoretical home that offered concepts and a language that assisted in making meaning of the social reality of recovery from sexual abuse, identifying dynamics that impacted on participants' recovery, and presenting the findings to interested parties. This chapter describes the process of finding recognition theory developed by Axel Honneth (1995b) and why it was chosen to underpin this study; it explores Honneth's theoretical position within critical theory and traces the influences of the giant's shoulders he stood on for the development of recognition theory, for example Hegel, Mead, and Habermas. Table 1 provides an overview of the organisation of this chapter and its themes.

The discussion of the philosophical underpinnings of this study is, in contrast to common practice, taking place in Chapter Two because recognition theory is not only the frame of reference for the design and the analysis of this study, but has also had an integral part in the review of the literature. To introduce the main concepts of recognition theory ahead of the literature review was therefore considered important for following the argumentation made.

Table 1 Chapter Content: Finding a Philosophical Home

Finding a Philosophical Home
Not Speaking About But Giving Voice to...
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Not Speaking About But Giving Voice to...

Once I had made the decision to undertake this PhD study, I had three distinct needs that influenced my choice of philosophical theory. Firstly, the theory had to have a critical focus on social interactions to reveal dynamics of injustice and domination survivors had relayed to me over the years. As I investigated a number of critical theorists I found Honneth and recognition theory. After a rudimentary glimpse at recognition theory I had an immediate sense of excitement and knew I had found what I was looking for. The three categories of love, rights, and solidarity and the corresponding interactions within primary relationships, legal institutions, and one's wider community seemed to address the significant areas that I believed influence the recovery from sexual abuse. I understood that recognition theory is closely positioned to the persons it investigates by making "...the experience of social suffering ... not just the object of theory, but more fundamentally its epistemic guideline" (Deranty, 2004, p. 304). I envisaged that by using recognition theory I would be able to give voice to survivors' experiences rather than speaking about them. "...The imbalance between the extent to which professional groups and consumer groups are given a voice in research journals and in decision making processes about mental health services" (Lothian & Read, 2002) made giving voice to survivors' experiences very important to me.

Secondly, because I had seen many studies that remained on the descriptive level, I looked for a theory that had the depth to go beyond the description of helpful or unhelpful, good or bad, and trace the origins of survivors' delight in helpful or their distress in unhelpful interactions. Recognition theory meets this need through its emphasis on developmental processes that are involved in the forming of identity. Honneth (1995b) links social suffering to the frustration of moral expectations for due recognition, which he believes harm a person's identity and prevent autonomy and self-realisation. Thus using recognition theory for this study promised to provide the conceptual tools to explore survivors' struggle within the notion of identity formation.

The third need I had was to use a theory that is survivor-friendly and uses language and concepts that are rooted in the practical experience of study participants and can easily be used by them for evaluation of this study and of their experiences. My hope was to present a study that is not only useful for service providers and/or academics, but also informative, educative, or maybe even enlightening for survivors. The emancipatory focus of critical theory already reassured me that this need could be met. Recognition theory emphasised this by the use of concepts such as love, rights, and

solidarity that provide easy accessible meaning for readers in general and survivors in particular.

Standing on the Shoulders of Giants

Recognition theory is Axel Honneth's (1995b) contribution to critical theory that describes social processes through which individuals derive a sense of self and identity. He asserts that positive relationships with one-self (self-relations) depend on successful intersubjective processes with others who give recognition and approval to a person's being, abilities, and accomplishments.

Honneth (1995b) claims that recognition needs arise in three different social contexts each requiring a distinct form in which recognition is given. Recognition through love is given in the context of emotional bonds of intimate (primary) relationships. It is given specifically in the mode of emotional support which leads to the development of self-confidence. Recognition given through the granting of rights is given in the context of legal systems in the mode of cognitive respect which leads to the development of self-respect. The third form of recognition is solidarity given in the context of a community of shared value orientation in the mode of social esteem which leads to the development of self-esteem (Honneth, 1995b). These three forms of recognition are discussed in detail in the section 'core concepts of recognition theory' further on in this chapter, pages 20-32, after the exploration of the theoretical foundations of recognition theory.

Honneth (1995b) and Taylor (1992) share the belief that recognition is a basic and vital human need. It is this very claim that captured my attention when I searched for an underpinning philosophical framework for this study. It held the promise that I would have the opportunity to make visible survivors' experiences of being granted or denied recognition in their interactions with service providers and how their basic human needs are affected. Honneth, who is at present the director of the Institut für Socialforschung (Institute for Social Research), Frankfurt, Germany, also known as the 'Frankfurt School', has developed recognition theory from his deep understanding of critical theory. The following shows how Honneth's recognition theory is indebted to concepts from other critical theorists.

Recognition Theory: Grounded in Critical Theory

After the First World War several German philosophers established the Institute for Social Research in Frankfurt that came to be known as the 'Frankfurt School', the birthplace of critical theory. Established in 1924, the institute began as a place where the history of socialism and Marxism could be researched with the hope to "...one day to hand it over to a victorious German soviet state" (Wiggershaus, 1995, p. 9). The institute attracted philosophers such as Horkheimer, Pollock, Fromm, Adorno, Marcuse, and the Marxist Carl Gruenberg. They saw themselves as heirs of Marx and Hegel (Wiggershaus, 1995) and had in common the vision to create a critical theory that explained the social, political, and cultural problems of their time (Calhoun, 1995a; Wiggershaus, 1995). Their aim was to reformulate Marxist theory and make it relevant to society of their time which they saw as being affected by ever increasing capitalism (Agger, 1991).

Critical theorists of the early Frankfurt School understood the development of the human species to be hampered by disturbed relations of production that led to class struggle. In contrast, Habermas's emphasis is on processes of will-formation. He believes that the formation of beliefs and convictions that motivate persons towards taking actions, thus the formation of will, is distorted by social, cultural, or political conditions that perpetuate dominance and inequality (Honneth, 1997). "So a critical social theory correspondingly analyses the process of species will-formation in order to free it from the force of un-comprehended dependencies" (Honneth, 1997, p. 239), a dynamic also described as false consciousness.

Honneth (1995b) expands critical theory's traditional focus on relations of production and redistribution by widening the focus of critical investigation to include all forms of social suffering. This step flowed from his understanding that contemporary social struggles are the result of interactions of groups that find themselves in social situations in which they feel disrespected because their moral expectations for recognition of their physical integrity, social integrity, or honour and dignity have been violated (Honneth, 1995b). Thus recognition theory is based on the description of social suffering which is the result of his deep-seated commitment that "...theory should never be severed from the real social experience, from the depth and multidimensionality of social suffering as social" (Deranty, 2004).

When Honneth developed recognition theory he turned to Hegel's (1799) early writings that, influenced by the Aristotelian model of the polis-states of antiquity, had already described the struggle for recognition. Honneth took the basic principles of

Hegel's ideas and developed his theory of recognition. With recognition theory he claims he developed a normative theory that explains and interprets the moral development of society (1995b). With this aim Honneth followed Hegel, who was interested in exploring the moral development of entire societies and in identifying conditions that lead to the formation of ethical life (Honneth, 1995b). Hegel (1979) suggested that the ethical progression of societies takes place through struggles for recognition. He proposed that subjects who are denied mutual recognition are unable to achieve individualisation and ego-competence and recurring denial of their recognition needs leads subjects to engage in social struggle for recognition. The progress of ethical life, according to Hegel (1979), reveals itself in the three recognition levels of love, rights, and state, whereby each level shows increasingly demanding and complex patterns of recognition.

Honneth (1995b) follows Hegel and distinguishes Love, Rights, and Solidarity as the three forms of recognition necessary for the development of positive self-relations. He divides social life into three distinct areas and states that social integration is to take place "via emotional bonds, via the granting of rights, and via a shared orientation of values" (Honneth, 1995b, p. 94).

Creating Emancipatory Knowledge

Recognition theory is firmly grounded in the principles of critical theory of confronting social inequalities, domination, and injustice. Critical theory pursues this aim through "emancipation and enlightenment, at making agents aware of hidden coercion, thereby freeing them from coercion and putting them in a position to determine where their true interests lie" (Geuss, 1999, p. 55).

By incorporating the principles of self-reflection from Freudian analytic theory, critical theory provides a framework for examining the relationships between power and knowledge, how these relationships impact on the social world, and for re-interpreting the meaning of these relationships (Agger, 1991; Geuss, 1999). The focus on self-reflection is one of the concepts that distinguish critical theory from positivism. Critical theorists reject positivism because as a theory of science it does not require the investigation of its own interest in maintaining the status quo and it harbours the notion that knowledge can be discovered and simply reflects the object of investigation. Habermas's (1984) concern is that science, which is connected to positivist views of the world, is no longer understood as only one form of possible knowledge but has become

the most dominant form of ideology in late capitalism. He believes positivism promotes passivity and fatalism and reproduces existing relations of domination and social inequality by reducing the social world to patterns of cause and effect.

A criticalist is broadly defined by Kincheloe and McLaren (Kincheloe & McLaren, 1994) as a researcher who offers social and cultural criticism with the assumptions that "...all thought is fundamentally mediated by power relations that are socially and historically constituted and facts can never be isolated from the domain of values or removed from some form of ideological inscription" (p. 263). Facts and truth statements need to be evaluated within their discursive context and under consideration of existing power relations.

It is Habermas's (1984) position that knowledge about the world around us is constituted with a certain agenda or interest in mind or for a specific purpose that motivates the generation of knowledge. He distinguishes between three major knowledge-constitutive interests. They are the technical (empirical-analytical that answers cause and effect questions), practical (hermeneutic sciences that cover the intersubjective dimension of human interactions), and the emancipatory interest generated by critical sciences. It is knowledge generated from the position of emancipatory interest that aims to reveal social constraints that perpetuate dominance and inequality (Criab, 1984; Habermas, 1984; Held, 1980; Honneth, 1997). Honneth's (1995b) recognition theory is used in this study to explore if there are social constraints survivors of sexual abuse may be under. The experiences of participants in this study will be explored by reflecting on the circumstances under which their recognition needs are met or not met. By tracing the development or maintenance of survivors' self-confidence, self-respect, and self-esteem links will be made as to which of their recognition needs may have been affected. Conclusions will then be drawn about pathways that assist the recovery from sexual abuse.

Social Reproduction through Communicative Action

By developing recognition theory Honneth aimed to address critical theory's lack of "a model of social conflict grounded in a theory of communication" (Honneth, 1997, p. xvii). He built on the work of Foucault and Habermas who already had started to make the domain of social interactions a focus of critical theory. Habermas had already moved away from the original program of the Frankfurt School with its emphasis on class struggle and the sphere of production by introducing concepts of individual and

social psychology to explain the link between social and institutional power dynamics, ego development, and individual identity formation (Held, 1980; Honneth, 1997). Honneth sees the action-theoretic paradigms of Foucault's struggle and Habermas's concept of mutual understanding as "...attempts to interpret in a new way the process of a dialectic of enlightenment" (Honneth, 1995b, p. xi). The work of both these theorists has provided concepts of struggle and mutual understanding that enabled Honneth to clarify and advance his own theory of recognition (Honneth, 1997).

Struggle has become a core concept of recognition theory as it represents the pathway to mature relations of recognition and the development of identity. Honneth (1997) describes Foucault's concept of power as "...only a momentary systematic state that...remains exposed to a continually renewed process of testing through social conflict" (p. 160). However, Foucault's concept of power and struggle is very different from Honneth's assertion that identity development takes place through overcoming disrespect through the struggle for recognition.

Although Foucault (1980, p. 92) understands power as "...the process which through ceaseless struggles and confrontations, transforms, strengthens, or reverses [a multiplicity of force relations]", he only considers physical demonstrations of power. Honneth believes that Foucault's concept of power falls short of explaining all human suffering of injustice because he does not regard "...the psychic suffering of individuals as the social expression of the disciplining and repression which affects the human body" (Honneth, 1995a, p. 131).

Habermas, who is less focused on power relations and the function of conflict for his conceptions of social change (Calhoun, 1995a) has inspired Honneth with his emphasis on the importance of mutual understanding. Indeed, mutual recognition is the precondition for the development of positive self-relations. With his major work, the theory of communicative action, Habermas aimed to develop the normative foundations for a critical social theory based on the analysis of communicative processes itself. His major concern was that the "increasing tendency to define practical problems as technical issues threatens aspects of human life; for technocratic consciousness not only justifies a particular class interest in domination, but also affects the very structure of human interest" (Held, 1980, p. 253).

Identity, Attachment, and Recognition

Recognition Theory is based on the premise that the development of identity is dependent on interactions with others in the social spheres of primary relationships, legal relations, and community that influence the acquisition of self-confidence, self-respect, and self-esteem. Services that are involved in the recovery from sexual abuse occupy these three social spheres. This makes recognition theory well suited for examining how they shape recovery. While the actual provision of therapy may fall into the sphere of primary relationship and affect mainly the development of self-confidence, issues regarding access to services may fall under legal relations and affect mainly the development of self-respect. Issues that involve the social integration, appreciation, valuing, and achievement of survivors of sexual abuse may, on the other hand, affect mainly the development of self-esteem.

In developing recognition theory Honneth (1995b) also drew on Mead's (1934) theory of intersubjectivity and identity formation. According to Mead (1934) the self is formed in a socialising process that includes experiences and activities firstly with significant others, for example parents, and later on with more generalised others, for example members of the wider community such as friends, teachers, neighbours. Calhoun (1995a, p. 196) concludes that "In the modern era, identity is always constructed and situated in a heterogeneous field and amid a flow of contending cultural discourses". Thus the self continuously shapes and develops in response to experiences with others. It is this property of the self that gives hope that recovery from sexual abuse is possible. Self-structures that have been negatively affected by the disrespect of abuse can be influenced positively through experiences of emotional support, care, respect, and appreciation.

Mead (1934) proposed that identity is formed by the self that emerges as a reflective process in the context of social experiences. Through people's ability to reflect on their own actions and experiences the self becomes an object to itself, the 'me' (Blunden, 2006; Honneth, 1995b). It is this reflexivity of the self that distinguishes human beings from animals. Reflexivity also means that in the position of self-observation one is able to reproduce in oneself the meaning that one's actions may have on the partner in interaction. It is through this ability that people arrive at a consciousness of the social meaning of their behaviours (consciousness) resulting in the development of a consciousness of their self (self-consciousness) (Blunden, 2006; Honneth, 1995b).

Self-consciousness is seen as a product of a person's self-reflection and the internalisation of the actions and attitudes of others towards him or her-self. Through the process of internalisation these actions and attitudes are understood as expressions of one's self. Thereby subjects see themselves through the eyes of the 'other' (Honneth, 1995b). "...a subject can only acquire a consciousness of itself to the extent to which it learns to perceive its own action from the symbolically represented second-person perspective" (Honneth, 1995b, p. 75).

Honneth (1995b) follows Mead (1934) who understands identity formation as a process in which the 'me' has been conceived through the perspective of the other. This perspective gradually expands as the child's interactions involve an increasing number of others to take in. Mead uses the example of role-playing whereby the child imitates and integrates into its self-understanding patterns of conduct of significant others. With maturation the child moves on to engage in competitive game playing. Now the child needs to integrate and represent actions and expectations of an even larger number of others. Honneth (1995b) claims that this progression shows how social norms and actions are generalised on an increasingly widening scale. He concludes that a person's socialisation takes place along processes of internalisation of norms and actions of an increasingly widening group of people that ultimately comprises all members of society. Thus Mead's concept of one's dependence on the other for understanding one-self gives Honneth (1995b) the framework for claiming that through the experience of being granted recognition subjects may develop positive self-relations of self-confidence, self-respect, and self-esteem, the pre-conditions for self-realisation. He states that

...unless one presupposes a certain degree of self-confidence, legally guaranteed autonomy, and sureness as to the value of one's own abilities, it is impossible to imagine successful self-realisation, if that is to be understood as a process of realising, without coercion, one's self-chosen life-goals (Honneth, 1995b, p. 174).

Erikson (1977) is another theorist that claims that identity formation takes place through social processes in which the self is formed through interactions with the 'other'. He identifies eight developmental stages over a subject's life-time whereby each stage requires the subject to resolve increasingly complex psycho-social conflicts. For example in the first stage between 0 and 18 months the infant has to resolve the conflict of basic trust versus mistrust. Crain (1985) explains Erikson's trust as being similar to confidence in the sense that it represents "...a basic faith in one's providers" to be "...reliable and predictable" (p. 163). If the familial circumstances prevent the development of trust – or, using Honneth's theoretical concepts, if recognition through

love is not given – the infant develops mistrust and the development of self-confidence is hampered. Other psycho-social conflicts to be solved are autonomy versus shame between the ages 18 months and 3 years that leads to self-control, courage and will; between the ages 3 and 5 initiative versus guilt that leads to a sense of purpose; between the ages 6 and 12 industry versus inferiority that leads to a sense of method and competence; between the ages 12 and 18 identity versus role confusion that leads to devotion and fidelity; between the ages 18 and 35 intimacy and solidarity versus isolation that leads to affiliations and love; between the ages 35 and 55-65 generativity versus self absorption and stagnation that leads to production and care; and finally between the ages 55-65 until death integrity versus despair that leads to wisdom (Erikson, 1977). He believed that problems due to unsuccessful solving of a conflict are cumulative and hinder subjects to be successful with solving the conflict of following developmental stages.

Erikson's theory of psycho-social development highlights the importance of relationships for the development of the self throughout one's lifespan. To be in relationship with the environment and with people has been, throughout history, a precondition for human survival and human development. "In order to experience oneself as an autonomous 'I' we have to experience the 'Other'. Without the 'Other' there is no 'I'" (Rahm, Otte, Bosse, & Ruhe-Hollenbach, 1993, p. 80). Thus, a person's relation-to-self depends on one's ability to view oneself through the perspective of the 'other' in an interactive process. Ainsworth (1969) implies that humans may be genetically predisposed to form close attachments to their caregivers. This is further explained by Lewis and his colleagues (2001) as a function of the limbic brain. They stress that only mammals have a limbic brain, which they claim organises and regulates relational schemata of humans that provides the impetus to form strong attachments to others to insure the survival of the species. New understandings as a result of recent neuro-biological advances will be discussed in Chapter Three.

Readiness to form a connection or attachment bond is signalled through expressive gestures. Expressive gestures of recognition have long been identified as necessary for human infants' psycho-social development, for affect regulation, for the development of the brain, and for identity formation (Cozolino, 2002; Honneth, 2001; Schore, 2003a; Siegel, 1999; D. Stern, 1977). These authors are convinced that expressive acts of care, which Honneth conceptualises as giving recognition through love, are so significant in human interactions because they signal encouragement and

caretaking and convey in abbreviated form that the other has one's well-being in mind and will engage in caring practices.

Adults have developed a wide range of symbolic abbreviations in the form of verbal and nonverbal ways to alert other persons of the intention to be empathic and to treat them with respect and care or with hostility and disrespect. These symbolic abbreviations could be expressive acts or gestures of recognition such as empathic gestures, facial expressions, body posture, or a speech act (Honneth, 2001; Mead, 1934; Schore, 2003b; Siegel, 1999). Depending on the context in which the encounter takes place a person may, for example, smile at someone caringly, embrace someone lovingly, greet someone respectfully, or acknowledge someone friendly. Each expression signals a different level of readiness to connect with another person (Honneth, 2001).

If Mead and Erikson are right in their conception that identity formation continues over one's lifespan and is dependent on interactions with others, then service providers' interactions with survivors over the years could have a considerable impact on survivors' identity formation and thereby significantly shape recovery. It is conceivable that sexual abuse in childhood may leave a person with mistrust, shame, guilt, or a sense of inferiority which may lead to being unable to successfully navigate all following developmental conflicts and thus be significantly impaired in overall daily functioning all through adult life.

Core Concepts of Recognition Theory

The exploration of the concepts of critical theory in which Honneth's recognition theory is embedded in is followed by a discussion of the core concepts of recognition theory. The different forms of recognition are examined, Honneth's understanding of social suffering as an asymmetrical recognition relation is discussed, and the dialectic of struggle is explored. Table 2 gives an overview of the main concepts of Honneth's recognition theory with further discussion of each form of recognition throughout the study.

Table 2 Honneth's Recognition Theory

RECOGNITION THEORY			
Forms of recognition	Love	Rights	Solidarity
Context	Primary relationships	Legal relations	Community of value
Mode of recognition	Emotional support	Cognitive respect	Social esteem
Practical relations to self	Basic self-confidence	Self-respect	Self-esteem
Forms of disrespect	Abuse and rape	Denial of rights, exclusion	Denigration and insult
Threatened component of personality	Physical integrity	Social integrity	Honour and dignity

(Honneth, 1995, p. 129)

Recognition through Love

Honneth follows Hegel closely by conceiving the first form of recognition to be recognition given through love. Hegel drew his concept from the parent-child relationship as the first social relationship in which the mother's and the child's being and neediness are mutually recognised (Honneth, 1995b). Honneth extends the concept of love to all primary relationships in which strong emotional attachments are formed, such as the parent child relationship, intimate sexual relationships, and friendships. Moving away from perceptions of romantic love he uses love in the sense of

“affirmation of independence guided – indeed supported – by care” (Honneth, 1995b, p. 107). Although the therapeutic relationship is not specifically mentioned in Honneth’s text, it is asserted here that recognition through love can be applied to the therapeutic context because of the strong emotional attachments and dependencies that are formed between therapist and client (Briere, 2002; Herman, 1992).

When Hegel developed his concept of recognition through love he was unable to conceptualise the processes between mother and infant that led from symbiotic dependence to individualisation in which both come to acknowledge and love each other as separate beings (Audard & Grosz, 2000; Honneth, 1995b). The accumulated knowledge in developmental psychology in the two hundred years since Hegel has enabled Honneth to fill the conceptual gap in Hegel’s model. Honneth (1995b) turned to developmental theorists such as Winnicott and Stern for support for his assertion that recognition through love is the first form of recognition and forms the basis for all other recognition relationships.

For Honneth (1995b) the core of Winnicott and Stern’s theories is the primacy of the attachment bond between parent and child whereby the development of the self and a sense of identity is formed through the struggle of “symbiotic self-sacrifice and individual self-assertion” (p. 96) between child and parent. Infants are absolutely dependent on the parent for the satisfaction of their needs, for learning to be able to differentiate between self and environment, for their release of instinctual tensions, and for receiving tender comfort. Winnicott (1971) claims these needs are met by holding the infant with love. He perceives that holding goes beyond the physical holding and includes the creation of an intersubjective space in which actions and thoughts are governed by love and concern, for which he uses the concept of ‘good enough mothering’ (Winnicott, 1971).

Only by being held in this particular way can infants “...learn to coordinate their sensory and motor experiences around a single centre and thereby develop a body-scheme“ (Honneth, 1995b, p. 99). He incorporated Winnicott’s (1971) paradoxical conclusion that subjects (children) through the unsuccessful attempts to destroy the other (mother) are able to establish the other (mother) as real, different, and available for the satisfaction of one’s need for love. This allowed Honneth (1995b) to explain the process that leads from the parent-child’s symbiotic one-ness to the establishment of parent and child as individuated beings, which was missing in Hegel’s model.

Honneth (1995b) concluded that bonds based on affection rely on resolving the tension between symbiosis and self-assertion through the means of mutual recognition

(Honneth, 1995b). If the mother manages the child's unconscious attempt to destroy her without withdrawing her love, the child can develop a sense of confidence and basic trust of having his or her needs met. To have basic trust in the world as a just place in which his/her needs are going to be met, allows the child to mature psychologically. It leads to the child's ability to be separate, to be alone (Honneth, 1995b; Winnicott, 1971), and to develop a basic sense of self-confidence (table 2). Honneth (1995b) understands self-confidence as a subject's ability to express his or her needs, desires, and anxieties without having to fear rejection or abandonment.

Many scholars (Atlas & Wolfson, 1996; Briere, 1994; Brodsky, Cloitre, & Dulit, 1995; Gershuny & Thayer, 1999; Herman, 1992; Zanarini, Ruser, Frankenburg, Hennen, & Gunderson, 2000) have stressed that the lack of 'good enough mothering' demonstrates disturbances in the interpersonal relations between mother and child. When these disturbances coincide with abuse and neglect, disorders such as borderline personality disorder, narcissistic personality disorder, or post traumatic stress disorder (PTSD) may develop. Honneth (1995b) explains disturbances in interpersonal relationships as the breakdown of the "communicative arc suspended between the experience of being able to be alone and the experience of being merged" (p.105) whereby the child or the parent is no longer able to "...detach himself or herself either from the state of egocentric independence or from that of symbiotic dependence" (p. 106).

Honneth (1995b, p. 106) re-interprets psychiatric disturbances that might be due to abuse, neglect, or the breakdown of interpersonal experiences as "relational pathologies in terms of structural one-sidedness in the balance of recognition". This places the legacies of sexual abuse not within the framework of mental illness but within a communicative process of significant relationships gone wrong whereby a person's sense of identity and positive self-relations are attacked and/or negatively affected (Briere & Elliott, 1994; Honneth, 1995b; Kearney-Cooke & Ackard, 2000; Schore, 2003b).

Disrespect in the sphere of recognition through love is expressed, according to Honneth (1995b), in the form of maltreatment, rape, or torture. In rape or torture a person's physical integrity is threatened by being forcibly deprived of any opportunity "...to freely dispose² over his or her own body (and) causes a degree of humiliation that

² The translation of the German expression "gehindert frei über seinen Körper zu verfügen" is ambiguously translated with the expression 'deprived to freely dispose over his body' and invites mis-

impacts more destructively than other forms of disrespect on a person's practical relation-to-self" (p. 132) (table 2). He claims that being defenceless and at the mercy of others alters peoples' sense of reality and lastingly damages their confidence in their autonomy over their own bodies (Honneth, 1995b). It leads to social shame and the demise of trust in the reliability of the social world, and ultimately the loss of basic self-confidence (Honneth, 1995b). He speaks of disrespect when a person's normative expectations of recognition have been violated and due recognition has not been given. Disrespect covers not only discourteous behaviour but encompasses experiences such as physical and sexual abuse, neglect, rape, torture, exclusion, denial of rights, discrimination, disenfranchisement, humiliation, degradation, insults, and denigration (Honneth, 1995b).

The significance of recognition through love for the recovery from sexual abuse lies in its indication that deficits due to the withholding of recognition through love or acts of disrespect (abuse or neglect) earlier in life may be reversed through receiving recognition through love in the form of emotional support and care from service providers. Alternately, service providers that withhold emotional support might add to survivors' distress, the demise of their self-confidence, or the collapse of their identity.

Recognition through the Granting of Rights

Recognition through the granting of rights by legal systems is the second form of recognition (table 2, page 19). Honneth (1995b) describes legal recognition as the recognition of the universal rights of human subjects. He explains these universal rights as civil rights such as liberty, political rights such as participation in will-formation, or social rights that guarantee basic welfare and a fair distribution of social resources. These rights refer to those claims that persons can legitimately raise and defend because they participate with equal rights in the institutional order as full-fledged members of a community (Honneth, 1995b).

For the development of recognition through the granting of rights Honneth (1995b) interprets Hegel's model of society as a society in which persons are no longer defined by their inherited social status but are considered to be free and treated as equals, independent from gender, race, or class. Honneth (1995b, p. 13) sees Hegel's concept of ethical society as a community of free citizens in which public life offers

interpretation of the word dispose. The meaning of the German text is better translated as 'deprived from having full control over one's body'.

“...the opportunity for the fulfilment of every single individual’s freedom” whereby through “...a process of recurring negations...the ethical relations of society are to be successfully freed from their remaining one-sidedness and particularities” (p. 15). Honneth (1995b, p. 174) associates freedom with self-realisation which he defines as “realising without coercion one’s self chosen life goals”. He believes that self-realisation can only be achieved through experiences of recognition that facilitate the development of positive self-relations of self-confidence, self-respect, and self-esteem.

Honneth (1995b) stresses that it is not enough for legal systems to grant rights. Marginalized groups need to have the means and be given the opportunities to be able to attain existing rights (Honneth, 1995b). To give an example, in order to attain their right for treatment funding survivors with a history of sexual abuse need to be given the opportunity to access services that provide treatment. This might mean, for example, that information about availability of treatment funding is readily accessible to them and that services are available that provide such treatment.

Honneth (1995b) points out that to practice the rights granted by legal systems individuals require a minimum standard of living such as education and economic security. In the context of recovery from sexual abuse that might mean that in order to be able to access their right for treatment funding, survivors need to be informed that their psychiatric disturbances might be linked to their experience of sexual abuse. It might also mean that basic human needs such as food, housing, or safety need to be taken care of.

Just as recognition through love is necessary for persons to develop self-confidence, recognition through the granting of rights is necessary for persons to develop self-respect. Only when persons are able to “view oneself as a person who shares with all other members of one’s community the qualities that make participation in discursive will-formation possible” (Honneth, 1995b, p.120) are they able to develop a sense of self-respect, the ability to perceive oneself as a morally responsible individual whose actions are respected by others.

Having rights enables us to stand up like men, to look others in the eye, and to feel in some fundamental way the equal of anyone. To think of oneself as the holder of rights is not to be unduly but properly proud, to have minimal self-respect that is necessary to be worthy of the love and esteem of others. Indeed, respect for persons ... may simply be respect for their rights, so that there cannot be the one without the other. And what is called ‘human dignity’ may simply be the recognisable capacity to assert claims (Feinberg quoted in Honneth, 1995b, p.120).

Thus legal rights reassure subjects of their equality, autonomy, and generally of their entitlements to cognitive respect and concern. They can respect themselves because they are respected by others. By having rights such as the provision of free health care New Zealanders may expect to be able to enjoy these rights. When this is not possible, for example due to rationing of health care, conditions are created for the struggle for recognition to arise. When the discussion is concerned with who is worthy of society's resources and who is not, subjects may feel harmed in their positive self-relations and may suffer feelings of hurt, anger, shame, or indignation. An individual's self-respect is detrimentally affected by being excluded from certain social rights within society (Honneth, 1995b).

The harm lies not only in the denial of rights or social exclusion, but also in the implicit message that one is not equal to others and is not being granted equal moral rights (Honneth, 1995b). "Thus the kind of recognition that this type of disrespect deprives one of is the cognitive regard for the status of moral responsibility that had to be so painstakingly acquired in the interactive processes of socialization" (Honneth, 1995b, p. 134).

Recognition through Solidarity

Honneth (1995b) explains that recognition through solidarity is given in communities of individuals with shared values, shared concerns, and shared interests. These communities need to be open and fluid enough to reflect the concerns of its individual members, and in which members are able to earn esteem. He understands solidarity as "...a relationship in which subjects mutually sympathise with their various different ways of life because, among themselves, they esteem each other symmetrically" (Honneth, 1995b, p. 128).

Solidarity is related to one's relationship with the community and one's ability to attribute social value to one's own abilities, individual forms of life, and manners. For the acquisition of "...undistorted relations-to-self, human subjects always need – over and above the experience of affectionate care and legal recognition – a form of social esteem that allows them to relate positively to their concrete traits and abilities" (Honneth, 1995b, p. 121).

Whereas self-respect is based on legal rights that recognise individuals' equality and universality, for Honneth (1995b) social esteem is based on recognition of differences and particularities that distinguish individuals from each other. How much

social esteem is extended to a person or group depends on the value that is placed by society on their traits or achievements. These value horizons are shifting historically and reflect the self-understanding of certain groups and/or societies (Honneth, 1995b). How much value is attributed to a particular form of self-realisation "...depends on the dominant interpretations of societal goals in each historical case" (Honneth, 1995b, p. 126). The attribution of value is also influenced by the ability of social groups to draw the attention of the public to their accomplishments and to demonstrate that their activities are benefiting and/or are relevant to the greater good of society (Honneth, 1995b).

Unions are an example where a large group of people (employees) has come together in the spirit of solidarity to represent the interests of the group as a whole and its individual members. Women's Refuge is another example of a movement in which not only the interests of women who live in violent relationships are represented publicly and politically, but who also provide services such as safe housing, information, and practical support. Survivors of sexual abuse find support, information, or counselling from a wide range of local agencies and/or support services such as Rape Crisis centres, women's centres, or counselling centres for survivors of sexual abuse. These services provide not only services but also experiences of solidarity for survivors of sexual abuse. However, small local agencies often lack the ability to draw public attention to the issues concerning sexual abuse to the extent a national organisation could have³. Such a national body could contribute significantly to the public awareness of sexual abuse and its legacies and thereby create the possibility for a much greater experience of solidarity for survivors of sexual abuse.

Interpersonal experiences in which social esteem is denied are commonly subject to the struggle for recognition. This struggle takes place when groups or movements aim to increase the social value of their mode of self-realisation. Examples for such recognition struggles are nurses going on strike for better work conditions or higher pay, or women organising a 'rape-awareness-march' through the inner city of Auckland, New Zealand. Honneth (1995b) states that the outcome of these struggles is proportionally related to the power that groups have and the public attention they can raise.

When people are unable to acquire self-esteem through solidarity, when their traits and abilities are demoted as inferior, they will lose personal self-esteem. The lack

³ There have been discussions amongst sexual abuse support agencies in New Zealand to establish a national network of agencies working against sexual violence at the time of editing this study.

of social approval and group solidarity postulates the devaluation of one's patterns of self-realization. Individuals "...can not relate to their mode of life as something of positive significance within their community" (Honneth, 1995b, p. 134), which may result in them feeling denigrated and insulted.

Controversial Views

Critical theorists are currently divided in their views of the core-problems that critical theory should address. Some sides insist that class-based struggles, economic injustice and re-distributive issues need to take centre stage (Fraser, 2003). Others counter that reforming the representations and interactions of marginalised groups, for example groups based on sexual orientation, racial categories, national identity, ethnic identity, or religious movements, is at the heart of today's social struggles (Boucher, 2004; Honneth, 1995; Taylor, 1992). Honneth (2003) claims that his theory of recognition is suited to address both re-distributive and recognition issues, in fact, he asserts recognition theory can account for all forms of injustice.

...the conceptual framework of recognition is of central importance today not because it expresses the objectives of a new type of social movement, but because it has proven to be the appropriate tool for categorically unlocking social experiences of injustice as a whole" (Honneth, 2003, p. 133).

Honneth (2003) justifies his claim that all experiences of social injustice can be explained with recognition theory as asymmetrical recognition relations by referring to studies that investigated the motivational source behind labour movements, social resistance of colonized people, and the women's movement from which he concluded that "...subjects perceive institutional procedures as social injustice when they see aspects of their personality being disrespected which they believe have a right to recognition" (p. 132).

Emotions are given a key role in recognition theory. They inform subjects that injustice has occurred. He proposes that negative emotions such as shame, hurt, rage, or indignation experienced through exclusion, insults, or degradation "...could represent precisely the affective motivational basis in which the struggled-for recognition is anchored" (Honneth, 1995b, p. 135). He believes that emotions are the link between suffering and motivation for action. They allow individuals to realise that their legitimate claim for recognition has been denied.

The function of emotions as reliably informing subjects of injustice is heavily contested by other writers (Fraser, 2003; Jurist, 1994; Kompridis, 2004; Thompson,

2005). Fraser (2003) believes that emotional suffering is not a reliable indicator that injustice has occurred because subjects' internal assessment is open to misinterpretation or impaired subjectivity. She would rather see that the exploration of injustice concentrates on situations that manifest externally and that the impediments to subjects' full participation as equal citizen are publicly verifiable and accessible to democratic deliberation. Ikäheimo (2007, p. 13) agrees that feelings in themselves are not an authoritative indicator that social injustice has occurred and suggests

...to articulate the feelings so that their possible normative weight can be discussed and decided upon in collective discourses. This certainly requires that the subjects of these feelings or experiences are respected as (actual or potential) communication partners, but it does not mean that they alone can decide the truth of the matter.

It is conceivable that people feel hurt without injustice having occurred, for example when situations are mis-perceived. Others may be treated disrespectfully and not be aware of that fact and do not feel hurt. A whole range of ideological, psychological, cultural, and cognitive process could lead to a distorted sense of injustice or a distorted emotional reaction to certain incidences (Thompson, 2005). Jurist (1994) explains that trauma victims in particular may be so affected by the psychological impact of trauma that they are unable to interpret their emotional reaction accurately or evaluate their situation objectively. This indicates that survivors of sexual abuse may not be able to voice their concerns effectively and accurately.

Addressing health professionals assertively may only be possible when they have experienced enough recognition through emotional support and care to develop self-confidence. Health care practices in which survivors of sexual abuse are not treated with emotional support and care or respected as equal communication partners in the decision making processes may hinder the development of survivors' self-confidence and self-respect and prevent the expression of discontent with the treatment they receive.

Fraser (2003) and Kompridis (2004) voice the concerns of those critical theorists who believe that by basing social critique on ethical concepts of self-realisation the traditional focus of critical theory on economic redistribution is abandoned. They claim that recognition theory inhibits matters of misrecognition from being discussed as a violation of justice or the failure to meet the moral obligation for equality and equal participation in social life. Fraser (2003) fears that discussing matters of social injustice on the basis of impediments to individuals' self-realisation and harmed self-identity

fails to acknowledge that misrecognition is communicated through social institutions whereby "...institutions structure interactions according to cultural norms that impede parity of participation" (p.29). She stresses that the claim for recognition should not be the repair of psychological damage to one's self-identity but to overcome institutional patterns that create a category of social actors who are subordinate, deficient, or inferior. Fraser's point of view is opposed by Honneth's (2003) who claims that traditional theorists who measure the inclusiveness of society by applying the concepts of rationality do not consider that "...pathologies that do not pertain to the cognitive dimensions of human beings [do not]...come to light at all, thereby resulting in a one-dimensional philosophical anthropology and an inadequate basis for social critique" (Rundell, Petherbridge, Bryant, Hewitt, & Smith, 2004, p. 15).

A specific critique of recognition theory is that Honneth falls short of explaining by which criteria the legitimacy of recognition claims should be justified, or how legitimate claims using illegitimate means should be addressed (Deranty, 2004). Although Honneth (2003) acknowledges that contemporary demands for recognition are made not only by peaceful but also by militant and nationalist groups he does not indicate how to establish the legitimacy of such claims. His account of social suffering through the denial of recognition claims also falls short of explaining the dynamics by which the suffering of the individual ultimately could lead to the uprising of social groups as they struggle for recognition (Deranty, 2004).

The Dialectic of Struggle: Reconciliation and Conflict

Recognition theory regards human integrity to be closely linked with patterns of approval and recognition (Honneth, 1995b). Because of the dependence on others for the forming of a positive sense of identity, experiences of injustice and disrespect "carry with it the danger of an injury that can bring the identity of the person as a whole to the point of collapse" (Honneth, 1995b, p. 132). He states that if experiences of injustice are perceived as intolerable and the associated negative emotions are shared by many, social critique may lead to resistance and to collective political action.

...the collective resistance stemming from the socially critical interpretation of commonly shared feelings of being disrespected is not solely a practical instrument with which to assert a claim to the future expansion of patterns of recognitions. For the victims of disrespect ... engaging in political action also has the direct function of tearing them out of the crippling situation of passively

endured humiliation and helping them, in turn, on their way to a new, positive relation-to-self (Honneth, 1995b, p. 164)

He posits that subjects engage in various forms of struggle when their needs for recognition have not been met. Through resisting disrespect and raising claims for recognition subjects are able to dispel emotional tension and could arrive at a new self-understanding (Honneth, 1995b). He describes this process as the two alternating stages of conflict and reconciliation. Honneth (2003, p. 119) identifies peoples' struggles with disrespect not only as public protests or political revolts, but also ranging from "...confrontations with the authorities, to desperate efforts to maintain the integrity of both family and psyche, to the mobilisation of aid by relatives or friends". Struggles therefore represent the conflict side of the dialectic that aim at (re-)establishing relations of mutual recognition and thereby enable the individual to reconcile his or her sense of identity. In mutual recognition a person's original identity is expanded by the recognition of the 'other' and leads to the reconciliation between self and other (Sinnerbrink, 2004).

Honneth follows closely the path already outlined by Mead (1934) by asserting that threats to one's identity claims provide subjects with means and insights required for re-asserting their claims for recognition. Subjects learn about their own distinctive identity through "...each new provocation thrust upon them" (Honneth, 1995b, p. 23). Each new provocation gives subjects the opportunity to protect their integrity by identifying positively with all aspects of their being and finding ways to resist disrespect (Honneth, 1995b). He states that the development of more mature relations of recognition is only possible through resisting disrespect. This is based on the assumption that only "...when actions are problematical during their performance that humans make cognitive gains" (Honneth, 1995b, p. 72).

Not only individuals' development of identity but also the moral development of society is shaped by the expansion of reciprocal recognition through morally motivated struggles for recognition. Honneth (1995b, p. 15) elaborates on this by stating "...that the history of human spirit is to be understood as a conflictual process in which the moral potential inherent in natural life is gradually generalised".

Recognition theory emphasises people's struggle to remove themselves from circumstances in which they experience asymmetrical distribution of power to restore or develop a positive identity. This emphasis makes recognition theory a suitable framework for this study in that it provides a vehicle to explore survivors' struggles with asymmetrical power distribution between them and providers of public as well as

private mental health services. Recognition theory enables us to explore sexual abuse as an assault of a person's identity and it explains the potential benefits that can be gained from counselling or psychotherapy. Most of all, by understanding the significance of struggle within the importance of identity formation, recognition theory can assist exploring the tension of service provision that may be 'good' and 'bad'.

Conclusion

This chapter outlined recognition theory developed by Axel Honneth and discussed how his thinking has been guided, shaped, and influenced by the great fathers of critical theory and by other theorists who have left their footprints in the sands of history influencing how people today understand the world around them. Recognition theory follows the tradition of critical theory revealing and explaining injustice in society by identifying the social conditions that hinder or facilitate self-realisation, which, according to Honneth, is at the core of social conflict.

Recognition theory is seen to be useful for this study because it emphasises the impact of intersubjective processes on survivors' positive self-relations and identity. Because recognition theory addresses the spheres of primary relationships, legal relations, and social relationships it is able to explain the consequences survivors suffer as a result of disrespect in a range of different contexts.

The following chapter provides a review of the literature that addresses the relevant issues that arise in the context of recovery from sexual abuse. Explored are models of recovery, services involved, and the legacies of sexual abuse.

CHAPTER THREE

SEXUAL ABUSE: THE INVISIBLE PAIN

Compared to previous centuries that saw widespread abuse and victimisation of children and women (DeMause, 1998), the last thirty years have seen a big change in how sexual abuse is dealt with in the public sphere. Sexual abuse is now openly condemned, protective laws regulate how legal institutions deal with incidences of sexual abuse, literature, both fiction and non-fiction is easily accessible, services that assist in the recovery from sexual abuse are available, and many scholars have investigated the causes and the impact of sexual abuse and explored appropriate treatments for recovery from the legacies of sexual abuse. Whereas the 1980s saw a flood of information and disclosures of sexual abuse fuelling public and scholarly interest, since then the emphasis has been on disbelief, doubt, and denial, threatening to render sexual abuse invisible again.

The present understanding of the relevant issues for the recovery from sexual abuse will be discussed in this chapter to provide the context for this study. This includes an overview of the invisibility of sexual abuse over history, an exploration of the legacies of sexual abuse, and a discussion of controversial issues that contribute to the maintenance of the invisibility of sexual abuse.

Table 3 Chapter Content: The Invisibility of Sexual Abuse

Sexual Abuse: The Invisible Pain
Defining Sexual abuse
Sexual Abuse: A Her&History of Suffering
Controversial Issues Social Denial The Backlash
The Legacies of Sexual Abuse Harmed Self and Harmed Body Attachment Disturbances Lack of Social Skills

Defining Sexual abuse

The focus of this study is to identify how services shape recovery from sexual abuse. Although there is a wide range of definitions used for sexual abuse throughout the literature, the following definitions for sexual abuse are commonly applied in New Zealand and will assist in understanding recovery from it. The terminology used varied whether the victim was a child or an adult, whether the perpetrator was a family member or a stranger, whether or not penetration had taken place, whether violence or coercion was involved, and whether the experiences involved exposure to sexual material or rather physical contact. Depending on the different circumstances expressions such as rape, molestation, seduction, fondling, incest, sexual assault, sexual violence, and sexual exploitation have been used (Julich, 2001).

How specifically sexual abuse is defined depends to a large extent on the context in which the definition is applied. Rather than being able to agree on one definition that everyone can agree on, different agencies, individuals, or researchers use their own definitions that meet their explicit or implicit underlying interests or focus within sexual abuse. Studies that investigated experiences of sexual abuse and its legacies have usually set their own operational definitions that would serve the interest of their studies. Most studies set inclusion/exclusion criteria by upper age limit, nature of the abuse experience, the relationship to the perpetrator, the age difference between perpetrator and victim (Julich, 2001).

Child protection services may use a much broader definition of sexual abuse than, for example, used by research studies. The very general definition used by the New Zealand Department of Child, Youth and Family (CYF) on their web-page 'Reporting Child Abuse and Neglect' states "Sexual abuse is when children (sometimes even toddlers and babies) are used in a sexual way by someone older. This includes everything from obscene exposure, touching the genitals in a sexual way, to rape. It doesn't include normal sexual play between children of approximately the same age" (CYF, 2003a).

In contrast, definitions used by the legal system may be less wide ranging. The Crimes Act 1961, on which ACC's criteria for treatment funding are based, limits the legal definition of sexual abuse to contact abuse. It includes sexual violation, sexual coercion, incest, sexual intercourse, indecency, sexual assault, infecting with disease and female genital mutilation (ACC, 2002).

The American Psychological Association (APA) identifies as the central characteristic of sexual abuse the "...dominant position of an adult that allows him or

her to force or coerce a child into sexual activity” (APA, 2001). These activities may include contact abuse such as “fondling a child’s genitals, masturbation, oral-genital contact, digital penetration, and vaginal and anal intercourse” (APA, 2001). They also include non-contact abuse such as exposure, voyeurism, and child pornography and the abuse by a peer.

The broadest and most inclusive definition of childhood sexual abuse has been made by the Standing Committee on Sexually Abused Children (Malhotra & Biswas, 2005), stating “Any child below the age of consent may be deemed to have been sexually abused when a sexually matured person has engaged or permitted the engagement of that child in any activity of a sexual nature which is intended to lead to sexual gratification of the sexually mature person” (p. 17).

Julich (2001) mentions that the definition of sexual abuse also differs whether a study uses offender-centred criteria such as motivation for offending, the nature of the abusive action that should be included, and the severity of the abuse, or whether more victim-centred criteria are applied, for example betrayal of trust, misuse of power, and the inability of children to consent.

Discussing the wide range of definitions used in a variety of contexts gives already a pre-view of how difficult and complex exploring sexual abuse is when already at its onset the question ‘what is sexual abuse’ has such a multitude of answers. Recognition theory perceives maltreatment (abuse) that takes away a person’s control over his or her own body as a threat to their physical integrity. It constitutes the denial of recognition through love in the form of emotional support and harms the development of self-confidence and a positive identity (see table 2, page 19).

Sexual Abuse: A Her&HisStory of Suffering

The circumstances under which children grow up in present day New Zealand are probably better than ever before as there is a governmental Office of the Commissioner of Children. Clear policies about the welfare, health, and treatment of children (CYF, 2003b; MOH, 1998a) outline strategies for the prevention of child abuse and neglect, for interventions with problem behaviours, educational programs, health development programs, and programs for child health services (MOH, 1998c, p. 103).

Research of sexual abuse and child abuse has drawn a chilling picture of the acceptance of sexual abuse over history and the suffering it has caused males and females throughout the world (DeMause, 2002; A. Miller, 1983; Rush, 1980). Rather than occurring as isolated incidents, sexual abuse has been common practice over

history. DeMause (2002) suggests it is more accurate to speak of the universality of incest than of a universal incest taboo. DeMause (1998, p. 217) believes that "...child abuse has been humanity's most powerful and most successful ritual...it has been the cause of war and social violence...and the eradication of child abuse and neglect is the most important social task we face today".

He explains that abusive childrearing practices have been the norm over history where parents have used children as 'poison containers' into which they could pour their unacceptable or 'bad' feelings and rid themselves of depression, anger, or fear. From the tribal societies all through antiquity and the rise of Christianity to the Middle Ages children's role was to be sacrificed for the sins of their parents, to save the world from chaos, to appease the gods, and to give emphasis to their prayers for prosperity, good luck, and health. Children were killed, tortured, mutilated, and emotionally abandoned (DeMause, 1998), or sold as slaves, as servants, or lived as sacred prostitutes in temples (Rush, 1980).

DeMause (1998) explains that raping girls was advertised as rejuvenating and a way to overcome the fear of death. Raping girls was not a crime against the child, but against the father's sovereignty over his child and it was custom for fathers to brutally punish and even kill the raped girl (DeMause, 1998; Rush, 1980). Pederasty, boy rape, and boys serving as temple prostitutes was widespread if not universal in all early civilisations in Europe, the Near and Far East, Asia, and America. In Ancient Greece and Ancient Rome men were expected to have sex with boys. A boy who could not find a pederast for himself fell in disgrace. Boys were given to guests for sexual use, and doctors prescribed sex with boys as therapy (DeMause, 1998; Rush, 1980). With the rise of Christianity children were sent to wet-nurses, 'professional feeders and professional killers', monasteries, foundling homes, sold as slaves, or sent into debt bondage where they led a life of hard labour and physical and sexual abuse (DeMause, 1998; Rush, 1980).

DeMause (2002) concludes that the lack of care and concern for their psychological and physical wellbeing resulted in children growing up to become adults who project their feelings of anger, hate, and fear 'into their children/poison containers' or they tried to dispel these bad feelings through acts of violence, crime, and even wars. Thus history teaches that unacknowledged sexual abuse may have a devastating impact on society. Learning from history would entail acknowledging sexual abuse and help survivors to deal with the legacies so that re-enactment through crime and violence will cease to occur.

Honneth (2007) views acts of crime and violence as a response to experiences of misrecognition. When there are no democratic structures that enable individuals or groups to draw attention to their experiences of victimisation or disrespect, they could turn to crime or violence. A strong correlation was found in the United States as well as other countries between income inequalities, low social status, and poor social relations with a higher rate of homicides, violence, mortality, increase of relative deprivation, poor quality of life, and poor health (Wilkinson, 2002).

During the centuries in which the social order was estate-based, individual rights were directly linked to social status that depended on birth, age, function, and gender. Honneth (2003, p. 138) assumes that there must have been already an implicit, basic practice of love and care in estate-based societies "...without which children's personalities cannot develop at all", even though recognition through love as a universal right had not yet been developed. He believes that the first child protection laws, the acknowledgement of childhood as worthy of parental protection, marked the beginning of a new form of social relations that was built on emotional support, love, and care. With the beginning of the 12th Century Church moralists, paediatricians, and educationalists started to warn against sexual and physical mistreatment of children. Protective laws, schooling, and child instruction manuals marked the beginning of a historical development that led to the emergence of humanistic, religious, and political revolutions that announced the early stages of our modern times (DeMause, 2002).

It took a long time for these early attempts to effectively curtail the sexual and physical abuse of children and women. Women and girls were still open prey for men of medieval families. Parents forced their daughters and sons to have sex with boarders, lent them to guests as part of one's hospitality, in return for expected favours, gifts, or money (DeMause, 2002). Pederasty was common in medieval times and seen as the main reason that the average man did not marry before his early 30s. Schools, monasteries, taverns, or shops, all were places where boys were in danger of being sexually abused by men. Favouring boys for sex was so widespread in medieval times that it was even suggested that public female brothels should be established in order to try to keep men away from boys (DeMause, 2002).

From about the beginning of the 16th Century through to the end of the 19th Century sexual abuse was not just widespread in lower class families but also very common amongst the aristocracy, descended into the secrecy of family. Although the courts began to deal more frequently with rape and incest cases, the majority of victims were not believed or cases were hushed up through bribery. Children contributed to the

household income by child prostitution, or were openly sold “by public advertisements in most European cities” (DeMause, 2002, p. 368). Rush (1980) estimates that in Victorian London one in sixteen females was a prostitute who started her career either after childhood rape at home or through being sold by her parents into prostitution. While child abuse has been condemned publicly, medical records from the 19th century speak of widespread venereal diseases on children’s genitals, anuses, and mouths that corresponded with their fathers’ ulcerations of the penis, and of the birth of a large number of babies as the result of incest (DeMause, 2002).

The beginning of the 16th Century marked the time when more families started to raise their children themselves rather than giving them to wet-nurses, monasteries, or selling them as slaves. The first mentioning of the concept of ‘Mother’s Love’ in the literature was found in the early 18th Century, the beginning of people developing empathy with others. The improved level of care led to decline in child mortality, emotional bonds with parents became more noticeable and marriages were freed from economic or social pressure making place for feelings of affection, care, and love between partners (DeMause, 2002). Children advanced in personal growth through more care from their parents. They also witnessed married love and companionship between their parents and use them as a model for their own life. “The recognition that individuals reciprocally bring to this kind of relationship is loving care for the other’s well-being in light of his or her individual needs” (Honneth, 2003, p. 139). DeMause (2002) is adamant that the central cause of violence is to be found in the abusive and love-less childrearing practices throughout history.

The ubiquity of child abuse and neglect in historical sources makes even the most horrific descriptions found in contemporary clinical and child advocacy reports seem limited in comparison. It is no wonder that historians have chosen to hide, deny, and whitewash the record here uncovered, in order to avoid confronting the parental abuse of children that has been the central cause of violence and misery throughout history (DeMause, 2002, p. 379).

DeMause (2002) believes that the provision of love and care has been central for society’s development towards empathic and caring relations amongst its members and the establishment of increasing individual rights over the centuries. Since the beginning of the 20th Century children grew up being loved and cared for. DeMause (2002) is convinced that parents who support their children in reaching their goals and their full potential and do not use their children as poison containers, contribute to a more humane society. He sees evidence for that in those young adults who protest in our cities against wars, discrimination, and oppression. Over time society’s ambivalence

towards sexual abuse has diminished and protective laws are in place in New Zealand that condemn the (sexual) abuse of children and adults. This is discussed more fully in the following section.

Controversial Issues

The world has seen devastating catastrophic events such as natural disasters, extreme poverty and famine, wars, political terror, slavery, and the abuse of individuals on a grand scale. Yet, in the aftermath of devastation, traumatized individuals have usually been able to recover and rebuild their lives and their countries. Experiences of trauma seem to be a normal part of life of individuals and communities who go through "...an ebb and flow of suffering and disintegration, alternating with social unity and hope" (deVries, 1996, p. 398). One characteristic of human societies is that people come together and seek closeness with others to help with the integration of traumatic experiences. "Emotional attachment is probably the primary protection against feelings of helplessness and meaninglessness; it is essential for biological survival in children, and without it, existential meaning is unthinkable in adults" (Kolk & McFarlane, 1996, p. 24).

The importance of social support in the recovery from sexual abuse has been documented over the years by many scholars (Briere, 2002; Draucker, 1999; Glaister & Abel, 2001; Herman, 1992; Kolk & McFarlane, 1996). They consider external validation and human support vital for the recovery from sexual abuse and for the prevention and/or treatment of post traumatic stress symptoms. However, social denial, the backlash, and medicalisation contribute to the invisibility of sexual abuse, creating a climate in which the provision of social support and the delivery of services for the recovery of victims of sexual abuse are negatively affected.

Social Denial

Throughout history sexual abuse, as shown in the previous section, has been a 'normal' experience of women and children, although perpetrators, institutions, and scholars have discounted and denied the extent to which sexual abuse occurred (DeMause, 2002). This changed with the rise of the feminist women's movement in the early 1970s that brought the extent of (sexual) violence against women and children to the public's awareness. Rush, who was one of the first women who openly spoke out in 1971 about sexual abuse called her book "The Best Kept Secret: The Sexual Abuse of Children"

(Rush, 1980). Indeed, secrecy and denial were the most occurring dynamics that accompanied sexual abuse.

Jülich's (2001) feminist analysis explains the invisibility of sexual abuse with society's patriarchal acceptance of men's dominance over women sustained by constructs of denial and justification by scholars, authorities, religious leaders, and psychiatrists. DeMause (1991) claims that this shroud of silence was maintained by studies that state that incest has been prohibited by all known cultures since the dawn of mankind and which conclude from this 'universal incest taboo' that, not only has incest rarely taken place, societies would not have survived if incest had occurred.

Survivors of sexual abuse contribute to the invisibility of sexual abuse through dynamics that are part of the legacies of sexual abuse. Herman (1992) observed that victims assign blame and responsibility for the abuse to themselves. They may feel they could have prevented or stopped the abuse, that they should be able to cope better, or that they should 'put the experience behind' them. This will prevent them from bringing attention to their struggle and impedes the public discussion of sexual abuse.

Survivors also contribute indirectly to the social denial of sexual abuse. Sidanius and Pratto (1999) suggest that survivors' self-debilitating behaviours such as silence, withdrawal, refusing to ask for help, excessive dependency on services, self-harm, and suicide attempts, give support to ideologies held by service providers that maintain discrimination and provides them with a rationale for group based stereotypes. In addition, low self-confidence, learnt helplessness, and feelings of shame and guilt prevent victims from expressing their needs and effectively seeking help (Kolk, 1996). These survivors may not get the caring attention other survivors may get and not feel comfortable to disclose their history of sexual abuse. Services may therefore not be informed of a history of sexual abuse and instead treat the presenting symptoms such as depression, leaving the person's history of sexual abuse invisible.

This tension between needing help and self-blame is mirrored by victims' immediate environment and by society who fluctuate between compassion, blame, feelings of revenge, and responsibility. Kolk and McFarlane (1996) explain that society at large becomes resentful of being reminded that safety and predictability is at best tenuous and Herman (1992, p. 2) reminds us that "The knowledge of horrible events periodically intrudes into public awareness but is rarely retained for long. Denial, repression, and dissociation operate on a social as well as an individual level". Society's reaction then seems to follow more conservative impulses in the attempt to maintain the

belief that "...the world is essentially just, that 'good' people are in charge of their lives, and that bad things only happen to 'bad' people" (Kolk & McFarlane, 1996, p. 28).

Similar to other countries, New Zealand's society reacts with ambivalence when dealing with victims of sexual abuse. Reports of child sexual abuse are usually met with compassion and public demand for safer environments for our children and harsher punishments for perpetrators. However, once children grow up and become adults, their plea for support and compensation is viewed rather suspiciously. Adult survivors of childhood sexual abuse may suffer significantly from the long-term effects of their abusive experiences and therefore rely on social resources. This reliance on help and support may put them at risk to be seen as threatening the social fabric simply by not being able to be self-reliant and instead being dependant on social assistance.

Recognition theory states that autonomy and independence is achieved through recognition in the form of love, rights, and solidarity. For victims of sexual abuse to become autonomous and independent they would need to receive emotional support and care, receive recognition that a criminal act has been perpetrated on them, and be socially esteemed for their struggle towards recovery from sexual abuse. Society's ambivalence in dealing with victims of sexual abuse does not meet these needs and may hinder recovery.

Kolk and McFarlane (1996, p. 33) warn that the "failure to deal with the plight of victims can be disastrous for a society. The costs of the re-enactment of trauma in society in the form of child abuse, continued violence, and lack of productivity, are staggering". By not fully comprehending the full scope of sexual abuse in society it will be impossible to clearly identify to what extent sexual abuse trauma may be causal to incidences of child abuse, violence, and poverty.

The Backlash

The question whether sexual abuse happens to the extent victims and many researchers claim generates considerable public interest both overseas and in New Zealand. Although most prevalence studies indicate that sexual abuse occurs in epidemic proportions (Bremner, Shobe, & Kihlstrom, 2000; Jamieson, Walker, Daicar, & Reid, 1998; Kaplan & Manicavasagar, 2001; Ross, 1995), scholars, professionals, and supporters of the false memory interest group have questioned these claims and dismissed them as bizarre, confabulated, products of people's fantasy, or as outlandish attempts to seek attention (Acocella, 1999; Hood, 2001; Jamieson, Walker, Daicar, & Reid, 1998). Jülich (2001) describes the reasons for the backlash with a string of

incidents that created panic and stretched people's willingness to believe. It started with allegations in the United States of satanic ritual abuse and widely publicised crèche cases that involved alleged multiple offenders and multiple victims.

In the wake of these lawsuits, interest groups of people, who claimed they had been falsely accused, started their campaign to undermine all allegations of incest and sexual abuse. The most widely known is the False Memory Syndrome Foundation. This foundation was predominantly focused on what is called recovered memory or delayed memory retrieval of sexual abuse. According to them therapists implant false memories of abuse into the mind of unsuspecting (female) clients. This claim has found a welcoming home in the minds of many professionals and lay people alike because it plays on people's fear to be taken advantage of (McFarlane & Kolk v.d., 1996).

Julich (2001) points out that claims of implanted false memories do not take into consideration that only a small percentage of survivors report delayed memory retrieval. Although most have never forgotten about the abuse and did not need the prompting of a therapist, they only understood in their adult years that they had been sexually abused. Julich (2001, p. 53) claims that prior to adulthood "The way in which children have understood their circumstances has been influenced by the interpretation of adults around them". Elliot and Briere's (1995) study that investigated post-traumatic stress related to delayed recall of sexual abuse in a general population study concluded that traumatic memories cannot be implanted in peoples mind, delayed memory retrieval is common whether people are in psychotherapy or not, and amnesia after experiences of trauma are not dependant on social class.

McFarlane and Kolk (1996) noticed that delayed memory retrieval was neither contested nor of any public interest as long as it was discussed in the context of combat neurosis of Vietnam veterans or amongst survivors of disasters. Only when children and women reported similar symptoms in the context of taking legal steps against fathers and/or men for incest and sexual abuse did the discussion about delayed memories become passionate and controversial. It appears that when accusations are made that strike at the social fabric of society and challenge the patriarchal order, both male and female bystanders join the battlefield and accusations of sexual abuse have sparked passionate responses from scientists, journalists, and politicians. McFarlane and Kolk (1996) noticed that these responses in support of victims or the accused often stand out for only paying selective and biased attention to the complex issues at hand.

The most publicised cases in New Zealand involved the Christchurch Civic Crèche that led to the conviction of Peter Ellis, a crèche worker, and the Centrepont

Community in Albany/Auckland that led to the conviction of several adults. Both cases generated much public interest and claims were made by the accused and their supporters that therapists had sparked these false allegations by suggesting that sexual abuse had taken place (Hood, 2001; Julich, 2001).

Hood (2001) supported Peter Ellis and claims that his conviction was unjust. She goes on to call prevalence studies unrealistic that indicate that about one in four females and one in ten males are sexually abused by the time they turn 18. She believes that the extent of sexual abuse is not known and questions whether experiences of sexual abuse are indeed causing lasting damage. She wonders whether sexual abuse is just one of the adverse experiences of childhood. Her book, which has received the Montana Medal for Non-Fiction in 2002 has caused strong reactions amongst those scholars and practitioners that work with victims of sexual abuse (E. Davies & Masson, 2003). Davies and Masson point out that the book is unbalanced and of poor scholarly standard lacking any scientific basis, that it is based on 25 year old studies that have since then long been proven wrong, and that it makes unsubstantiated claims.

McFarlane and Kolk (1996, p. 567) suggest that "...The method of polarised legal arguments does science and society a disservice, particularly in the field of trauma". They see problems arise when the argument is about right or wrong rather than focusing on how to help victims to recover from distressing states caused by distressing memories. Once victims ask of society to be bystander while they accuse their perpetrator and ask for compensation and recognition, difficult issues arise for legal systems. Courts follow the strict rule of requiring evidence against any accused person, which is deemed innocent unless proven guilty. To provide this evidence is in most cases very difficult because victims usually can not provide physical evidence and rely solely on their recall of the events of abuse (McFarlane and Kolk, 1996).

There is not only the difficulty of verifying one's recall of an event that in most circumstances has taken place in secrecy and privacy, there seem to be also sizable financial interests at the heart of denying the problem of sexual abuse. Individual perpetrators and powerful social institutions such as insurance companies, armed forces, and churches have a great interest in sweeping abuse occurrences under the carpet. For them enormous sums of money for compensation and damage claims are at stake (McFarlane and Kolk, 1996).

Unfortunately, the multifaceted interest in denying the reality of trauma is so powerful, the fear of being taken advantage of is so deep, and the human need to find specific individuals and organisations to blame for our ills is so pervasive,

that this debate is unlikely ever to be driven primarily by attention to the facts (McFarlane and Kolk, 1996, p. 39).

The Legacies of Sexual Abuse

Sexual abuse is a traumatic event that, due to its interpersonal nature, leaves behind a trail of a person's impaired sense of self and systems of attachment and meaning making (Briere, 2002; Herman, 1992). Herman (1992, p. 96) describes the dilemma of children trapped in abusive environments as "Unable to care for or protect herself, she must compensate for the failures of adult care and protection with the only means at her disposal, an immature system of psychological defences".

To what degree a person is affected by sexual abuse depends on the circumstances of the abuse and the person's resilience. Circumstances such as the age of the victim, the victim's relationship to the perpetrator, the frequency of the abuse, the severity of the abuse, and the available social support for the survivor of sexual abuse influence the affect sexual abuse has on a person (Briere & Elliott, 1994). In general, the younger the victims, the more frequent and severe the abuse, and the closer the relationship to the perpetrator, the more destructive is the impact of the abuse experience for the victim (Spaccarelli & Kim, 1995). Factors that have shown to increase victims' resilience are high sociability, active coping style and a belief in one's ability to control one's life. People with these qualities are seen to be able to use others for support, are actively applying coping strategies, and have an internal locus of control (Dufour, Nadeau, & Bertrand, 2000; Heller, Larrieu, D'Imperio, & Boris, 1999; Herman, Russell, & Trocki, 1986; McFarlane & Yehuda, 1996; Spaccarelli & Kim, 1995).

It is difficult to 'prescribe' specific interventions and pathways to recovery because the affect of sexual abuse on victims can vary significantly from person to person and treatment therefore cannot be generalised. It is conceivable that a person could be affected to a degree that s/he is unable to function at all without intensive and continuous support from health professionals, whereas others may only be mildly affected and need very little assistance, if any at all.

In order to provide services that lead to the recovery from sexual abuse, health professionals need to understand each survivor's experiences of abuse and the affect it had on his or her physical and mental health, self-development, cognitive functioning, and interpersonal functioning. How these areas could be affected by experiences of sexual abuse is explored in the remainder of this chapter.

Harmed Self and Harmed Body

The trauma of sexual abuse is especially harmful to a person's self-development because it signifies the severing of intersubjective connections with caring others. Honneth (1995b, p. 132) understands sexual abuse as the withholding of recognition through love that deprives a person of "...The successful integration of physical and emotional qualities [which are] subsequently broken up from the outside, thus lastingly destroying the most fundamental form of practical relations-to-self, namely, one's underlying trust in oneself". For the development of positive self-relations and a positive identity individuals need recognition through love in the form of emotional support and care (Honneth, 1995b). Without receiving such recognition individuals will not be able to develop self-confidence and autonomous functioning.

Recent research (Cozolino, 2002; Perry, Pollard, Blakely, Baker, & Vigilante, 1995; Schore, 2003b; Siegel, 1999) investigated the connection between abuse, neurobiological process, and the development of self and presented new information about the impact on mind and body. They concluded that from the moment of birth, the young infant depends on the mother for adjustments and the organisation of his or her physiology, for example body temperature, breathing pattern, digestive system, and emotional states. Through supportive interpersonal experiences with attuned caregivers neural processing networks develop that integrate affective states, sensations, behaviours, and consciousness into functional cortical circuits which give the growing child the ability to cope with increasing levels of stimulation and arousal. Cozolino (2002, p. 23) explains, "The human brain does grow in response to (moderate) challenge and new learning". The development of the brain takes place through positive and negative interactions within significant relationships whereby the quality of these interactions is represented in the structures of neural networks (Siegel, 1999).

These neural networks are involved in a person's construction of the self and form the matrix for the developing personality through the weaving of conscious and unconscious experiences of somatic, temporal, or interpersonal nature into a narrative of ourselves and our identity (Cozolino, 2002). Honneth's (1995b) claim, that recognition is a vital human need, finds confirmation in the new understanding of brain development that explains clearly the necessity of being given recognition through love for a person to be able to regulate affective states, behaviours, cognitive processes, and have a positive sense of self.

Just as positive interpersonal experiences are associated with building neural structures that assist with the regulation of affective states and the development of a

positive sense of self, the absence of these experiences is connected by Cozolino (2002) with lacking these structures. Growing up in an environment of abuse and/or neglect may cause the neural development of the child to be interrupted, arrested, or reversed, leading to the inability to regulate and control states of arousal and subsequently to a lack of self-confidence (Cozolino, 2002; Lewis, Amini, & Lannon, 2001). Indeed, research using brain-scans has revealed that children with a history of abuse or neglect had brains that were less developed and smaller in size than brains of children from supportive families (Schoore, 2003a).

It is believed that neural structures for the regulation of affective states are compromised by stress experienced through abuse or neglect impacting on a neuro-physiological level by an increase of the child's level of norepinephrine, dopamine, endogenous opioids, and glucocorticoids and a decrease in serotonin (Cozolino, 2000). As a consequence, adaptive mental processes may collapse that are needed for the maintenance of an integrated sense of self and overall mental well-being (Cozolino, 2002; Schoore, 2003a; Siegel, 1999). Such collapse could manifest itself in incoherent narratives of past and present experiences, disturbances of identity and self-relation, fear, over-compliance, non-compliance, aggressiveness, or elusiveness.

Survivors of sexual abuse may encounter a wide range of psychiatric disturbances that can be linked to compromised neural networks necessary for self-regulation and overall functioning (Cozolino, 2002; Perry, Pollard, Blakely, Baker, & Vigilante, 1995; Schoore, 2003b; Siegel, 1999). Besides causing problems with regulating internal states, these disturbances may be noticeable in the inability to establish and maintain social contact, in problems with memory and reality testing, and a negative sense of self (Cozolino, 2002; Lewis, Amini, & Lannon, 2001). Together, they may cause a complex trauma response that then is "...woven into the structure of personality, often making it difficult to identify and treat" (Cozolino, 2000, p. 263).

Van der Kolk (1994) has been one of the first psychiatrists that investigated the connection between neuro-physiological changes and trauma. He and others (Kolk, 1996; Perry, Pollard, Blakely, Baker, & Vigilante, 1995; Rothschild, 2000) stated that in cases of trauma and stress, such as sexual abuse, that span over an extended length of time, the heightened stress-states may lead to continuous and excessive stimulation of the amygdala. This over-stimulation is seen to interfere with the regulation of cognitive processes and may result in alexithymia or speechless terror, explained as a person's inability to express experiences in meaningful linguistic forms (Kolk, 1994).

Without access to linguistic representation victims may not be able to make meaning of their experiences through self-reflection and self-expression. As a result their experiences remain un-differentiated and un-verbalized. The de-somatisation of emotions, that usually takes place through symbolic representation, is thereby inhibited and traumatic memories remain unorganised and un-symbolised in the psyche (Kolk, 1994; Kolk et al., 1996). Instead, symptoms may be communicated through the body as somatic symptoms or re-enactments (Rothschild, 2000). Somatic symptoms have been identified to function as a substitute for communicating distress, for symbolising cruel relationships, for containing internal conflict, or for managing interpersonal issues (Aaron & Anderson, 1998).

The recovery process may be delayed or side-tracked when distress is communicated through somatisation. Depressive affect, states of heightened anxiety, mood-swings, and anger, so often encountered in persons with a history of sexual abuse (Briere & Elliott, 2003; Feiring, Taska & Chen, 2002; Drossmann, Lesserman, Nachman, Gluck, Toomey, & Mitchel, 1990), may have become part of survivors' personalities and any obvious links with experiences of sexual abuse may have become invisible (Cozolino, 2002). "Because victims cannot make clear-cut statements that convey the reality of what happened to them, traumatic memories start leading a life of their own in form of disturbing symptoms and the victims become patients" (Kolk & McFarlane, 1996, p. 27). The connection between trauma and symptom has been lost and victims and service providers may be unaware of such a link.

The insidious infiltration of sexual abuse trauma into a person's mental and emotional processes and shaping of identity over time explains how the legacies of sexual abuse in fact contribute to the invisibility of sexual abuse in society. Having lost the connection between trauma and symptom, victims of sexual abuse present to others their impaired ability to regulate states, to think, and their sense of flawed personality. Herman (1992) explains the impairment to the victim's self with a loss of power, control, and autonomy. She explains that victims' "...capacity for intimacy is compromised by intense and contradictory feelings of need and fear" (p. 56) as they struggle with feelings of shame, doubt, guilt, inferiority, and most of all the lack of trust in self and others.

Recovery from a neuro-physiological perspective has to lead to the building of new neural structures that enable positive affect regulation and biological homeostasis. This is made possible through the brain's plasticity over a person's lifespan and its ability to continuously grow and reorganise itself (Schore, 2003b). The pathway to

recovery is in experiencing environments that provide stimulation, complexity, new knowledge, and the learning of new skills through stage-appropriate, optimal challenges within significant or primary relationships based on support and care (Cozolino, 2002; Schore, 2003b). “Our history of being close with others, having affective attunements and resonating states of mind, allows us to connect with others and to have a sense of coherence within our own internal processes” (Siegel, p. 298). Recovery from sexual abuse is therefore possible when service providers are affectively attuned and able to connect with victims offering emotional support and care. They thereby facilitate the organisation and coherence of survivors’ internal processes that have been negatively affected through experiences of sexual abuse (Lewis, Amini, & Lannon, 2001).

This section has explored the impact of abuse on neuro-biological processes and the connection between receiving recognition through love and the development of neural structures necessary for overall functioning. The following explores in more detail how sexual abuse may interfere with attachment processes and impact on the ability to have meaningful and effective relationships.

Attachment Disturbances

The importance of emotional bonds and attachments for human functioning, prospering, and self-development has been discussed over the years in a large variety of contexts by a large variety of scholars (Ainsworth, 1969; Bowlby, 1988; Briere, 2002; Harlow, 1986; Herman, 1992; Honneth, 1995b; Mead, 1934; D. Stern, 1977; Winnicott, 1971). Lewis and his colleagues (2001) suggested that humans and all other mammals have inbuilt neuro-physiological structures in the limbic cortex through which they attach to the parent or caregiver. This attachment dynamic is to assure the physical and emotional survival of the individual and the species. Harlow (1986) was one of the first who showed in his seminal study with rhesus monkey babies that the need for attachment and contact for these little monkeys was stronger than the need for food. Altogether, these studies confirm Ainsworth’s (1969, p. 970) argument that “Attachments are durable, even under the impact of adverse conditions. This implies the formation of intra-organismic structures presumably neuro-physiological in nature”.

These intra-organismic structures that initiate attachment seeking behaviours are also of significance in understanding the legacies of sexual abuse and in formulating needed experiences to assist in the recovery from sexual abuse. Herman (1992, p. 51) is adamant that

The damage to relational life is not a secondary effect of trauma, as originally thought. Traumatic events have primary effects not only on the psychological structures of the self, but also on the systems of attachment and meaning that link individual and community.

In the case of interpersonal trauma that threatens victims' physical and/or mental survival, they are drawn to attach to the perpetrator in an unconscious attempt to elicit a caring response and to minimize the threat to their lives (Graham, Rawlings, & Rigsby, 1994; Ross, 2000). This attachment to the perpetrator becomes even more noticeable when the perpetrator is a family member or otherwise known to the victim. When abused by a person close to them, victims struggle to integrate the fundamental human task of attachment with the instinctive recoiling from pain through withdrawal or shutdown, which is a source of considerable emotional conflict in the recovery process (Anderson, Martin, Mullen, Romans, & Herbison, 1993; Freyd, 1998; Ross, 2000).

In order to become or stay attached to the perpetrator on whom the child's well-being depends, it assigns responsibility for the abuse to itself. Ross (2000) calls this psychological phenomenon 'the shift of locus of control'. For reasons that make perfect sense to it, the victimised child comes to believe that it deserved to be abused or even has caused the abuse (Briere, 2002; Freyd, 1998; Ross, 2000). This cognitive shift of assigning responsibility to itself not only protects the child's attachment to the perpetrator but also provides it with a sense of control over changing the situation. By being extra 'good' and anticipating the wishes and wants of the perpetrator, the child might now be able to elicit a caring response from the perpetrator (Ross, 2000). For some victims of sexual abuse 'being good' becomes a life position of being over accommodating and over compliant with the people around them.

The damage caused by this attachment dynamic to the victim's self-relations, in particular to their self-confidence and self-respect is so fundamental that it becomes one of the main foci of recovery. Ross (2000) and Briere (2002) both imply that the recovery process needs to address the attachment to the perpetrator issue by attending to the cognitive distortions that are inherent in victims' sense of responsibility for sexual abuse. This is often strongly defended against, because the self-preservative instinct to attach is reactivated by starting to view the perpetrator as bad and hurtful (Ross, 2000). This process that is usually accompanied by intense feelings of loss, isolation, abandonment, or even impending death is described by Ross (2000, p. 264) as "...the deepest conflict, the deepest source of pain, and the fundamental driver of the (clinical) symptoms".

The dynamics discussed here as the attachment to the perpetrator may also be instrumental in victims' contribution to the invisibility of sexual abuse. Once victims have assigned responsibility for the abuse to themselves they may either not feel the need to disclose incidences of sexual abuse or they feel unable to talk about the abuse or vital aspects of it due to feelings of shame, guilt, denial, or strong loyalties to the perpetrator (Anderson, Martin, Mullen, Romans, & Herbison, 1993).

Lack of Social Skills

Herman (1992, p. 51) stated that "Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community". The betrayal of the child's trust by a person close to it and the disrespect for the child's physical integrity and autonomy is believed to be the cause of a range of problems in the long-term social functioning of victims of sexual abuse (Briere, 1994; Herman, 1992; Julich, 2001; Kolk & McFarlane, 1996).

Because sexual abuse takes place in the context of (close) relationships in which the child is overpowered by age-inappropriate actions that symbolize a betrayal of the child's trust and a disrespect for the child's physical integrity and autonomy, victims are often left feeling unsafe in the company of people, which leads to being ambivalent, fearful, unresponsive, and uncomfortable. The wide range of physical, mental, and psychological problems prevent survivors of sexual abuse from having rich and meaningful social relationships. Their struggle with issues of control, self-esteem, trust, and intimacy keeps them from initiating relationships and makes it difficult for them to maintain any relationships they may have formed. As a result, survivors of sexual abuse often feel alienated from other people and from their community. Instead they often withdraw socially and live in isolation (Briere, 1994; Herman, 1992; Julich, 2001; Kolk & McFarlane, 1996). Honneth (1995b, p. 133) describes the impact of abuse with "...the loss of trust in oneself and the world, and this affects all practical dealings with other subjects, even at a physical level".

Survivors may have problems with sexual intimacy and may feel generally less satisfaction in their relationship. It is not unusual for people with a sexual abuse history to engage in abusive relationships and they are prone to being re-assaulted. Other survivors may go to the other extreme and engage in brief multiple sexual relationships and sexually acting out. Also, a history of sexual abuse seems to be directly related to teenage pregnancies indicating the difficulty victims have with maintaining their

boundaries and possibly confusing the concepts sex and love (Briere & Elliott, 1994; Herman, 1992; MacDonald, 2001; MOH, 1998b).

Survivors' difficulties with navigating relationships are also contributing to the invisibility of sexual abuse in society. Some survivors may struggle so much with trust issues that they are not able or willing to leave their isolation and engage with services. Others may not be able to engage effectively with service providers and struggle to convey their experiences and express their needs, which may render them to repeated re-traumatisation.

Prevalence of Sexual Abuse

If the world lasts into the 22nd century, future historians may well ask how it could be that human society at the end of the 20th century was so irresponsible that it could let several million children be kept in slavery to serve the sexual appetites of adults.
O'Grady in (Paterson, 2003, p. 19)

Prevalence studies have an important role in the understanding and treatment of psychological problems related to incidences of sexual abuse. Besides informing society of the size of the problem, it informs policy makers over the need for child protection policies and services, for policies regulating funding for treatment, and for the justification of specialist places for treatment. Like other studies, prevalence studies also raise the question of how representative they are and how accurate they reflect what is really going on.

Prevalence studies vary simply because most research projects use different definitions of sexual abuse (age of victims/perpetrators, contact/non contact abuse, force), different research methods (survey, questionnaire, interviews, review of literature, official statistics), different inclusion/exclusion criteria for participants/informants (general population, patient in hospitals/mental hospitals, prison inmates, occupants of shelters, prostitutes) and they control or do not control for under-reporting, over-reporting, non-reporting or false reporting (Brodsky, Cloitre, & Dulit, 1995; M Cloitre, Tardiff, Marzuk, Leon, & Portera, 1996; Fergusson, Horwood, & Lynskey, 1996; Moncrieff, Drummond, Candy, Checinski, & Farmer, 1996; Russel, 1984). Thus the following exploration of prevalence studies should be read with caution bearing in mind it does not claim to provide any conclusive information, but aims to show a useful continuum for conceptualising the extent of the problem caused by sexual abuse.

Overseas findings estimate the number of people who experienced sexual abuse lie between 12-34% for women and between 8-16% for men (Finkelhor, Hotaling, Lewis, & Smith, 1990; Gorey & Leslie, 1997). These estimates are fairly consistent world-wide and accepted internationally by researchers and health professionals. “Enough credible figures cluster around or exceed 20% to suggest that the number of female victims has been at least this high” (Finkelhor, 1994, p. 37).

The national statistics from the Ministry of Health (MOH, 1998b, pp. 161-162) for sexual abuse in New Zealand mirror overseas findings. A study of teenagers found that 17% of females and 6% of males experienced sexual abuse by the age of 16 (Fergusson, Horwood, & Lynskey, 1996). In contrast, an Otago study of women between the ages 18-65 reported that as much as 32% have experienced sexual abuse before the age of 16 (Romans, Martin, & Mullen, 1996). These statistics indicate that approximately 600,000 New Zealander, females and males, have experienced some form of sexual abuse (Julich, 2001).

DeMause (1991) insists that more realistic and correct estimates of sexual abuse for the United States are around 60% for girls and 45% for boys, similar to studies conducted in Canada, Europe, Middle East, India, Asia, and Africa. These higher percentages came about after he made adjustments for eliminating non-contact abuse (e.g. exhibitionism), the requirement of force or a five year age difference for sexual abuse of children over 12 years old, by including populations that usually have a high percentage of sexual abuse history such as prison inmates, prostitutes, psychotics, and occupants of shelters, by considering the fact that a large percentage of participants of each study refused to be interviewed who might have been the most abused, by accounting for unconscious memories of abuse, and by accounting for abuse prior to age five that people usually do not recall other than in ongoing therapy.

One important question that comes out of prevalence studies is how significant the studies are considering that Mullen and colleagues (1996) noted that only 7% of the abused women had reported the abuse to either the helping profession or the police (MOH, 1998b). This number is fairly consistent world-wide. Such a low rate of reporting to services raises rather more questions than prevalence studies answer.

How then can it be determined whether services are effectively providing treatment for the legacies of (childhood) sexual abuse when current research conducted in clinical settings represents at best 7% of persons who suffered from such a history? According to my understanding there is no evidence that research with treatment specific foci such as modality, theoretical background, or frequency that only considers

less than 10% of those persons that had been sexually abused can be representative for any conclusive statements about how they shape the recovery from sexual abuse.

If prevalence studies indicate that about 20% of women have experienced sexual abuse, is our understanding of the impact of sexual abuse correct if the understanding is only based on 7% of the indicated cases in the prevalence studies? Are the remaining 93% of survivors who do not seek treatment also struggling with daily functioning, health, or mental health issues or are they symptom free? How many survivors do experience health or mental health problems but do not attribute them to their history of sexual abuse? Do they seek help for their problems and if so, are these services helpful in alleviating their symptoms? Is there a need to rethink treatment protocols in mental health settings given the high percentage of sexual abuse in clinical populations?

Answers to the above questions might give relevant information about the factors that ameliorate or prevent the development or maintenance of health or mental health problems due to sexual abuse. Knowledge about how they coped with the experience of sexual abuse and what enabled them to avoid involving services could be very valuable to policy makers, service providers, and survivors alike. Thus research that would access those survivors of sexual abuse that have not used services would provide valuable information that might shed an unexpected light at how things are. This would be an important topic for further research outside of this study.

Conclusion

This chapter has provided the context for this study by exploring relevant issues of sexual abuse. As the history of sexual abuse was discussed it was noticed that, although sexual abuse of both females and males has been a serious social issue throughout history, the extent of the abuse has been invisible in the public sphere. This only started to change around the 12th Century when laws were passed to protect children from the unbridled assaults of adults. The increased love and care amongst families led to an improvement of children's circumstances and marked the beginning of the development of a new sphere of intersubjective relations that was based on emotional support and care.

The discussion of the controversial issues surrounding sexual abuse showed that society as well as survivors of sexual abuse contributed to the invisibility of sexual abuse by complex processes of denial and dissociation from traumatic events. The controversial points of view of the delayed memory debate have been discussed and it

was concluded that the adversarial handling of sexual abuse disclosures was detrimental to science and society and did not help finding solutions for survivors recovery needs.

The exploration of the legacies of sexual abuse focused on the harm that is caused to a person's self-development and the body. It emerged how intertwined both were mainly through the neuro-biological processes whose function is the regulation of affective states, assistance in meaning making, and memory processing. The neuro-biological processes that were compromised by the experiences of sexual abuse led to a disturbance in attachment behaviours and to a lack in social skills. As a result survivors of sexual abuse struggled with impaired sense of self, impaired ability to function in everyday life, lack of meaningful and intimate relationships, and with social isolation. It has been pointed out how these processes have also contributed to the invisibility of sexual abuse.

The chapter finished with a brief discussion of prevalence studies that outlined the extent to which sexual abuse is prevalent in the general population in New Zealand. When the prevalence results were contrasted with the low percentage of survivors that become know to services the question was posed whether our understanding of the impact of sexual abuse and of effective treatment is valid given that the relevant research is based only on those 7% of survivors of sexual abuse that approach services.

In the following chapter the services will be discussed that are used by survivors of sexual abuse during their recovery journey.

CHAPTER FOUR

RECOVERY AND SERVICES

This chapter is dedicated to the discussion of recovery and of the main services involved in survivors' recovery from sexual abuse. Table 4 provides an overview of this chapter. The notion of recovery will be explored through the lens of abuse-focused frameworks of Herman and Briere, through the lens of Recognition Theory, through the 'Recovery Model' as the basis of New Zealand's mental health strategy, and through investigating the relationship between recovery and social support.

The exploration of services will be limited to public mental health services, psychotherapists and counsellors in private practice, and ACC as the main service providers involved in the recovery from sexual abuse. The discussion of the services might evoke the impression as if they are homogenous, unified systems that can be summarised under the category of, for example, 'public mental health services'. However, Calhoun (1995b, pp. 220-221), states that using the abstractness of categories "encourages framing claims about them as though they offered a trump card over the other identities of individuals addressed by them". Translating his concern to the discussion about services may mean that, for example, using the broad category of public mental health services may not do justice to subcategories that are collapsed under this term. For example Community Alcohol and Drug Services, Crisis and Emergency Services, or individual mental health professionals that make up these services may not necessarily share the same qualities that are discussed in the sections about services.

It is therefore acknowledged here that using broad categories involves a certain amount of reductionism and objectification. This risk is taken to be able to explore the relationships and interaction between survivors and larger systems that provide services for the recovery from sexual abuse.

Table 4 Chapter Content: Recovery and Services

Recovery and Services
Recovery Abuse-Focused Models of Recovery The Recovery Model
Recovery and Social Support Forms of Social Support Impact of Social Support Services and Social support
Services Public Mental Health Services Psychotherapists and Counsellors The Accident Compensation Corporation (ACC)
Otherness: Barriers to Inter-Professional Co-operation The Drama Triangle

Recovery

The notion of recovery is interpreted very differently depending on who defines recovery and in what context the term recovery is used. In the context of this study models of recovery are explored that are relevant for survivors of sexual abuse.

Abuse-Focused Models of Recovery

The term abuse-focused therapy describes treatments that consider the multi-level impact of sexual abuse on a person’s emotional, mental, physical, psychological, and social functioning (Cohen & Mannarino, 2000). Scholars are beginning to see evidence that

The brain continually changes to reflect aspects of its environment. In other words, its neural architecture comes to reflect the environment that shapes it. An enriched environment is one that is characterised by a level of stimulation and complexity that enhances learning and growth; an impoverished environment presents little stimulation, novelty, or challenge (Cozolino, 2002, p. 22).

Abuse-focused treatment models are based on the premise that childhood trauma and neglect interrupts and/or inhibits the normal development of the child in the areas of brain-growth and development, psychosocial development, development of self-structures, and the acquisition of affect regulation skills. They take into consideration that treatment has a role in providing experiences that assist in developing such

structures (Cozolino, 2002). This may involve building interpersonal skills (i.e. assertiveness, trust, intimacy), emotion regulation skills (i.e. observing and describing emotions, tolerating strong emotions), the decontamination of cognitions (i.e. attribution of responsibility, people are unsafe), and one's self-concept (i.e. freeing self from blame or shame) (Briere, 2002; Herman, 1992; Ross, 2000).

Treatment goes beyond the reduction or control of intrusive or disabling symptoms and usually considers the development of skills and self-resources needed to live well in spite of the experiences of sexual abuse (Briere, 2002; Herman, 1992; Linehan, 1993). Models that can be termed abuse-focused address the developmental needs that enable the establishment of positive self-relations of self-confidence, self-respect, and self-esteem that Honneth (1995b) identified as vital for a person's self-realisation and autonomy.

Abuse-focused treatment models have been identified as most effective in the treatment of sexual abuse survivors and may incorporate trauma theory, cognitive, behavioural, and psychodynamic theories and represent a number of widely used therapeutic approaches (Briere, 2002; Courtois, 1999; Herman, 1992; Kluft, 1999; Putnam, 1989). They have in common that treatment balances interventions of exploration with interventions of consolidation and thereby "challenge and motivate psychological growth, desensitisation, and cognitive processing" without overwhelming "...internal protective systems and retraumatise [the client] and motivate unwanted avoidance responses" (Briere, 1992, p.10).

Treatment progresses in three main stages. The first phase of treatment is the establishment of self-resources such as affect regulation skills and the ability to maintain a coherent sense of self. Self-awareness and a positive self-relation are equally important self-resources. This phase is followed by trauma processing which consists of identifying the traumatic event and by exposing the survivor to abuse related material. Such material will be emotionally and cognitively processed firstly by being activated and secondly by experiencing disparity between the original experience in the past, for example not being believed, and the present experience of being believed in treatment. The third phase pays attention to developing the 'new story' or a coherent narrative of one's life that includes a new sense of identity and a new way of relating to self and others (Briere, 2002; Courtois, 1999; Herman, 1992; Kluft, 1999; Putnam, 1989).

Herman (1992) explains that the experience of sexual abuse accompanied by coercion, force, unpredictability, authoritarian control, and powerlessness erodes the survivor's trust in people. She believes that "The first principle of recovery is the

empowerment of the survivor ... No intervention that takes power away from the survivor can possibly foster her recovery no matter how much it appears to be in her immediate best interest” (p. 133).

Abuse-focused treatment models embedded in the traditions of psychotherapy attend predominantly to survivors internal processes as treatment proceeds. The main focus is to provide an environment of empathic understanding, care, insight, and cognitive de-contamination to promote the development of positive self-structures. Whilst empowerment and re-connection with one’s community is an important principle underlying abuse-focused treatment, therapists in private practice are limited in providing opportunities for social interaction outside of the therapy session.

The Recovery Model

The notion of recovery has been a major paradigm shift in mental health care. This shift was initiated in the United States in the 1980s by consumers’ writings (Deegan, 1988; Leete, 1989; Unzicker, 1989) about their experiences of recovery from mental illness. These writings were followed by long-term empirical studies reviewed by Harding (Harding, 1994) that showed that recovery from mental illnesses was possible even in cases that were traditionally thought of as being chronic. Over time a consumer driven model of recovery emerged in the United States that was based on consumers’ collaboration, equality, and participation in their treatment (Anthony, 2000).

Core to the recovery model is the generation and maintenance of hope in the possibility of a better, healthier, and meaningful life. Such hope is ideally shared amongst families, caregivers, and the mental health professionals involved in the treatment of consumers. Hope directs the focus to treatment outcomes and points towards the steps that need to be taken to achieve these outcomes. It provides the individual with the motivation to continue in the recovery process when difficult and painful times have to be mastered and it symbolises recognition of a person’s ability to overcome mental illness. Such recognition is instrumental in the development of self-agency and building of a person’s self-confidence (Honneth, 1995b). Without hope recovery is impossible. “Loss of hope kills recovery” (MHC, 1998, p. 15).

Other mainstays of the recovery model are the principles of empowerment that emphasise survivors’ ability to be responsible for their own recovery, and the principle of education that encourages the expansion of survivors’ knowledge base instrumental to maximise and self-direct their recovery. The aim is to involve survivors in their

treatment and in their lives, to achieve full participation in society and in the planning of mental health services (MHC, 1998). The Mental Health Commission's vision is to have services that are sensitive to the changing needs and preferences of people, are accessible, culturally safe and sensitive, are cost-effective, respect people's rights, create supportive social environments, and that work integratively on all levels to achieve maximum wellness and independence for survivors (MHC, 1998, p. 15).

The aims of the recovery model (MHC, 1998; MOH, 2005) correspond with the concepts of Honneth's (1995b) recognition theory in that a person's self-relations are positively influenced by being cared for and supported (recognition through love) which enables the development of self-confidence. By being treated as equals, capable of taking part in meaningful decision making, survivors are respected as a full-fledged citizen (recognition through rights) and thereby enabled to develop self-respect. By being able to contribute actively to the shaping of one's recovery path and of service delivery, survivors are given the opportunity to demonstrate that their contribution is of value to the community (recognition through solidarity) which enables the development of self-esteem (Honneth, 1995b). Thus by following the principles of the recovery model, survivors of sexual abuse are given the opportunity to develop positive self-relation of self-confidence, self-respect, and self-esteem and move towards autonomy and self-realisation.

Although the recovery model was adopted in 1998 by the New Zealand government (MHC, 1998) its implementation into mental health services has been slow and is far from being achieved (Goldsack, Reet, Lapsley, & Gingell, 2005). This is partly due to traditional thinking in the mental health sector that emphasises health practitioners' expertise and medical technology (assessments, tests, pharmaceutical intervention, psychological interventions, and case management) and de-emphasises the importance of the relationship between patient and mental health professionals and patients' knowledge and competence (Anthony, 2003; Barnett & Lapsley, 2006; Draucker, 1999).

A frequent concern of mental health professionals with a medical orientation is that implementing recovery principles such as empowerment, equality, and participation in services that deal with acute mental illness endangers patients' safety and compromises the effectiveness of services. These professionals sometimes perceive the recovery model as appropriate for rehabilitation services but not for acute services (Goldsack, Reet, Lapsley, & Gingell, 2005). However, Goldsack and colleagues studied home based treatment programs in New Zealand as part of recovery oriented acute

mental health service and found that "...recovery concepts can align well with acute service provision" (p. 32).

Patients' push towards recognition of their rights and their ability to have something to contribute towards the designing and delivery of services challenges the traditional identities of mental health practitioners. Principles of the recovery model are incompatible with traditional understandings of mental health services of the past century (Anthony, 2000). They require mental health professionals to give up long held identities of being the only experts in the recovery from psychiatric disturbances. The struggle to implement recovery principles in mental health services could be understood as a recognition struggle between mental health professionals and patients. The gain in positive self-relations of patients would require a giving up of status of professionals.

The recovery model is an overarching concept that could incorporate abuse-focused treatment, but has a much wider scope than just treatment. It includes mental health services, crisis services, support services (housing, work programmes, day centres), and primary mental health services (family doctors and general practitioners). Thus, in contrast to the 'power over model' of traditional psychiatry, the recovery model offers a philosophical framework based on equality and participation that guides a holistic approach to recovery from psychiatric disturbances.

Recovery and Social Support

Traumatic or catastrophic events are a common fact of life and, according to a large American study (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), experienced by over half of the general population (50% of all women, 60% of all men). Traumatic or catastrophic events are interpersonal trauma (abuse, violence or crime), accidents, natural catastrophes, or war trauma. Yet only 2.5% of men and 5% of women develop chronic psychological problems that require professional attention (Schore, 2003a). Similarly, not everyone who has experienced sexual abuse develops psychiatric disturbances. A literature review of studies of the long term sequelae of sexual abuse concluded that between 20 and 44% of victims of sexual abuse had recovered well from the trauma and functioned effectively in adulthood (Dufour, Nadeau, & Bertrand, 2000). Their findings, combined with the prevalence research that concluded that only 7% of survivors of sexual abuse come in contact with services (see page 51), indicate that resilience factors such as personal resilience and social support are vital factors for preventing psychiatric disturbances in the aftermath of sexual abuse.

Forms of Social Support

The finding that a large number of victims recover well from trauma has prompted intensive study of the factors that influence a person's resilience for psychiatric disturbances after experiences of sexual abuse. Studies identified that the level of stress and the severity of psychiatric symptoms found in survivors of sexual abuse depended on the child's age at the onset of the abuse, the severity and frequency of the abuse, the child's relationship to the perpetrator, and the presence or absence of supportive structures within the abused child's environment (Dufour, Nadeau, & Bertrand, 2000; Heller, Larrieu, D'Imperio, & Boris, 1999; McFarlane & Yehuda, 1996). The outcome of these studies led to the current understanding that the provision and/or restoration of social support is a main buffer against the destructive force of stress and trauma (Runtz & Schallow, 1997; Spaccarelli & Kim, 1995; Tremblay, Hebert, & Piche, 1999). Social support and closeness with others helps survivors with the integration of difficult experiences and are vital for survivors' recovery (Herman, 1992; Kolk & McFarlane, 1996). "Emotional attachment is probably the primary protection against feelings of helplessness and meaninglessness; it is essential for biological survival in children, and without it, existential meaning is unthinkable in adults" (Kolk & McFarlane, 1996, p. 24).

Hyman, Gold, and Cott (2003) define social support as "assistance provided to individuals who are coping with stressful events" (p. 295). Social support can occur in the forms of formal and informal social support. Starzynski, Ullman, Filipas, and Townsend (2005) see romantic partners, parents, other family members, and friends as informal support sources, and clergy, police, medical personnel, mental health professionals and rape crisis counsellors as formal support sources (p. 418). Hyman, Gold, and Cott (2003) have identified four different forms of social support. They are appraisal support, tangible support, self-esteem support, and belonging support.

Appraisal support is giving advice or guidance for coping with problems and can be given by formal or informal sources. Being able to access free budgeting advice services may be an example of appraisal support. Contact with service providers could generate appraisal support, especially services that offer training in living skills, distress tolerance skills, or interpersonal skills.

Tangible support relates to having access to material resources that assist in coping with stress. Tangible support is most likely given by formal support sources and may be therapy, education, justice, or other support (Starzynski, Ullman, Filipas, & Townsend, 2005). ACC funding for treatment and compensation are two specific ways in which New Zealand society offers tangible support.

Self-esteem support is the perception that one is valued by others. “It is the positive evaluation of the self in the social context, as well as social support, that corrects the negative effects of stressful events” (deVries, 1996, p 400). Hyman and his colleagues (2003) conducted a study with 172 women and concluded that self-esteem support and appraisal support are the forms of support most strongly related to the prevention of PTSD and to effective adjustment. The therapeutic relationship might take on an added importance when health care professionals are the primary source for self-esteem support due to the lack of social contact commonly observed in survivors of sexual abuse (see page 55). Interventions and interactions based on equality, empowerment, respect, empathy, and understanding may be experienced by victims as being emotionally supported, cared for, and valued, which Honneth (1995b) describes as the mode of recognition that facilitates the development of self-confidence and self-esteem.

Belonging support is the last category and relates to the feeling of being part of a group that has a shared interest (Hyman, Gold, & Cott, 2003). Being part of such a group (belonging support) and being valued (self-esteem support) provide the context in which individuals are able to thrive because social groups are the site in which a person’s self-understanding may thrive (Honneth, 1995b). Survivors have the opportunity to encounter solidarity within their community when they experience that their concerns are equally meaningful to others, that others share their interests, and that their values are values others live by as well. Honneth (1995b) states that “...one cannot conceive of oneself as a unique and irreplaceable person until one’s own manner of self-realisation is recognised by all interaction partners to be a positive contribution to the community” (p. 89-90). Survivors may experience a sense of belonging support within their social environment when friends disclose their own experiences of sexual abuse, in the therapeutic context, as they attend support groups for sexual abuse survivors, through reading the stories of other survivors in the media or in books, or through support groups on the internet.

Impact of Social Support

Several studies (Draucker, 1999; Glaister & Abel, 2001; Palmer, Brown, Rae-Grant, & Loughlin, 2001) explored what constituted helpful mental health care and what facilitated recovery from survivors' points of view. These studies identified that health professionals needed to listen and be empathic, be warm, trustworthy, non-judgemental, and understanding. Furthermore, professionals needed to share survivors' pain and provide the opportunity for connections with other survivors, acknowledged survivors' feelings, be accepting, respectful, and, overall have an empowering approach to treatment. These studies concluded that survivors are not so much concerned with 'what' health professionals did or what techniques and approaches they used, but how health professionals engaged with them. These findings are in stark contrast with the general direction of research that aims to identify the best therapy model or therapeutic technique. "While clinicians and researchers are busy trying to determine the most effective approaches and techniques, survivors are concerned with support, validation, kindness, and most of all, empowerment" (Draucker, 1999, p. 27). The attitudes health professionals displayed towards survivors have been the main factors in shaping recovery and in forming the basis for effective healthcare (Heginbotham & Elson, 1999). Wells (2004), a survivor of sexual abuse and a user of public mental health services in New Zealand appealed to services that they start listening to survivors' stories of pain and abuse instead of eagerly medicating pain away. Wells' request reflects the conclusions of the studies mentioned here into the effectiveness of social support for survivors of sexual abuse. Services that were perceived as helpful and assisted effectively in the shaping of recovery were those that integrated the principles of social support into service provision.

Whereas empirical studies have shown that the establishment of social support has been linked to improved perceived health and a decrease in PTSD symptoms, they also indicated that negative responses from formal or informal support sources, were linked to a decrease in perceived health and an increase in psychiatric disturbances (Andrews, Brewin, & Rose, 2003; Campbell, 2005; Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001; Starzynski, Ullman, Filipas, & Townsend, 2005). A main indicator for a person's ability to cope in adulthood with the legacies of sexual abuse is perceived social support. Runtz and Schallow (1997, p. 223) concluded that social support may be one of the factors that "...differentiate between those maltreated subjects who are relatively healthy and those who continue to show evidence of their struggle with the after-effects of child maltreatment". Those survivors who have had social support may

be those individuals that have shown to have no need for professional help and cope satisfactorily with the challenges of every day life.

Services and Social Support

Campbell (2005) was interested to find out whether survivors' perception of the way they have been treated by service providers corresponded with how service providers viewed these interactions. She interviewed 81 rape survivors and 66 service providers (26 nurses, 18 doctors, and 22 police officers) these survivors had contact with. Campbell found that survivors' perceptions of interactions matched service providers' recall of what happened.

Interestingly, Campbell (2005) found out that doctors and police officers were unaware of how distressing and re-traumatising their actions have been for survivors. This was in contrast to nurses, who have been aware of how their actions affected survivors. Campbell concluded that some service providers may be unaware of the detrimental impact of their actions and procedures, especially when these actions and procedures have been established as normative and necessary, for example when policies are followed that require restraining of agitated survivors. It is Campbell's (2005) recommendation that service providers who may not have in depth clinical experiences with survivors may need specific training to avoid additional stress or even retraumatisation of survivors of sexual abuse.

Another study by Liebkind and Eranen (2001) investigated the attitudes of 875 future human service professionals (lawyers, medical doctors, nurses, professionals in social sciences, police officers) towards trauma victims and concluded that severely traumatised victims with poor adaptation elicited more negative attitudes than low trauma/well-adapted victims. "The depressing conclusion is that the general attitudes of the future human service professionals in our study were most negative toward those in greatest need of help and support" (Liebkind & Eranen, 2001, p. 471).

Social support studies (Andrews, Brewin, & Rose, 2003; Campbell, 2005; Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001; Starzynski, Ullman, Filipas, & Townsend, 2005; S.E. Ullman & Filipas, 2005) indicate that the attitudes towards victims by informal sources such as friends and families and by formal sources such as providers of social/helping services may have a significant impact on recovery by either alleviating or aggravating psychiatric disturbances. Services may find that integrating the principles of recognition and social support such as empowerment, care,

understanding, and valuing into service provision survivors of sexual abuse will be able to develop self-confidence, self-respect, and self-esteem. This will impact positively on survivors' recovery and lead to their overall improvement, to autonomy, and to a positive sense of identity (Honneth, 1995b).

Services

Services involved in the recovery from sexual abuse are ACC and privately practicing counsellors and psychotherapists, and public mental health services. These three services are discussed in the remainder of this chapter.

Public Mental Health Services

The New Zealand government provides funding for mental health services through District Health Boards (DHBs). There are in total 21 DHBs whose function is to provide funding for provision of health and disability services. The mainstays of clinical services provision are community mental health centres staffed by a multidisciplinary team of mental health nurses, psychiatrists, psychologists, social workers, occupational therapists, and support workers. Survivors with psychiatric disturbances will be provided with assessment, treatment, support, and, if applicable, with referral to specialised services. Problems are treated "...usually with medication and sometimes with psychotherapy" (MHC, 2007). Other public mental health services funded through DHBs include crisis services, in-patient hospital units, respite services, supported accommodation, support and rehabilitation services, services of mothers and babies, children and young people, older people, services for Maori, services for Pacific People, alcohol and drug services, eating disorder services, and either in-patient or community based forensic services. In 2003 DHB providers have in total attended to 86,676 people and made 851,658 contacts with service users to coordinate care and provide individual treatment (MHC, 2007, p. 40).

As mentioned previously (p. 58), in 1998 New Zealand incorporated the recovery model into the national mental health policy as guiding principles for service delivery (MHC, 1998; MOH, 2005). Although incorporating the recovery model has been the aim of the national mental health policy for over eight years, the implementation of this policy is slow. Goldsack and colleagues (2005) assume that recovery principles of self-help and survivor participation are more likely to be adopted in the area of rehabilitation rather than in services that treat acute mentally ill people. This may explain why many mental health services have not yet implemented

government policy and translated recovery principles into comprehensive system changes.

Anthony (2003) criticises the reluctance to fully implement the recovery model. He believes that the implementation of the recovery model into mental health systems is hindered by traditional mental health thinking that creates walls between health professionals and survivors and impedes survivors' recovery. He further states that such thinking favours specialist knowledge and technology and underestimates the potency of the therapeutic alliance between health practitioner and survivors. Instead it reflects the still widespread attitude that persons with mental health problems are unable to make useful decisions and choices about their recovery (Anthony, 2003).

The executive summary of the National (United States) Research Project For The Development of Recovery Facilitating System Performance Indicators (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002, p. 5) identified that

...the formal system often hinders recovery through bureaucratic program guidelines, limited access to services and supports, abusive practices, poor quality services, negative messages, lack of 'best practice' program elements, and a narrow focus on a bio-psychiatric orientation that can actually serve to discount the person's humanity and ignore other practical, psychological, social, and spiritual human needs. At the core of such hindering forces is the operationalisation of society's response to mental illness, that of shame and hopelessness and the need to assert social control over the unknown and uncomfortable.

While necessary changes to integrate the recovery model into mental health service delivery in New Zealand are still waiting to be made, public mental health services are criticised for not providing services needed. A recent study identified that survivors were driven into a state of mental crisis by delays in receiving mental health care (Barnett & Lapsley, 2006). Barnett and Lapsley interviewed 40 young adults (aged 18-29 years) who have had significant contact with mental health services. They concluded that community mental health services act as gatekeeper for accessing specialised non-acute services, turning survivors away, and "prevent access to services by people who are outside the 3% of the population who have the most severe problem....those with symptoms of non-psychotic spectrum disorders had a far harder time gaining access" (Barnett & Lapsley, 2006, p. 89). They also noted that community mental health services provide only the most basic service of "medication, a little support, and referrals to occasional appointments with psychiatrists" (p. 91). Thus survivors often live in outpatient settings, are heavily medicated and numbed by the

lack of meaningful activities in their daily lives (Barnett & Lapsley, 2006; Vaughn, 2006).

Barnett and Lapsley's research participants complained that they were not asked about abuse in the assessment phase and had not been given an opportunity to talk about sexual abuse trauma or other forms of trauma they may have experienced. The lack of attention to abuse or trauma histories by mental health professionals has been discussed widely. Although between 50-80% of survivors in psychiatric care have a history of trauma, these incidences are seldom inquired into by mental health professionals (Cusack, Frueh, & Brady, 2004; J. Read, Young, Barker-Collo, & Harrison, 2001). Read et al (2001) surveyed 114 psychologists and psychiatrists in New Zealand who stated they did not attend to abuse issues because they had to attend to more pressing issues, they feared clients would be additionally distressed by inquiring about trauma, they feared they could induce 'false memories', or they had a belief-system based on biological etiology of psychiatric disturbances.

However, research has shown that those survivors in psychiatric care who did not progress, all had a history of sexual abuse (Everett & Gallop, 2001; Jennings, 1994; J. Read, 1998; J. Read & Fraser, 1998). Thus by not attending to abuse issues recovery is hindered, because the origins of their psychiatric disturbances are not addressed (Everett & Gallop, 2001; J. Read, 1998; J. Read & Fraser, 1998; J. Read, Young, Barker-Collo, & Harrison, 2001; Wells, 2004). An example of the possible tragic outcome of this silence is given by Jennings (1994) who described the case of her daughter Anna. Anna struggled for 19 years in the mental health system with severe and chronic psychiatric disturbances. She had been treated for a number of disturbances such as borderline personality, schizophrenia, conduct disorder, anorexia, bulimia, and obsessive compulsive disorder without giving attention to her history of sexual abuse. Comments by Anna or her mother regarding a history of sexual abuse were ignored. After repeated, unsuccessful attempts to have her sexual abuse trauma addressed, Anna took her own life at the age of 32.

Failing to place psychiatric disturbances in the context of abuse is discounting the violation and injustice survivors have experienced (Johnstone, 2002; J. Read & Fraser, 1998). Both the discounting and the pathologising of their trauma symptoms by attaching the label of mental illness is a withholding of survivors' rights. Their right is to have the injustice of the abuse recognised and to have treatment that addresses the distressing experiences that drive psychiatric symptoms (Johnstone, 2002; J. Read & Fraser, 1998). By withholding legal recognition in the form of ignoring the abuse and

not providing abuse-focused treatment, survivors' self-respect may be injured (Honneth, 1995b).

Although the connection of psychiatric disturbances and sexual abuse has been mentioned in many studies discussed here, acknowledgement of this link is still missing in official governmental reports. The recent release of the mental health survey Te Rau Hinengaro (MOH, 2006) mentions mental disorders, suicidal behaviours, and disabilities in the New Zealand population without mentioning sexual abuse at all in the whole study. Similarly, the story of the development of mental health services in New Zealand, Te Haererenga mo te Whakaōranga 1996-2006 (MHC, 2007) mentions sexual abuse only three times in relationship to sexual abuse allegations in the Lake Alice Hospital case (p. 35), in the description of Moana House, Dunedin, a therapeutic community for male offenders (p. 58), and in the context of mental health promotion and prevention (p.223) as one of the factors that need to be eliminated for mental health and wellbeing to be achieved. This lack of attention to sexual abuse leads to the conclusion that, although sexual abuse is repeatedly connected with the occurrence of psychiatric disturbances, the shroud of silence and invisibility is maintained by society, mental health services, and policy makers and still inhibits awareness and insight into the magnitude of its impact on the population's mental health.

Psychotherapists and Counsellors

Psychotherapists and counsellors (therapists⁴) are both able to look back over a long history of ethical values that have as central theme and primary obligation the physical and emotional wellbeing of clients, their right to confidentiality, privacy, self-determination, and a secure therapeutic working relationship (NZAC, 2006; NZAP, 1986). Saakvitne and Abrahamson (1994, p. 189) explain "The goal of psychotherapy is to understand the complex meaning of psychological and interpersonal events, largely through the creation of meaning in the therapeutic relationship". The NZAC (2006) formulates the nature of the counselling relationship as "Counselling involves the formation of professional relationships based on ethical values and principles. Counsellors seek to assist clients to increase their understanding of themselves and their relationships with others, to develop more resourceful ways of living, and to bring about

⁴ For the rest of this study the term 'therapist' is used for both psychotherapists and counsellors and the term 'therapy' for psychotherapy and counselling. The intention is to avoid ideological discussions about differences between psychotherapists and counsellors and acknowledge that both terms are used by professionals who come from a wide range of professional backgrounds (i.e. psychologists, psychotherapists, counsellors, social workers, nurses) to provide abuse-focused therapy.

change in their lives”. The guidelines in the respective codes of ethics (NZAC, 2006; NZAP, 1986) envisage that therapists create an alliance with survivors that is built on collaboration, respect, reliability, understanding, challenge, and autonomy. Judith Herman (1992) describes the nature of the therapeutic relationship with survivors of trauma as follows:

Though the therapeutic alliance partakes of the customs of everyday contractual negotiations, it is not a simple business arrangement. And though it evokes all the passions of human attachment, it is not a love affair or a parent-child relationship. It is a relationship of existential engagement, in which both partners commit themselves to the task of recovery. (p. 147)

The landscape of therapy in New Zealand changed dramatically in the late 1970s, when the public became more aware of incidences of sexual abuse and survivors were able to apply to ACC for funding of their therapy sessions. From here on therapy for sexual abuse in New Zealand became linked with managed care principles. A managed care company is defined as an insurance company or other entity that manages the “delivery and financing of health care with the intention to eliminate unnecessary and inappropriate care and to reduce costs” (Langwell in Wineburgh, 1998, p. 433).

Until then therapy was mostly used by financially affluent clients who paid privately for their treatment. The focus of therapy was negotiated solely between client and therapist. The availability of ACC funding meant that a large number of survivors of sexual abuse, who may otherwise not have been able to afford therapy, started to use therapy as a pathway to recovery.

The conditions and arrangements under which therapy took place were no longer negotiated solely between therapist and client but also involved ACC. The client-therapist dyad became a triad that “...behaves differently because of the tension between the different assumptions, goals, and values represented by each leg of the triad” (Wineburgh, 1998). While therapists’ primary obligation was the client’s wellbeing they found they had to comply with ACC’s procedures and policies that were perceived to limit their ability to provide optimum care. “The feelings of helplessness that force adaptation to managed care practices are compared to the traumatic bond between victim and abuser...[and]...subvert the identity of the psychotherapist and the humanistic aims of psychotherapy” (Cary, 2001).

The changed circumstances demanded therapists to re-think their approach to therapy and adapt to managed care principles. Clients were now frequently from a socio-economic group that was unable to pay privately for their treatment and

compliance with ACC procedures became paramount for receiving treatment funding. Therapists struggled to acclimatise to the level of oversight ACC exercised through reports and assessments and to their clients' dependency on ACC for funding. Cary (2001) and Edward (1999) describe managed care practices as abusive, intrusive, unethical, compromising survivor's safety, and being destructive for the therapeutic alliance. Similar sentiments were raised in New Zealand where therapists have found that the managed care framework adopted by ACC prevented them from shaping recovery within their traditional understanding of ethical practice and was harmful to survivors' recovery (Carroll, 1997; Mitchell, 2003; NZAP, 2003).

Providing treatment under the umbrella of ACC funding guaranteed a steady flow of clients and therefore income. Therapists and clients paid for it with the loss of independence and freedom to proceed as they please. While therapists' main concern should be clients' wellbeing they became agents of ACC who have to follow procedures and policies that put restrictions on therapists' ability to provide care, because the client "...has now entered a disciplinary technology centred on production, for health care has become a commodity that is managed to achieve a profit" (King-Keenan, 2001, p. 216). As concepts of the therapeutic dyad and autonomy are no longer guaranteed in the work with survivors of sexual abuse, therapists are challenged to understand the impact of ACC on their therapeutic work, on their professional standards, on their ethical principles, the social reality, and on their economical reality.

Over the last ten years ACC has increasingly introduced control strategies to monitor therapists and their work through increasing the frequency of reports and reviews, increasing requirements for therapists' approval as ACC counsellor, requiring therapists to annually confirm supervision arrangements and continuous training, requiring compliance with medication suggestions, and practitioner profiling whereby for each therapist the average number of sessions with clients are registered.

Therapists overseas and in New Zealand (Edward, 1999; Mitchell, 2003; Wineburgh, 1998) believe that these control strategies imply that therapists are incompetent, not trustworthy, and do not adhere to professional standards. Edwards (1999) points out that therapists are hindered in their ability to be fully attuned to their client when their knowledge and expertise is constantly questioned. Constant control strategies undermine clients' confidence in the therapist as capable, strong, well trained, and skilled. Clients with a severe history of childhood sexual abuse need to be able to perceive their therapist as strong and capable to revisit and process terrifying experiences. Jung and colleagues (1996) have shown that when clients are not able to

believe in those qualities in their therapist but perceive s/he is powerless and vulnerable to the managed care company, they get disillusioned, view therapy and the potential outcome negatively, and may not even engage in therapy under managed care. As clients strive for self-determination and autonomy as part of their recovery, they need to experience these qualities in their therapists as a reflection of potency and power. Indeed, power "...often plays a very important role, for the therapist without power, although he could do little harm, would also have little ability to help the patient" (Chodroff, 1996, p. 301).

Once clients are refused further treatment funding therapists have the ethical responsibility to assure that clients remain safe and are able to continue treatment. There may be no free services clients could be referred to or the established therapeutic relationship has become important to the client's safety making it ethically irresponsible to refer clients to other services or therapists. This means that therapists at times may have to provide treatment for a significantly lowered fee (Wineburgh, 1999).

This section has explored the tension between therapists and ACC. Having a stable income source through working with ACC funded survivors comes to the price of having to give up some aspects of freedom the profession traditionally enjoyed. Due to this tension many therapists have chosen to stop working with ACC funded clients (Mitchell, 2003). Such silent retreat, however, means an opportunity is missed to engage in a political dialogue with the government and/or ACC about proudly upheld care-principles.

The Accident Compensation Corporation (ACC)

Survivors with a history of (childhood) sexual abuse are eligible for funding for therapy through ACC because treatment and compensation for personal or mental injuries sustained through accidents are covered under the Accident Corporation Compensation Act of 1972. Absorbed into the ACC scheme was the 'Criminal Injuries Compensation Act 1963' which covered a wide range of criminal acts that lead to injuries, including personal and/or mental injuries caused by sexual abuse (Arnold, 2004). ACC funding is the only public funding source for sexual abuse therapy.

The government's aim was to provide an accident insurance that "...guarantees all New Zealanders essential care and compensation in the event of an accident occurring anywhere in this country" (DOL, 2000) regardless of cause or fault. Under the Act ACC is obliged to return victims to their role in the community as quickly as

possible without significant personal financial loss, to provide comprehensive entitlement, to assist with complete rehabilitation, to provide 'real' compensations, and to provide a range of services to reduce the impact of injury on individuals and the community. Services include initiatives to prevent injuries, to provide case management and rehabilitation services, to manage the relationships with health professionals throughout New Zealand, and to be administered efficiently (DOL, 2000). In return for this comprehensive insurance the scheme removed individuals' right to sue under common law for damages based on fault (MOJ, 1999).

New Zealand's welfare system has its roots in the ideology of the first Labour government under Prime Minister Michael Joseph Savage (1935-1940) who envisioned "a more just society, where all may live in comfort and security" (Labour, 2003). The aim of the Social Security Act (1938) was to provide "as generously as possible, for all persons who have been deprived of the power to obtain a reasonable livelihood through age, illness, unemployment, widowhood, or other misfortune" (Boston, 1999, p. 3). This act included the provision of a free and universal health care system that gave all New Zealanders access to services on the basis of need rather than on their ability to pay (Bowie & Shirley, 1994). A growing economy and full employment on a global and national level made these ideals financially sustainable.

A dramatic worldwide reduction in the rate of economic growth combined with rising unemployment and an explosion in expenditures for social assistance in the late 1970s caused the shift towards a more market-oriented business model (Boston, 1999; Bowie & Shirley, 1994). The free and universal health care system New Zealanders were accustomed to until the early 1970s changed into an economically oriented business-model. Whether services would be provided was no longer determined by survivors' needs but by rationing decisions made by bureaucrats based on prioritising certain conditions and on economic considerations (Boston, 1999; Bowie & Shirley, 1994).

This shift has also affected ACC policies. Being a government enterprise known as Crown Entity, a body owned by the Crown but not a department or office of parliament, ACC was "to operate on a commercial basis, with the clear intention that they be profit-driven" (Bowie & Shirley, 1994, p. 307). ACC's income consists of levies received from employers, employees, self-employed, motorists, and government contributions for unemployed people. From these income sources they have to cover the costs for the rehabilitation of accident victims. Included are costs for medical,

psychological, and dental treatment, income compensation, payments for permanent impairment, and living assistance (alteration of houses, wheelchairs etc.).

ACC responded to spiralling costs by increasingly enforcing the principles of managed care. Like managed care companies overseas ACC introduced control-technologies such as frequent and detailed reports, external assessments for the authorisation or re-authorisation of treatment, and decreasing the number of sessions approved with the rationale to improve efficiency, achieve higher levels of accountability, and improve the health status of the general public (Boston, Dalziel, & St. John, 1999).

There is widespread acceptance within New Zealand that the delivery of health care services is subject to restraints and trade-offs based on urgency, need, and severity (Coney, 1997). However, the Health and Disability Commissioner of New Zealand has been cautious about the benefits of managed care stating that "...cost containment or cost effectiveness do not, in themselves, produce better health outcomes or improve efficiency" (HDC, 2006). Suggestions were made to expand the concept of managed care to fit the specific circumstances of New Zealand, for example to involve consumers in decision making, to assure equitable funding of services, and to deliver services according to consumer needs (Coney, 1997; HDC, 2006; Paterson, 2004).

Since ACC adopted the principles of managed care, survivors and service providers of abuse-focused therapy were significantly restricted in shaping recovery processes according to survivors' needs (Mitchell, 2003). Procedures had to be complied with that controlled and influenced the therapeutic process and marked the beginning of the tension between therapists and ACC. Schwartz and Weiner (2003), case-managers in a managed care company, give as rationale for these control technologies increasing accountability of therapists and to ensure that services provided are necessary and appropriate. Ahles (2002), however, claims that these technologies are hidden rationing of health care because they save money by discouraging survivors from engaging in therapy.

Many writers (Cary, 2001; Edward, 1999; Karon, 1995; Saakvitne & Abrahamson, 1994; Sperling & Sack, 2002) claim that the different layers of oversight and control reflect managed care companies' distrust in the competency and trustworthiness of therapists. Schwartz and Weiner (2003, p. 393) explain that "...as the insurance industry refers to it, these conditions create a 'moral hazard,' which means that the existence of a benefit may ultimately influence the formulation, diagnosis and treatment recommendations". The suspicion is that therapists might be tempted to 'over

diagnose' and provide services that may not be needed or be provided to survivors who may not be entitled to receive them. Many therapists in New Zealand have responded to the lack of recognition of their integrity and competency by refusing to work with ACC funded survivors (Mitchell, 2003; Tyler, 2003a).

The following excerpts from the ACC Injury statistics 2005 (ACC, 2006a), section 13.1., Sensitive Claims (Table 5), is used to highlight the tension between therapists' concerns for appropriate care for their clients and ACC's concerns about exploding costs. The intention here is not to provide an in-depth cost-analysis but to highlight points that may be relevant for understanding how the use of funds is prioritised and how this may influence recovery.

Table 5: ACC injury Statistics 2005 - Cost Sensitive Claims

Costs New and Ongoing Claims by Expenditure Category - claims 2004/5 – (\$000)							
Year	A Total Nr of claims	B Total Costs of Claims	C Assess- ments	D Indep. Allow. Lumps. ⁵	E Med Fee Counsel.	F Weekly Compens. ⁶	G Miscell. Admin. ⁷
94-95	11.820	13.440	683	5.204	246	1.960	4.889
04-05	11.054	29.778	676	3.876	784	9.877	11.173
Increase/ Decrease	- 6.5%	+ 121%	- 1%	-25.5%	+218%	+ 403 %	+128%
Percent of Total Costs for 2004/5		100%	2.3%	13.0%	2.6%	33.0%	37.5%

The total costs for new and ongoing claims in the period between July 2004 and June 2005 have been just under \$30 million. The five categories 'assessments, independence allowance/lump-sums, medical fee/counselling, weekly compensation, and miscellaneous and/or administration' make up 90% of all costs for sexual abuse claims.

⁵ Lump-sum or independence allowance is paid if the injury has a serious, long term effect resulting in permanent impairment).

⁶ Weekly compensation is paid for loss of earnings as a result of a mental injury suffered through sexual abuse.

⁷ The category miscellaneous is for administrative costs according to ACC statistics department, email from 14 April 2004.

The remaining 10% are for dental treatment <0.0%, hospital treatment 0.09%, medical treatment 0.1%, support for independence for non-serious injury 5.5%, support for independence for serious injury 2.6%, transport to treatment 1%, and vocational rehabilitation 1.3%. As a benchmark: the Consumer Price Index (CPI) inflation rate according to the Reserve bank of NZ (Reserve Bank, 2006) between 1995 and 2005 has been 20.9%.

Column A and B:

As table 5 shows, the total number of claims has decreased by 6.5% over the last ten years, yet the overall costs have increased by 121%. This increase is mainly due to the rise by 218% in counselling fees, by 403% in weekly compensation, and by 128% for administration costs since 1995. The following explores briefly how these costs may translate into factors that shape recovery.

Column C: Assessments

The costs for assessments have been 5% of the total costs of claims in 1994/95. Whilst the number of claims has declined by 6.5% in the period 94/95 to 04/05, costs for assessments have declined by only 1%. However, this does not take into consideration the overall inflation rate of 20.9% for that time period. In contrast, except costs for independence allowance and lump sums, all other costs have risen significantly and far beyond the inflation rate. This leads to the conclusion that either less assessments are performed, or assessments are more effective and provide more useful information to assist ACC with monitoring clients' progress. The reduction in costs for assessments, after consideration of inflation, give rise to questioning the perceptions of therapists and clients that ACC is increasing their monitoring of the therapeutic process and progress.

Column D: Independence Allowance/Lump- sum

The costs for independence allowance/lump-sums represent 13% of the total costs for claims in the period 2004/05. However, compared to the period 1994/05 total payments for independence allowance have declined by 25.5%. Survivors of sexual abuse are entitled to these benefits dependent upon medical assessment that documents permanent impairment (independence allowance or lump-sums) (ACC, 2006b). Lump-sum payments for sexual abuse had been abolished by 1992 and survivors were only able to claim for independence allowance up to \$40 weekly for permanent damage due to sexual abuse. This changed in April 2002 when lump-sum payments of up to \$100,000

were possible again, although survivors have to wait for two years after counselling has started to demonstrate that their condition is permanent.

This suggests that independence allowance and/or lump-sum payments may be harder to get and ACC's assessment criteria may be followed more stringently. However, it might also indicate that survivors increasingly attend therapy, because independence allowance and lump-sum payments are only given when 'permanent impairment' is still assessed two years after survivors have started therapy. The decrease in independence allowance/lump-sum payments could also indicate that survivors have a better recovery outcome through therapy and therefore less permanent impairment. The decrease in independence allowance/lump-sum and the increase in counselling fees could also be a reflection of survivors using therapy more than in previous years. Yet, without accurate therapy outcome data that gauge the effectiveness of therapy, the reasons for increase/decrease in columns remains guesswork.

The issue of granting independence allowance or lump-sum payments has been hotly debated and concerns have been expressed that this benefit could be exploited and may lead to a flood of fraudulent claims (Forbes, 2002; Tyler, 2003b). Although survivors will be assessed by a mental health professional to establish permanent impairment, they are not required to report the abuse to the police or disclose the name of the perpetrator to ACC. Not making the reporting of sexual abuse mandatory has many implications that will be considered here briefly.

Sexual abuse is the only area in which ACC makes payments for compensation or allowances on the basis of self-report without requiring evidentiary support, a criminal conviction, or at least a report to the police. Questions of justice arise about the different treatment compared to victims of other crimes such as burglary or physical assault. Why is childhood sexual abuse treated differently to childhood physical abuse or neglect? There is incongruence here and the only person that benefits from the differential treatment is the perpetrator, who walks away from his crime a free man or woman. Not requiring reporting could be seen as a reflection of societal collusion with sexual abuse perpetrators. However, survivors of sexual abuse might not have strong enough self-structures (self-confidence and self-respect) to be able or ready to lodge an official complaint against their abuser and face the possibility of revictimisation through the legal system, the media, or the perpetrators (see exploration of social denial and backlash on pages 38-42).

Also, compensation has to come from public resources whereas some members of the public believe that "Compensation for sexual abuse should be the result of a

criminal prosecution, not administered by bureaucrats and administrators who might make the wrong decisions” (Tyler, 2003b). However, rape statistics (AWC, 2006) show that only 10% of reported rapes are presented to the courts of which only one third result in convictions. Statistics with such poor outcome for convictions are not encouraging survivors of sexual abuse to proceed with legal actions against their perpetrators.

Starting court proceedings against sexual perpetrators would also be difficult due to the lack of evidentiary support for sexual abuse claims. Survivors of sexual abuse are often engulfed in a web of shame, guilt, and fear. This makes it difficult for them to present their case convincingly. Without physical evidence, they have to rely on their report being believed. Yet often dynamics such as attachment to the perpetrator, discussed in Chapter Three (page 47), impaired memory processes Chapter Three (page 45), and fear of destroying one’s family when the perpetrator is a close family member, may prevent the disclosure from sexual abuse. Evidentiary support can also not be derived from the psychiatric disturbances survivors may suffer from because up to this date scholars have not been able to prove a causal link between incidences of sexual abuse and psychiatric disturbances. At present it can only be demonstrated that amongst those people who claim to have experienced sexual abuse, a number of psychiatric disturbances are common (see discussion in Chapter Three, pages 42-49).

Many survivors of sexual abuse may miss out on treatment if they only get assistance when they provide evidentiary support for their claims. They might not be eligible for treatment within public mental health services if their psychiatric disturbances are not amongst the 3% most severe mental health problems. This could in turn lead to a decline in functioning of a large number of people and cause an escalation of the demands on social services and social assistance.

Column E: Medical Fee/Counselling

Whereas in the period 1994/05 costs for counselling have been 1.83% or \$20.80 per claim, this amount has risen to 2.6% of the total expenditures in the period of 2004/05, or \$70.90 per claim. Thus the average cost per claim has tripled in the last ten years. This rise in expenditures is partly due to an increase in the hourly fee ACC pays counsellors. A few years ago ACC has, after a decade of not adjusting the hourly fee for counsellors, increased the payment from \$50 per hour to currently \$ 69.70 per hour. This increase accounts for just over 39% of the increase of the total amount for counselling fees.

However, the remaining increase is still substantial. One hypothesis for the increase has been given earlier under column D, independence allowance/lump-sums, arguing that the decrease in lump-sums and independence allowance may be a result of improved mental health due to intensified use of counselling. Thus a reduction of independence allowance/lump-sum may have to be balanced with the increase in counselling costs. Other explanations may be that counsellors use generally more sessions per client. This could justify ACC's increased suspicion whether treatments provided are appropriate and/or effective. It could also be that therapy is more utilised by survivors because it has become more acceptable to see a counsellor. It could also be that clients present with more severe psychiatric disturbances for which they did not find help in the public mental health services. Without having reliable outcome data that demonstrate a baseline of functioning at the beginning and at the end of ACC funded treatment, all these hypotheses are at best interesting possibilities.

Interesting as well as disturbing is the comparison of expenditures for counselling fees to other costs. Given that abuse focused counselling/therapy is the most effective treatment for the recovery from the legacies of sexual abuse (Briere, 2002; Herman, 1992) it is deeply concerning that only 2.6% (or 3.6% if transport is included) of the total costs for survivors of sexual abuse is spent on therapy. Almost as much (2.3%) is paid for monitoring treatment through assessments and reports and just under 15 times as much (37.5%) goes to administration along with just under 14 times as much (33%) which is spent on weekly compensation.

Column F: Weekly Compensation

Expenditures for weekly compensation for the loss of income (weekly compensation) have been 33% of the total costs for sexual abuse claims in the period 2004/05. This is a steep rise of 403% from \$2m to \$10m in the past ten years and the largest increase of all categories mentioned in the above statistic. It explains ACC's insistence on frequent reports and assessments and must be of great concern to them.

Claimants who have to stop employment due to stress and/or psychiatric disturbances that are linked to experiences of past sexual abuse can apply for weekly compensation for loss of income instead of going onto the sickness benefit. They have to present a medical certificate that testifies their inability to continue working and attend a psychiatric assessment to establish the severity of the impairment and the link with their history of sexual abuse. If ACC approves of their application for weekly

compensation survivors will be paid 80% of their last income dependant on presenting medical certificates at regular intervals.

There are several hypotheses that could be entertained to understand the reasons for this large increase. One explanation could be that over the years, through better information, both survivors and medical professionals are more aware of the availability of weekly compensation. Survivors might apply therefore more often for weekly compensation rather than trying to cover living expenses while on the sickness benefit. Another possible hypothesis is that some survivors did not receive effective treatment and have deteriorated to an extent that they became unable to continue working. Of course, it is also possible that some people abuse the system by applying for weekly compensation by lying about their condition or exaggerating their symptoms.

Although receiving weekly compensation might be a blessing for many survivors, it comes with some drawbacks. All those concerns given by politicians against making access to benefit too easy is also applicable for weekly compensation. Being on weekly compensation may reinforce learnt helplessness and survivors may become dependent on the benefit making it difficult to re-integrate into the workforce after an extended time on the scheme. Survivors may lose the motivation to better themselves and may have come to get used to a life without the pressure of the work-environment.

Column G: Miscellaneous/Administration

In total 37.5% of the expenditures of \$30 million for sexual abuse claims are paid for case management and administering the recovery process. This means that for each NZ dollar spent on treatment ACC spends 14.25 times as much for administration and case management. While the actual number of claims has decreased by 6.5% over the last ten years, the cost for administration has increased by 128%. Like with other categories in Table 5 the increase can only be explained to a small extent with the inflation over the last then years.

The increase of expenditures for miscellaneous/administration could be explained with a number of contributing factors. Firstly, the large increase in payments for weekly compensation may require additional administration for managing the increased workload and for assisting claimants to be re-integrated into the workforce. Regular assessments need to be organised, regular case meetings may need to take place to assure that claimants have access to available vocational programmes and 'back to work schemes' and claimants will be closer monitored to assure that they do not remain

unnecessarily on the scheme. Secondly, ACC might be suffering, like other large institutions, from a disproportional administration due to multiple layers of bureaucratic procedures and responsibilities.

Table 5 shows a concerning gap between expenditures for treatment (2.6%) and expenditures for administration (37.5%), compensations, independence allowance, and lump sum payments (46%). Repeated calls for a review of ACC processes and payment regulations may be justified to fully understand the relationships between the high costs for administration and other payments of compensations, allowances, and lump sums. Doubts have been expressed here whether current processes and expenditures are indeed the best way of assisting sexual abuse recovery.

Turf Battles in Providing Sexual Abuse Survivor Services

The previous discussion of public mental health services, psychotherapists and counsellors (therapists), and ACC has revealed a divergence in view and positions in relationship to the treatment of survivors of sexual abuse. It has emerged that public mental health services have a technical/medical orientation to finding solution to psychiatric symptoms, whereas therapists focus on (re)-developing self-structures through reparative processes within the therapeutic relationship. ACC, on the other hand, has adopted a case-management system of providing funding for treatment in an environment of financial constraints and exploding costs for sexual abuse claims. In an ideal world the involvement of three different institutions could be celebrated as a rich and varied source of assisting in the recovery from sexual abuse. Survivors of sexual abuse would not get the best of both worlds they would get the best of three worlds if these three institutions would co-operate to achieve the best outcome for survivors.

However, perceiving the ‘other’ professional worthy of co-operation has been difficult in the provision of services for the recovery of survivors of sexual abuse. Historically evolved values of psychotherapy, psychiatry, and administration have produced a baggage of presuppositions and assumptions about the ‘other’ that have hindered the mutual recognition of each other and created a divide that inhibits fruitful dialogue. Schön (1991), a strong proponent of inter-professional co-operation states that inter-professional co-operation is impeded because

Many practitioners, locked into a view of themselves as technical experts, find nothing in the world of practice to occasion reflection. They have become too skilful at techniques of selective inattention, junk categories, and situational control, techniques which they use to preserve the constancy of their knowledge-in-action (p. 69).

He explains the dilemma with health professionals' reliance on technical knowledge and their un-ease or unwillingness to reflect with practitioners from other professional groups on the effectiveness of treatments and interventions. Schön (1991) claims that inter-professional reflection is required to become more sensitive to patients' needs. Through sharing successes and weaknesses from clinical practice health professionals may learn from each other and create new knowledge. It may combine experiences of clinical practice, the swampy lowlands of messy problems that are usually more significant for human existence but less accessible for empirical and rigorous research, with theory that is generated through scientific methods that describe the high ground of manageable problems suitable for the application of research based theory and technical interventions, although they are seemingly unimportant to society (Schon, 1992).

Barriers to inter-professional co-operation between professionals in the mental health sector may be the lack of existing structures that make inter-professional dialogue possible, the lack of time set aside for processes of shared learning, discomfort by some with reflecting on successes and failures, unwillingness to give up power and show weaknesses, and/or the lack of recognition that there is a need for such inter-professional dialogue (Schon, 1991). Barriers are also erected through professionals' allegiance to a specific theoretical model that is usually believed to be unique, different, and better than other models. Botella (1999, p. 1) links this allegiance to processes of identity formation and claims that

...the process of developing one's identity as a psychotherapist entails... positioning oneself with one of these competing discourses. Belonging to a theoretical persuasion does not only provide a way to approach clinical practice, but also has important social functions such as providing a language and a supporting structure made up of Journals, conferences, training courses, and associations.

Decades of psychotherapy outcome research has shown that despite repeated attempts to establish the superiority of one model over the other, no theoretical model has shown to be better than others. Instead, all approaches work for some clients some of the time (Botella, 1999; Lambert, 1992; S. Miller, Duncan, & Hubble, 2004; Wampold, 2001). The resistance amongst professionals to accept that specific models and techniques have no specific effect is explained by Tallmann and Bohart (1999) with the rewards a professional receives by claiming s/he has curative powers. They list such rewards as status of leaders of specific approaches, the opportunity to 'sell' technical training programs, and to establish professional legitimacy. Botella (1999) hypothesises that the dominance of the medico/biological model in the treatment of psychiatric

disturbances is due to the worldwide support of the pharmaceutical industry on which, as Read (2006) claims, professional organisations, conferences, journals, research, and teaching institutions have become so reliant.

Schön (1991) has described professionals' need for recognition and respect as a pre-condition to engage in meaningful dialogue about clinical practice. However, recognition and respect are not always given. A recent study by Goodyear-Smith and her colleagues (2005) investigated the effectiveness of psychotherapists and counsellors compared to psychiatrists and psychologists. For the period of 2003, counsellors attended to 86.6% of all claims with an average of 12.87 visits per claim, psychologists attended to 12.7% of all claims with an average of 9.11 visits per claim, and psychiatrists attended to 0.7% of all claims with an average of 8.89 visits per claim. The researchers, a general practitioner and lecturer at Auckland University (Goodyear-Smith), a psychologist and lecturer at Auckland University (Lobb), and a senior analyst from Child, Youth and Family (Mansell), conceded they were unable to access any outcome data that could have shed light on the quality of the treatment provided or on the recovery experiences of claimants. Nonetheless, without providing any evidence they concluded that psychiatrists and psychologists "...achieve better outcomes and/or similar outcomes with fewer treatment visits per claimant" simply due to their higher professional qualification and recommended that "...both initial and final Diagnostic and Treatment Assessments" should be introduced because "...correct initial diagnosis and instigation of optimum treatment may be cost-effective (pp. 389-390).

Unfortunately it is not revealed how the study was funded or what the interests of the researchers were. This is particularly regrettable given that ever since Goodyear-Smith's husband had been convicted of sexual abuse crimes, she had been an activist for a group of individuals who claimed they were wrongly accused of sexual abuse crimes (Julich, 2001).

This study is an example of the subtle disrespect commonly seen amongst different groups of health professionals in New Zealand where judgements are made on the grounds of training and qualifications. MacKinnon (1993, p. 118), reported from her experiences in a multi-disciplinary psychiatric emergency services team that "After two hours of interviewing the patient and accompanying family members, we presented our assessment to the psychiatrist in charge. He then spent on average five minutes disputing the assessment and making orders for what was to happen". MacKinnon, a trained social worker and family therapist reported of her deep dissatisfaction when she had to learn that her perspective was rarely taken seriously by psychiatrists, although

her training had prepared her to believe that both her and her clients' view would matter.

A recent Canadian study (Austin, Rankel, Kagan, Bergum, & Lerner, 2005) discussed the moral tension psychologist experienced between following agency policy and meeting patients' treatment needs. Their finding was that psychologists felt disrespected and unsupported by their colleagues and their agency when they looked for support for difficult ethical treatment decisions that may have been outside of agency's policy. Without being able to consolidate patients' care needs with agency's policies these psychologists suffered from increased levels of stress and, in some cases, resigned from their agency.

Disrespect and the withholding of recognition are also noticeable in the professional contact between therapists and ACC. Policies and procedures implemented by ACC without consultation of therapists have been perceived as an excessive need to control and monitor treatment and implying mistrust towards therapists. Not only did therapists feel they were no longer able to provide treatment that would meet their ethical and professional standards, they also perceived ACC to withhold recognition of them as capable and competent health professionals (Mitchell, 2003; NZAP, 2003). Schön (1991) laments that policy makers and managers are often not aware of the sense of alienation evoked by changes that are imposed without consultation and preparation and wonders whether managers are willing to enter in a constructive dialogue with professionals and clinicians.

Therapists' frustrations and distress about the disrespect they perceived in their working relationship with ACC has been strong. Many showed their disrespect of ACC by refusing to accept working with ACC funded survivors, implying that ACC is unethical and uncaring (Mitchell, 2003). Yet, disrespect occurs not only between institutions and other professionals, but also inside larger institutions. The New Zealand Herald (2004) reported that Unions had warned ACC minister Ruth Dyson several times that ACC is bullying and overworking staff. Although ACC has denied the allegations, staff have reported "...they knew of colleagues who had nervous breakdowns as a result of working in a stressful and persecuting environment" (p. 1). The article claims that the relationships between ACC management and staff are based on mistrust, blame, and favouritism and almost a third of staff at the sensitive claims unit, the unit that only deals with sexual abuse claims, left in the twelve months period leading up to April 2004.

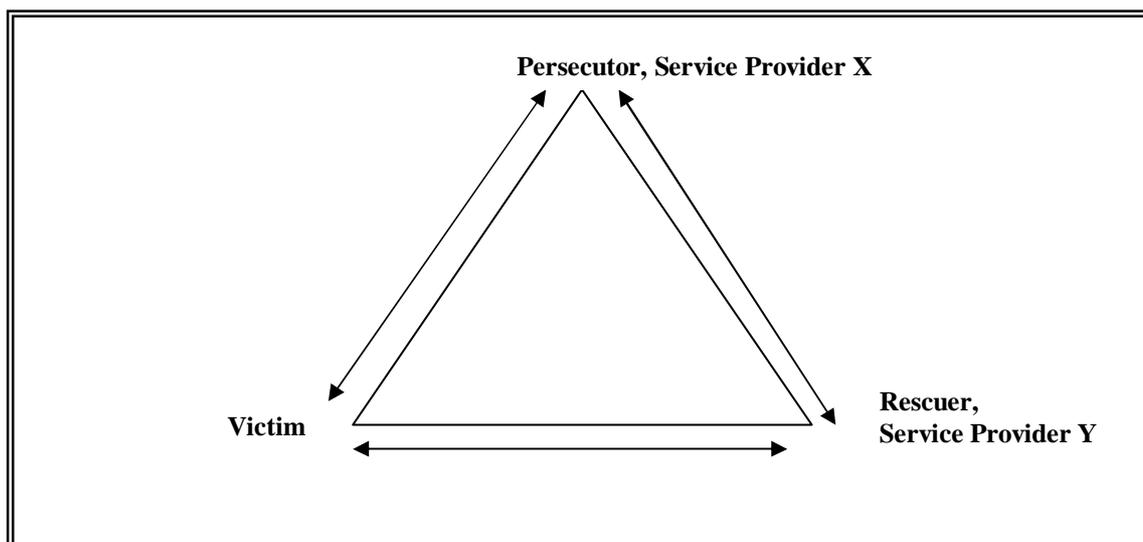
It appears that mutual recognition amongst professionals is not always present and the lack thereof interferes with inter-professional co-operation. Schön (1991) states that inter-professional co-operation is only possible when professionals have self-confidence, self-esteem, and a clear sense of their capabilities. Only then will they engage in a process of sharing their territory of expertise and relinquishing power. However, rather than receiving recognition for the difficult work in the ‘swampy lowlands’ (Schon, 1991) some health professionals feel disrespected by others that focus more on the ‘higher ground’ of technical ways of working. Service providers who are caught in dynamics of disrespect will experience diminishing self-confidence, self-respect, and self-esteem which will negatively impact on their professional identity and may negatively affect their work (Edward, 1999; Honneth, 1995b). If survivors of sexual abuse with their need for care are added to the dynamics, conditions are met for the victim/rescuer/persecutor dynamic of the drama triangle to unfold.

The Drama Triangle

The previous section has explored how inter-professional disrespect flourishes amongst professionals in the mental health sector. Karpman’s concept of the drama triangle (figure 1, page 84) may give useful insights into the dynamics that are commonly noticed in work with victims of sexual abuse. The dynamics of the drama triangle may be one explanation for the breakdown of mutual recognition between involved service providers. For example, while the victim is in distress and suffers, the ‘good’ therapist might be incensed with the allegedly unskilled or clinically dangerous ‘bad’ health professional, while the latter in turn question the therapists’ alleged over-involvement or the dependency creating behaviour.

The drama triangle is a model that demonstrates human interaction from a social and psychological perspective. It has first been described by Karpman (1968) within the framework of transactional analysis as a tool to describe habitual role positions individuals take on according to their life-scripts. According to Karpman (1968) the drama takes place in the switching of roles, whereby each individual occupies interchangeably each of the three available positions.

Figure 1 The Drama Triangle



It is not difficult to imagine how these dynamics over time could split health professionals into opposing rescuer or persecutor roles. While “Patients’ intense identifications with all aspects of their story leaves them alternately in the psychological spaces which correspond to victim, perpetrator, and rescuer “ (Chefet, 1997, p. 259), the dynamics of the drama triangle invites all three players to take alternately the positions of victim, perpetrator, and rescuer.

All positions have in common that they are ‘real’ for the players who feel genuinely entitled to act in the role-specific way. The victim (figure 1) feels persecuted by service provider X and appeals overtly or covertly to be rescued/helped by service provider Y. Together, victim and service provider Y may persecute/blame service provider X who then becomes the victim and may in turn persecute/disrespect service provider Y who takes his turn in becoming the victim. Abuse-based positions of victim, persecutor, and rescuer are re-enforced rather than new ways of behaving being explored.

Therefore, inter-professional co-operation has broken down and the lack of mutual recognition might have exposed service providers to stress or even vicarious traumatisation. That could have a negative impact on service providers’ ability to attend therapeutically to the needs of survivors and therefore have a negative impact on the shaping of recovery from sexual abuse (Blum, 1992; Edward, 1999).

Summary

This chapter has explored issues relevant for the recovery from sexual abuse. Core concepts of the recovery model and abuse-focused treatment models have been discussed and compared. This was followed by a discussion of studies that explored the important role social support has for the recovery from sexual abuse. Public mental health services, psychotherapy/counselling and ACC have been looked at as the main three service providers used by survivors of sexual abuse. A general overview has been given about how recovery from sexual abuse is treated by the three main providers. Barriers to inter-professional co-operation and its impact on the shaping of recovery have been presented and the drama triangle has outlined how service providers and survivors of sexual abuse might get caught in the re-enactment of abuse dynamics.

The following chapter provides an in-depth account of the methods used to explore the research question “How is the recovery of victims of sexual abuse shaped by the services available”?

CHAPTER FIVE

METHOD

This chapter describes in detail how this qualitative study has developed, starting from a clinician’s thoughts of concern, moving through a student’s attitude of curiosity and culminating in the researcher’s determination to contribute to the knowledge in the field of recovery from sexual abuse. It starts with introducing the researcher and her personal and professional background. This is followed by an in-depth description of the research process, including a discussion of participants’ rights, data collection and data analysis, and finally explores the trustworthiness of the study. Table 6 gives an overview of the chapter content.

Table 6 Chapter Content: Method

Method
The Researcher: My Personal and Professional Journey
The Research Process Developing the Research Question Sampling and Accessing Participants Participants’ Details
Ethical Considerations Do No Harm Informed Consent The Right to Self-Determination Freedom From Coercion Confidentiality
Data Collection Interviewing Participating Survivors Interviewing Participating Service Providers Focus Groups
Data Analysis Wrestling with the Data Coding Using NVivo Psychological Processes and the Drama Triangle Working with Models
Trustworthiness of the Research Credibility Transferability Dependability Confirmability
Conclusion

The Researcher: My Personal and Professional Journey

I am starting this Chapter with a personal introduction so that the reader may get a sense of how the background of my life has influenced the processes involved in completing this study.

I was born in 1949 in Hamburg, Germany. At that time Germany was still reeling from the impact of World War II (WWII). My family belongs to the working class and had been actively involved in the socialist movement for some generations, fighting for economic justice, equality, and emancipation. Having survived WWII and political persecution like many other socialists, my father became a member of the Socialist Party in post-war Germany. He felt passionately about human rights and the equality of the working class. His frustration was that after WWII the same 'group' of people succeeded economically and politically that had been prominent before the war, while labourers were still second-class citizens. I still remember joining my father as a young child on Labour Day demonstrations calling for social equality and emancipation of the working class and the underprivileged in general. He and I used to spend long evenings together debating the pitfalls of the 'Wirtschaftswunder' (own translation: the miracle of economic growth in the '50s and '60s), the rapidly widening gap between rich imperialists and poor working class members, and women's rights. My father was convinced that education and the acquisition of knowledge would be needed for the working class to have opportunities equal to those of the middle or upper class.

The socialist legacy has always been the background against which I formed my interests, thoughts, and actions. While raising three children I was actively involved in women's groups, women's refuge, and the German equivalent of play centres. Like many other Germans of my generation I have been interested in – if not obsessed with – the need to understand people and the interactions between people. I linked that to being bewildered and ashamed by Germany's past and the need to understand people's motivation to eagerly follow the Hitler regime. This led me, with some detours in between, to start training as a psychotherapist soon after I arrived in New Zealand in 1988.

As my professional career unfolded I noticed that I had a special affinity for working with trauma survivors. Whereas I often heard colleagues shying away from trauma work, I always felt comfortable and 'at home' with trauma. Growing up in a society/country where everyone was traumatised through experiences in the first forty five years of the last century, trauma has a peculiar familiarity for me and holds no fear. I know trauma can be survived!

Although with the passing of years and changing social circumstances my political stance has somewhat softened I still bring a definite critical view about social issues to my work as a psychotherapist and as a researcher. Thus my stance as a researcher is best described with a quote by Carspecken (1996, pp. 4-5) as

...a researcher or theorist who attempts to use her or his work as a form of social or cultural criticism ...(and) finds contemporary society to be unfair, unequal, and both subtly and overtly oppressive for many people. We do not like it, and we want to change it.

One way of changing society is to generate what Habermas (1984) called emancipatory knowledge, revealing hidden coercion, injustice, or domination. To achieve this, I will utilise my skills and experiences as a psychotherapist working in the field of trauma to increase the understanding of trauma that has resulted from interpersonal abuse and violence.

However, my background as a practicing psychotherapist also calls for particular attention to ideas and beliefs I hold which may influence my interpretations. My skill as a psychotherapist assists me in establishing rapport with the participants during the interviews and bringing a deep understanding of developmental, psycho-social, psychopathological, and psychological processes to the analysis of data. While this enables me to approach the data with an enhanced sense of theoretical sensitivity, it could also keep me from approaching the field 'fresh'. However, by being transparent and by identifying the different lenses I am using, the reader has the opportunity to come to his/her own conclusions.

It is understood that the creative process of analysis is influenced and shaped by the researcher's orientation on what is studied and by her ability to make sense of available data (Munhall & Oiler Boyd, 1993). I anticipated that my compassion for survivors of sexual abuse would impact on my research. Special attention had been given in supervision to tracing the impact of my assumptions that might lead me to over-identify with the participants of my study. I therefore concentrated to my best abilities on being a researcher and not a psychotherapist.

My assumptions impacted on the study in all phases of the process. I started this research with the rather naïve expectation of being able to reveal a 'right way' of delivering mental health services for victims of sexual abuse. I immersed myself in literature about the injustice of social and cultural circumstances that lead to sexual abuse, and of the impact globalisation has on social policies. However, the more I researched the more I became aware of the complexities of social life and the obstacles

governments and services face in developing policies that do justice to all members of society, and the obstacles survivors face in accessing and utilising the services available. My assumptions about the injustice of mental health services, policy makers, and ACC, as well as strong convictions about survivors' treatment needs underwent a radical transformation over the years.

The writing of the study has been a long journey of hard work and personal growth that crisscrossed through the emotional landscapes of excitement, fatigue, hopelessness, stubbornness, and determination. I had to get it 'right' and my frustration grew when I was told there was 'too much of this, or too little of that', and re-writing or editing was needed. I believed that I should have been told what the 'right way' was and that I did not get the help I needed. Only much later was I able to notice the parallel process between me writing this study and survivors recovering from sexual abuse. The 'helpful' interventions, for example encouragement and support gave me the energy to continue. Nonetheless, the perceived 'unhelpful' interventions, for example being told to re-write or re-think a chapter, offered me the opportunity to improve and strengthen my argument. I came to understand that I needed to balance the 'helpful' and 'unhelpful', the emotional support and care as well as the challenge, for my identity as a researching psychotherapist to develop and grow.

Rather than just adding new information to my knowledge base, the PhD journey became a journey of personal growth. Values and beliefs I had held for many years needed to be re-evaluated, discarded, or updated. Rather than repeating what I have learnt I had to integrate the new knowledge, digest it, make it mine, stand by it. Understanding became standing under what I had learnt and holding it up high.

The Research Process

The research process started with the development of the research question, the research proposal, and the application for ethical approval for the study from the Ethics Committee of the Auckland University of Technology and from the Health and Disability Ethics Committees, Northern X Regional Ethics Committee. Ethical approval was given on 10th December 2003 (Appendix A). Prior to applying for ethical approval consultation with the Māori Representative form the Auckland University of Technology had taken place to make sure the research is consistent with the provisions of the Treaty of Waitangi. Appendix (L) describes how these provisions were observed.

Developing the Research Question

The initial focus was on the power inequalities between ACC and survivors and was formulated as “The interplay between policy, provision of mental health services, and the consumer: Survivors of trauma and ACC”. This focus changed over time through reviewing the literature of the wider context of recovery from sexual abuse. The excerpt of my memo from 29 July 2003, figure 2, shows parts of this development. It also shows the strong assumption I held about ACC in the beginning, an assumption that underwent a remarkable shift by the time I completed the study.

Figure 2 Memo: Refining the Research Question, 29.7.03

The working title in my head is ‘how does ACC mess up the client? - I know there are a lot of presuppositions in that question: firstly clients are messed up – and...not all will be, and secondly that it is ACC who are doing the messing up.

I think it is important to limit the research to the severely disturbed/affected clients – recognising that many clients with less severe psychological damage ‘cruise’ through their therapy without much hassle. It becomes a problem when ACC is providing funding for serious mental health issues – and are they equipped to do so?

Is it the counselling services that shape clients’ wellbeing? I think ACC is also shaping the services. I don’t like the emphasis of the question to point away from ACC. Yet I also think...that ACC is shaped by wider social and economical factors.

Is the question becoming too big? Will I be able to address all the different aspects? Or will I focus on one area more deeply while only acknowledging other contributing factors? I want to avoid writing a study in the scope of “How to address world hunger” going on about the big and global without being able to be specific enough to be relevant and practical for people.

By the 3rd of December the Application for Ethical Approval was handed in with the research question finalised as “How is the recovery of victims of sexual abuse shaped by the services available?” and the focus had shifted away from ACC to all service providers involved in the recovery from sexual abuse.

The more my reading informed me about the scope of recovery and all the different factors that have an impact on the recovery from sexual abuse the more I felt the tension between ‘showing all that is relevant’ and the constriction of what is possible to address within the scope of this study. Once the philosophical framework was chosen I decided to make the interactions between survivors and service providers the focus of this study.

While I was looking at a number of well-known critical theorists I came across Axel Honneth and his recognition theory. Recognition theory immediately appealed to me because it spoke the language of psychodynamic understanding that good enough experiences are needed in early childhood for a person's successful journey through life. I could see that recognition theory had the conceptual power to guide the interpretation of conflicts experienced in close interpersonal relationships, with institutions and agencies (legal systems), and within the wider society. Most important for me, however, was that recognition theory provided a framework for explaining how conflicts in these three main areas harm a person's psychological well-being and development. I believed that these qualities made recognition theory suitable for explaining the impact services have on survivors and on the recovery from sexual abuse.

Sampling

After I had decided on the theoretical framework that underpins this study and the approval from the ethics committee had been given, I started planning for the collection of data. The initial plan was to conduct up to 20 semi-structured interviews (schedule Appendix K) with sexual abuse survivors with a history of sexual abuse and depending on the interviews to invite up to ten providers of sexual abuse services to participate.

I contacted 52 psychologists, psychotherapists, and counsellors in the wider Auckland area by mail in January 2004. Their addresses were taken from the membership list of the New Zealand Association of Psychotherapists and from my personal mail-out list. They were asked (Appendix B) to pass on the 'information sheet' (Appendix C) and the 'consent form' (Appendix D) to any client with a history of sexual abuse they considered suitable for this research. A further 55 letters with the same request went out in February 2004 to psychologists, psychotherapists, and counsellors taken from the ACC provider list for sexual abuse counselling services.

For inclusion in this study participants had to have experienced sexual abuse and counsellors needed to assess whether their clients were able to engage in the reflective interview process without the risk of being adversely affected by it. Excluded were clients who were in the active phase of trauma processing as defined by Herman's (1992) second stage of trauma treatment. No further inclusion or exclusion criteria have been made for this study.

Should participants identify any services as significant in shaping their recovery, the intention was to interview relevant services. After interviewing six participants

public mental health services, counsellors, and ACC had been mentioned by participants as influential for their recovery. The decision was then made to begin with the service provider interviews. Fifteen therapists with experiences in public mental health services and/or private practice were approached by mail and by phone with the request to participate as service providers in the research (Appendix F-J). They had not been connected to the participants.

The initial plan was to conduct semi-structured interviews (see schedule Appendix M) with service providers. After three interviews have been conducted it became apparent that providers introduced issues so distinct from survivors' data that it was decided in consultation with my supervisors to stop interviewing individual providers. The analysis of participants' data emphasised strongly the struggle they had with public services. It was then decided in November 2005 to seek ethical approval for conducting a focus group with service providers who were experienced in public and in private mental health settings.

Accessing Participants

Twelve survivors responded to my call for participation in this research project. Nine survivors were female Pakeha⁸, one a female Māori⁹, and two were male Pakeha. After consultation with one female survivor and her psychotherapist it was decided that participation in this research might be harmful due to the state of distress she was in when the interviews were to be conducted. One male Pakeha was excluded from the research because he had experienced physical abuse but no sexual abuse. The remaining ten survivors participated in this study project. Nine of them had experienced sexual abuse in their childhood. One participant had been sexually assaulted about two years prior to the start of this research. See appendix (N) for details of participating survivors.

Nine providers of counselling services expressed their interest in participating in this research. Two of those providers were unable to attend at the times scheduled for the interviews. Seven providers have been interviewed. Two attended individual interviews in 2004, one attended an individual interview in 2004 and participated in one of the focus groups in 2006, and four attended focus groups in 2006. All participating providers were female. Four providers worked in private psychotherapy practice as well as having current or past experience of working in the public mental health sector. Two

⁸ Pakeha is a Māori term used in New Zealand for white immigrants/residents/New Zealanders.

⁹ Maori are the indigenous people of New Zealand.

providers worked in private practice. One worked in private practice and had held a teaching position in a recognised counselling training program. There was therefore a variety of experiences the seven providers could draw on. See appendix (O) for details of participating service providers.

In 2005 I approached the ACC sensitive claims unit to inquire about the possibility of interviewing case managers. Participant information for service providers was included (Appendix F-J). I have been unable to interview ACC case managers but a senior manager from the sensitive claims unit was willing to answer some of my questions during a telephone conversation. The ACC manager has been included in the above list of participants.

In using the qualitative research method underpinned by critical theory the main sampling criteria is that rich data was aimed for that needed to be in depth from each participant. The sampling method for both survivor participants and service provider participants has been purposive (Baker, Wuest, & Stern, 1992). Purposive sampling describes the practice of selecting participants that are known to have or have had experiences that put them in the position to answer the research question.

Ethical Considerations

Studies that are conducted with human subjects have to comply with rigorous requirements for the protection of participants' rights. This is especially important if study participants are considered to be vulnerable, such as children or subjects experiencing mental or physical ill health (Polit & Hungler, 1991). The main considerations regarding participants' rights are briefly discussed here and a description is given of how these rights have been addressed in this study.

Do No Harm

A main concern for clinical practice and clinical research is participants' right not to be harmed (Polit & Hungler, 1991). Because survivors with a history of sexual abuse may still be vulnerable and struggle with psychiatric disturbances, I chose not to contact survivors directly. Instead I approached psychotherapists and counsellors with the request to identify survivors that, according to their judgement, may be advanced enough in their recovery that the research process would not harm them. I requested that participants had either finished their therapy or were in the terminating phase to ensure that they had worked through and / or gained enough distance from their traumatic past to minimise any possibility of re-traumatisation. Participating survivors

and service providers were informed about the availability of the Health Advocates Trust and received the Trust's contact telephone number should they have any queries or concerns regarding their participation in this research (see Appendix C,D,F,I).

Informed Consent

One of the mainstays of clinical studies is participants' right to informed consent. To meet the requirements for informed consent, full disclosure about the study process has to be given and the right to self-determination has to be assured (Polit & Hungler, 1991). Participating survivors in this study have been given the information material by their psychotherapist or counsellor and were able to make their decision within their own time. Participating service providers were given the information sheet directly.

The information material for both participating survivors and service providers gave clear details about the nature and the purpose of the study (Appendix C+F) prior to the commencement of the interviews. It was also pointed out that participants had the right to seek clarification about any aspect of the interview or the study before, during, or after the interviews.

Participating survivors and service providers were given information about how to contact the researcher should they wish to. It was also explained that informed consent would be an ongoing process and participants could re-decide and stop their participation in the study at any time. Such a provision takes into account the fact that the study process is difficult to anticipate, is ever changing, and might bring pleasant or unpleasant surprises for the participant (Munhall & Oiler Boyd, 1993).

The Right to Self-Determination

The right to self-determination is a cornerstone for informed consent. Honneth (1995b) explains that for subjects to be able to practice their rights they need to be given the opportunity to do so. For participants to be able to exercise their right to self-determination they need to be given sufficient information to fully understand what the study is about, whose interest is being served, and what their role in the study involves. To assure participants are given the opportunity to practice the right for self-determination participants need to be enabled to refuse participation at any point of the research process. This includes the right to stop at any point during the interview (Polit & Hungler, 1991).

Freedom from Coercion

Participants also have the right to freedom from coercion (Polit & Hungler, 1991). In this study this principle meant that participants who were victims of sexual abuse were not coerced to participate in the study. This was assured by having participants contacted by their therapist who had no personal gain or interest in them participating in this study. During interviewing, questions for survivors were made general with a broad focus, to enable participants to speak about any issues important to them. They were also invited to answer only those questions they felt comfortable with. When I noticed during the interviews that a participant was stirred up by a question or a topic he/she was talking about, I suggested a pause and inquired whether s/he was sure s/he wanted to continue.

Confidentiality

Confidentiality is a primary obligation in any research project. Participants have the right to anonymity and the right that their information be exclusively used for the proposed study (Polit & Hungler, 1991). To keep the confidentiality in my study I have asked participants to choose a pseudonym, which I would use when I referred to their responses. Audiotapes of the interviews and any demographic data of participants will be stored for 10 years at Auckland University of Technology in a locked facility. Any written material will only use the pseudonym of participants. Only my supervisors and I viewed any information given to me by the participants.

Data Collection

This study explores how services shape the recovery from sexual abuse. Because the request was that participants were in the end-phase of their therapy, the focus of data collection was participants' recollections about experiences in their near and/or distant past. Given that mainly historical data was to be collected, interviews of approximately 90 minutes length were conducted as the main source of data from individuals and the focus groups. They were audio taped and transcribed.

Interviewing Participating Survivors

Ten survivors were interviewed once and four of those were interviewed for a second time to further explore the shaping of recovery. These interviews were audio taped and later transcribed. My clinical background gave me the understanding that the establishment of trust and safety is pivotal in working with persons who have a history of interpersonal abuse. I considered it crucial to schedule enough time to establish rapport so that participating survivors were comfortable in expressing their thoughts and experiences about their recovery, and for the interview process to unfold safely. A posture of 'indwelling' was aimed for, in which the researcher can be "at one with the person under investigation, walking a mile in the other person's shoes, or understanding the person's point of view from an empathic rather than a sympathetic position" (Maykut & Morehouse, 1994, p. 25). To be able to spend an extended time period with the participants will often allow participants to volunteer more sensitive material and to become accustomed to the researcher, an important requirement of credibility (Krefting, 1991).

The survivors' interviews began with restating the aim of the research and the broad stated question "I would like you to tell me the story of your recovery, all the events and experiences that were important to you". Once participants started talking, they needed very little encouragement. On the contrary, the researcher had the impression participants were all too glad and willing to share their story. Initially, very little direction was given during the interviews apart from asking for clarification. As the study proceeded and the data of the first interviews was analysed, questions were used to expand on certain statements to explore an issue from a different angle. Such interview skills enhanced and supported the credibility of the research project (Krefting, 1991) and aided the process of comparative analysis of data, codes, and emerging concepts.

After initial analysis of these interviews I decided to interview participants again in 2005. I was able to contact four of the participating survivors and invited them to be interviewed for a second time. The aim was to clarify concepts and categories and to fill gaps that emerged from the first interviews. After interviewing four participants for the second time it was decided to stop further interviews of survivors because the questions that arose from the first interviews were answered and no new information had come forward. It was then decided, following discussion with my supervisors, to start interviewing service providers to also draw on their views of how services shape recovery from sexual abuse.

Interviewing Participating Service Providers

Three service providers were interviewed individually for approximately one hour. Although these interviews were audio taped two of the interviews were not audible due to a fault with the recording device. Thus a summary was made on the basis of recalling the interview. The service providers' interviews started with "I would like you to tell me about how you/your service shapes clients' recovery from sexual abuse, all the aspects in your day to day work with this client group that you consider important". It seemed that the individually interviewed provider participants struggled with answering the question, as is illustrated with the following excerpt from my research-journal, figure 3.

Figure 3 Field Notes 12.10.2004

FIELD NOTES OF INTERVIEW
I was struck by the fact that this experienced counsellor who is respected for providing good service for sexually abused clients, has difficulty in articulating the impact other services have on her and on her client. When I ask about "how the experience x has shaped her ability to work" she struggled for words and stayed mainly vague in her descriptions. Addressing the question from different angles did help marginally. Once I offered some concepts for her experience, she would acknowledge "Yes that's how it is, exactly".

The counsellor in the above field note had had a very hurtful experience with ACC (see page 213, Alexandra's quote) just a few days before the interview. When she talked about the impact that experience had on her she displayed similar symptoms to those clients display after being traumatised, for example difficulty talking about her experience, difficulty conveying the impact on her, and exhibiting signs of dissociation and/or numbness.

After the first three provider interviews I realised that they introduced new issues, for example professional supervision, workload, isolation, lack of support, vicarious traumatisation, and a case load with high proportion of trauma victims. These issues, although relevant for the provision of therapy for victims of sexual abuse, were so distinct from survivors' data that I felt they needed to be explored in further research that focuses on requirements for therapists to be effective in assisting recovery from sexual abuse.

The data from participating survivors showed the high value they put on support and care, a clear understanding of what recovery entailed, and the struggle they had with

public service providers. Therefore the decision was made in 2005 to recruit further service providers with experiences in both the private and public sector to deepen the understanding of survivors' data. The decision was made to use the format of focus groups, to expand and explore within a larger group questions based on the issues that have been raised by survivors. The Auckland Ethics Committee was approached again seeking approval for conducting focus groups with service providers. This approval was given on 29 November 2005 (Appendix E). I recruited another six individual providers.

Focus Group

Three service providers were interviewed in a focus group for approximately 90 minutes and this interview was audio taped and transcribed in the form of a summary memo. A further two service providers were interviewed in a focus group for one hour. During this interview I took notes and transcribed these later in the form of a summary memo. One service provider was interviewed by telephone conversation during which notes were taken. These were transcribed later in the form of a summary memo.

Focus groups as a qualitative research method have been increasingly used in the social sciences (Morgan, 1997). They are usually small groups of less than 12 participants in which the researcher provides the focus of the interview and the interactions of the group provide the data (Morgan, 1997). The key characteristic that distinguishes the focus group from group interviewing is the emphasis on the interactions between participants in the context of the topics that the researcher introduces. Group interviewing in contrast is interviewing several people at the same time and the main interaction is that participants respond to the researcher's questions.

The purpose of focus groups is to generate data about participants' attitudes, feelings, beliefs, experiences, reactions and to explore the degree to which participants agree on a certain topic (Morgan & Krueger, 1993). Focus groups have proven to be useful at different stages of a research project, for example in the explanatory stages to specify questions and guide the further path of a study or at the end to evaluate and assess findings that have been made. They have been used as the single method of research or to complement other methods such as individual interviewing (Krueger, 1988; Morgan, 1988).

I used the focus group in my research to explore service providers' view of the recovery process. For that purpose service providers were asked how they understand their role in the process of recovery from sexual abuse and to clarify how they perceived

that services shape the recovery from sexual abuse. Focus groups are ideally positioned to reveal the deeper structure of given issues through the interactions between participants who may offer multiple meanings and understandings during the interview (Lankshear, 1993). This was apparent in both focus groups. Participants took cues from each other and expanded on each others' concepts. That resulted in rich data about their role in assisting the recovery from sexual abuse.

Besides the usual limitations that are common to every research method there are some that are characteristic of focus groups. It has been noted that the researcher has less control over the data produced (Krueger, 1988; Morgan, 1988), and that participants may not be expressing their individual viewpoint when the consensus in the group is a different one. Also, the limited confidentiality may have influenced participants' answers because speaking in the group context is not providing the anonymity individual interviews may offer.

I wondered about this particular point in my experience with the two focus groups I conducted. I could imagine that psychotherapists may hesitate about expressing their individual view in front of others if that view did not confer with the 'politically correct' stance about sexual abuse or the ethical practice of psychotherapy. However, having conducted two separate focus groups and 4 individual interviews, I found that all these sources discussed similar issues of concern. This commonality suggests that the data reflects a position representative of a range of service providers who were psychotherapists or counsellors.

Data Analysis

Data analysis is described by Morse and Field (1995) as an active process in which theory emerges from data with active intellectual and creative participation of the researcher. This process calls for full immersion and familiarity with the data. Clarity about the data was sought through repetitive questioning and analysing by writing of memos, in discussions with supervisors, in looking at the existing literature, and in discussions with colleagues who work in the trauma field.

Processing the interviews showed that survivors felt hurt, blamed, shamed, and unworthy in response to some interactions with service providers. Their sense of self was diminished by these interactions they termed as 'unhelpful'. These interactions impacted on their self-understanding, on their being, and on how they defined themselves. The interviews also revealed interactions that were termed as 'helpful' and that had a positive impact on survivors' sense of self.

The data was explored sorting firstly by service provider categories and secondly by how they impacted on survivors' sense of self. This gave information about which self-relation (self-confidence, self-respect, self-esteem) was affected. The reverse path was taken as well. Interviewees' accounts of, for example, feeling belittled or not feeling treated like a responsible adult, gave information about which form of recognition (love, rights, or solidarity) was not given and/or expected to be given by survivors. Thus both a top-down and bottom-up strategy was used in the analysis of the data.

Wrestling with the Data

A difficulty in analysing the data was found in deciding whether incidents with service providers constitute a withholding of rights or a withholding of emotional support. Service providers could also be institutions when they act on behalf of the government and provide funding or treatment. They thereby become the enforcer of legal systems who can grant or withhold rights and interactions could be coded under legal recognition. Yet when survivors come into contact with service providers such as Work and Income Support New Zealand (WINZ) or ACC they deal with persons (staff) with whom survivors have some form of relationship. Thus emotional support or the withholding of emotional support extended within these relationships could also be coded under recognition through love.

I wrestled with the data and investigated the codes from various angles using Honneth's recognition theory. An example of 'wrestling with the data' and exploring coding possibilities is shown in table 9. The example demonstrates that interactions between people are very complex and may affect them on a number of psychological levels and coding under all three main categories 'Love', 'Rights', and 'Solidarity' could have made sense of the data. Not linking psychiatric disturbances to one's history of sexual abuse was finally coded under 'Rights' because the interaction took place in the context of legal systems rather than in intimate, primary relationships.

I searched through Honneth's articles and books but was unable to find guidance for how to deal with the 'grey' areas that indicate an overlap of the categories Love, Rights, and Solidarity. I concluded that recognition theory may need to be further developed in order to account for incidences in the health sector in which legal systems (recognition through granting of rights) may also be the source of direct care and support (recognition through love).

Table 7 Wrestling with Data

WRESTLING WITH DATA		
The node 'not linking' contained survivors' experiences Of not knowing that their problems may be linked to sexual abuse and service providers not asking about sexual abuse		
Possible Interpretations using Honneth: Lack of Recognition through either...		
- Love - Is it lack of care when	- Rights - Is it lack of cognitive respect when	- Solidarity - Is it lack of giving social esteem when
<p>...providers do not acknowledge whole person – including her history?</p> <p>...providers don't offer possible explanations for survivors, suffering?</p> <p>...providers treat symptoms and not possible underlying causes?</p> <p>...providers don't refer victims of sexual abuse for abuse focused therapy?</p>	<p>...providers treat survivors as mentally ill and not as victims of abuse?</p> <p>...providers don't give information about possible links between problems and sexual abuse and thereby hinder survivors from making informed decisions about their treatment?</p> <p>...providers hinder survivors from accessing ACC compensation and treatment?</p>	<p>...Providers don't acknowledge survivors' struggle with the legacies of sexual abuse?</p>

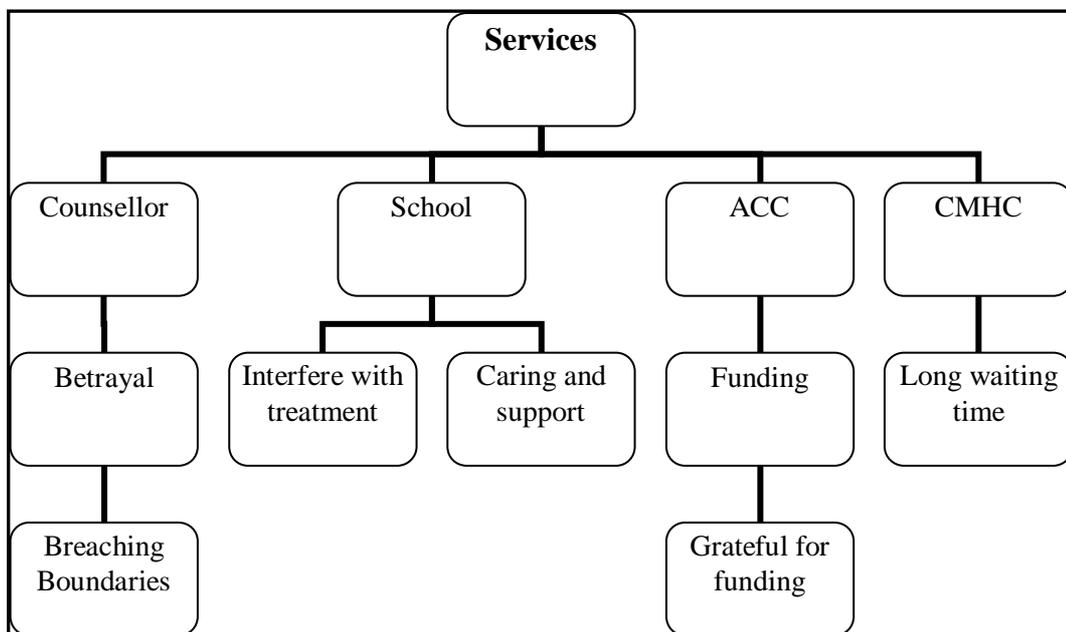
Coding Using NVivo

Data collection and data analysis went hand in hand. The analysis started immediately after conducting the first interview with substantive or initial coding. The transcribed interviews were examined line by line in order to discover the process expressed in the data (P. N. Stern, 1994). For the analysis of the transcribed interviews I used the computer software program NVivo 2.0. This program allows the researcher to handle rich text-based information and enables deep levels of analysis with linking, shaping, searching, and modelling.

Sentences or parts thereof were coded under child and parent nodes in a tree node system. A node is the result of categorizing statements made in the interviews (figure 4). A parent node is a higher level category whereas a child node is a sub-category of the parent node. A node tree was set up that had the main node categories of services (sentences in which services are mentioned by participants), shaping (access, interactions, attitudes, availability of services, abuse focus, communication, funding,

information, knowledge, policies, people skills, relationships, partnership, case management, and miscellaneous issues), issues (beliefs about services and about self, expectations, emotions, consequences), recovery (dimensions i.e. beginning, pre treatment, hard times, hindering recovery, helping recovery, and definition of recovery) client rights (entitlements, complaints, code of rights), wanting from services (staff with heart, trained staff, people oriented, respected, understanding, not pressured, time), aftermath of abuse (beliefs and messages that are legacies of sexual abuse), and participants'. The following figure 4 shows a small excerpt from the first node 'Services' after coding the first interview.

Figure 4 Example Node Tree



The first interview generated 170 different nodes in total. For ordering the data in this early stage of analysis I was informed by processes developed in grounded theory (Glaser & Strauss, 1967), for example open coding or fracturing the data into small analytic units, constant comparison of data, codes, and emerging concepts to define the parameters of categories used. Conceptualisation, the collapsing of categories, was delayed to avoid contamination of the data with preconceived ideas I might have and to make sure that important categories were not overlooked.

The coding of the first three interviews fractured the data into 257 different nodes. In the next stage these 257 different nodes were grouped using concepts from recognition theory using main nodes of 'Services, Disrespect, Recognition, Community, and Bonds of Love'. After three interviews I was left with a feeling of drowning in data.

The large amount of data, themes, and possible avenues to travel down, was overwhelming. At this point I started to compare substantive codes with each other to identify their similarities and their differences. That led to the next step. Nodes were collapsed or grouped together into larger categories by asking of each node what it was an example of. The aim was to reduce the number of codes and to explore the full range and scope of each category, their dimensions, and their relationship to other categories. It also increased my confidence in being able to manage the amount of data.

Psychological Processes and the Drama Triangle

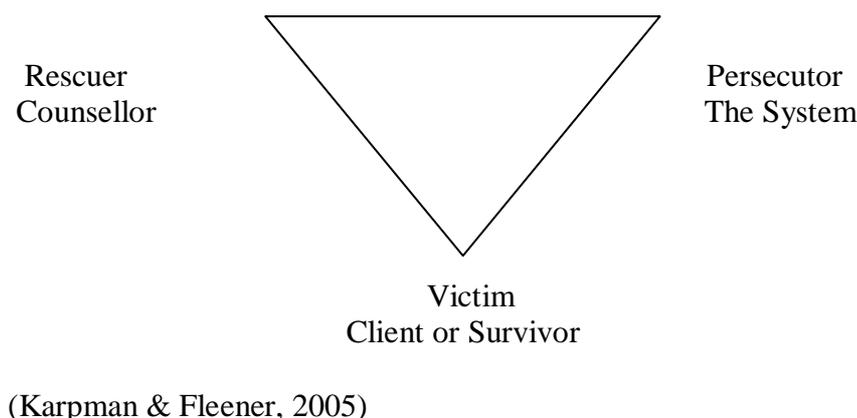
After all the survivors had been interviewed once, the data fell into two distinct good-bad polarities. Participants reported that their recovery has been shaped by acts of disrespect by services that were creating obstacles or even arrested their recovery (bad) and by providing recognition through emotional support that enabled them to overcome the obstacles and move towards recovery (good). I felt very dissatisfied with the simplistic black and white view and looked further. The following memo (figure 5) is a demonstration of a frequent struggle in the analysis of the data that I solved by using, in addition to recognition theory, psychological theories to arrive at a deeper understanding.

Jacob's 'fighting the system' through rebelliousness and criminal acting out gives him a focus for releasing his anger, but it keeps him from working through his pain and sexual abuse trauma. Thus 'fighting the system' protects his parents whose betrayal and abuse is unprocessed. He remains dependant on 'the system' and on his parents, which prevents him to achieve individualisation and autonomy. And although his anger at 'the system' may be justified, not shifting anger towards one's abuser(s) keep survivors of sexual abuse hostage to their past (Ross, 2000).

What would have happened if he had received recognition by social services when his parents were sent to jail? It is possible that his path would have been different and he might have become one of those 93% of survivors that cope with life without the help of agencies or services (see page 62). It is also possible that the abuse had already interfered at this point with his self-relations to the extent that he would have ended up at the same point he is now no matter how much help he received.

Figure 5 Memo: Analysis – The Drama Triangle

Once people engage with services and problems occur – either due to their own psychological problems or inadequate service provision or structure – we can often find a re-enactment of the drama triangle¹⁰). This is particularly demonstrated in Jacob’s interview. While he is absolutely furious with ‘the system’ and can not find much good to say about the government, agencies, health and mental health professionals, he is surprisingly quiet about the role his parents played in his life. He ascribes responsibility to himself and to ‘the system’ for not finishing school, becoming a criminal etc., but doesn’t mention that his parents were the perpetrators. This explains very clearly the trauma model¹¹, whereby the parents are kept free of blame in order to stay attachment-worthy and all his anger is either turned against himself or against the system. His counsellor is in danger to occupy the position of the rescuer.



This model (figure 5) shows clearly the danger that therapists may align or collude with clients as they vent their anger towards ‘the system’ or the other provider of services. It also showed me that I could, in the analysis of the data, be tempted to put ‘the system’ in the position of the persecutor that is responsible for the interactions of disrespect, the therapist in the position of the rescuer who provides interactions of recognition, and survivors in the position of the victim who had been unable to change their situation. I had to be vigilant not to act on the constant invitation by participants’ compelling stories of pain and trauma to re-enact the drama triangle and persecute ‘the system’.

My question of recognition theory as a model was how I could reflect the extent of survivors’ responsibility for the choices they make in their lives. That was possible once I started working with models and developed a model that incorporated mutual recognition. Now I was able to show that subjects will only receive recognition from persons or systems when subjects are able and/or willing to give recognition to them as well (Honneth, 1995b).

¹⁰ For a discussion of the Drama Triangle see pages 91-95, *Imagining the Other: Barriers to Inter-Professional Co-operation*

¹¹ For a discussion of the trauma model see pages 56-58, *Attachment Disturbances*

Although the data did not change in any significant way anymore I was for a long time undecided how to represent the different categories into a meaningful presentation of how services shape recovery. Sometimes codes seem to be too black and white and did not reflect the complexity of the incidents. An example is the participant who stated that she would have had a better life and would have cost the government less money if someone had asked her 20 years ago whether she had been sexually abused. I wondered whether not inquiring about abuse is an act of disrespect by the service provider. Who is responsible, the service provider or the survivor? Had services been offered and the survivor had been unable to take advantage of them? Did service providers lack in caring or was the survivor avoidant, in denial, or not ready for treatment? These and similar questions came up for me at many points of the analysis and caused a fair amount of creative impasse.

The therapist in me saw all the possible psychological dynamics of learnt helplessness and distorted cognitions, whereas the researcher needed to decide how to code the incident. I decided to code the incident as the health professional's failure to inquire about possible abuse or trauma in the person's past. However, examples such as this one also showed me the difficulty a study is faced with when data collection relies on the recall of survivors of sexual abuse. Without leaving the researcher 'hat' behind and slipping on the therapist's 'hat' during the interviews, it is impossible to ascertain to what extent the interviewee is aware of all the dynamics that led to not receiving services and to what extent their thinking may still be contaminated by abuse-based beliefs that may have prevented them to engage with services.

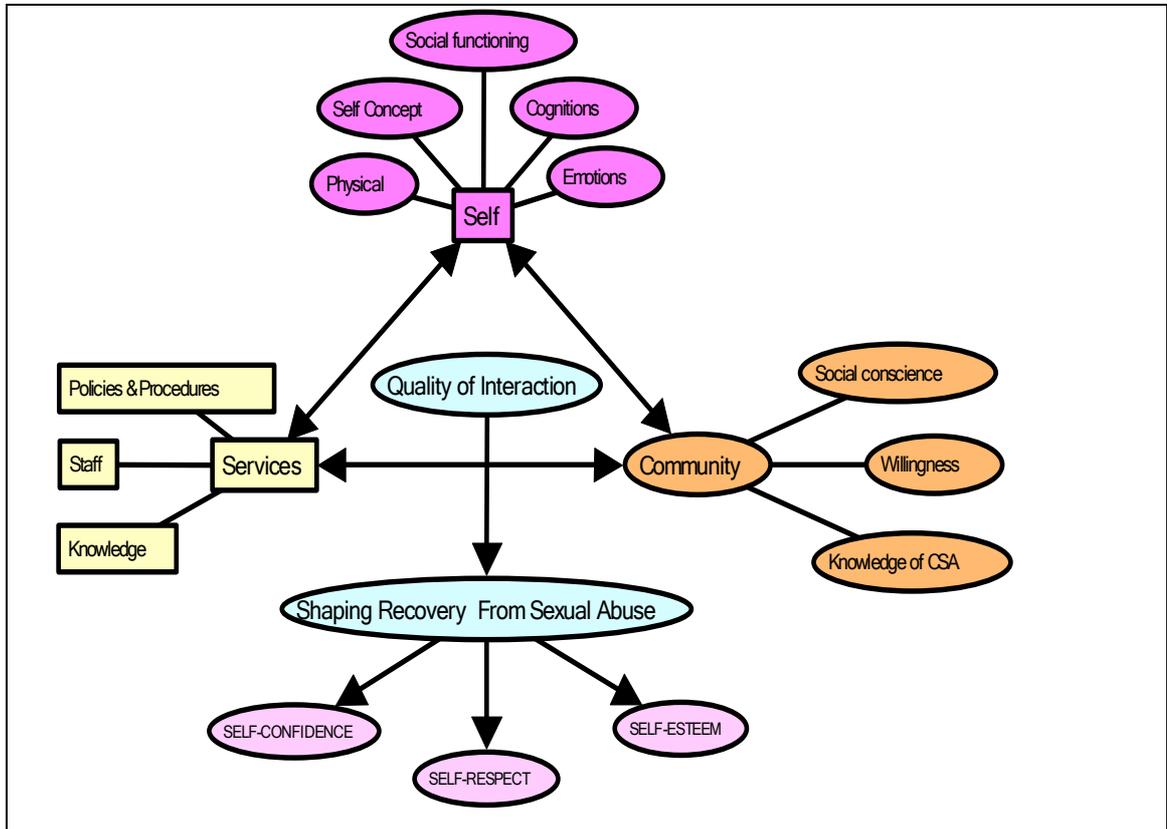
Working with Models

The use of models and diagrams helped greatly in analysing the data. Models were used for looking for connections, for indications of gaps that need to be filled, to indicate possible next steps, and for conceptualising and providing an overview over the large amount of data collected. Most of all, the models gave me an appreciation of the complexity of influences that determine the shaping of recovery.

Figure 6 shows how the analysis in the early stages focused on the influences that shape survivors, service providers, and the community in which they are both embedded in. Survivors, indicated by 'self' in figure 5, are influenced by the legacies of sexual abuse that are reflected in self concept, physical, emotional, cognitive, and social functioning. Service providers are influenced by the knowledge that guides their

practice, by staff qualities, and by policies and procedures. The community is influenced by willingness, knowledge about sexual abuse, and social conscience. The quality of the interaction between the three determines the shaping of recovery, which is reflected by self-esteem, self-confidence, and self-respect.

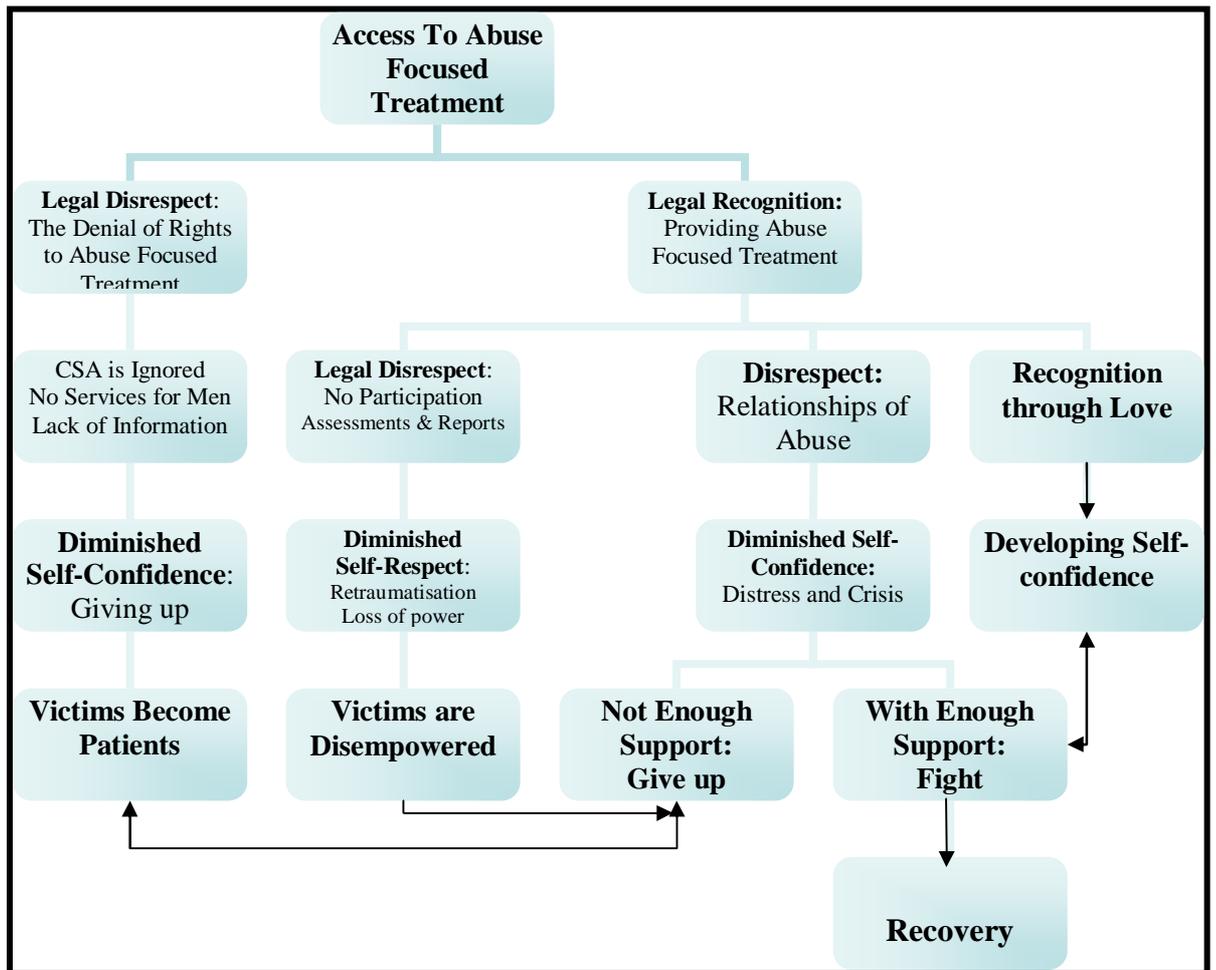
Figure 6 Process model 19.6.2005



The above model in figure 6 shows clearly the wide scope the research could take if all factors that contributed to recovery would be addressed and it emphasised the complexity of recovery from sexual abuse. However, the restrictions given by the parameters of the PhD study made it necessary to limit the scope of the analysis. While acknowledging the impact of influencing factors of all parties involved, survivors, service providers, and community, as a researcher I decided to restrict analysis to the interactions between service providers and survivors.

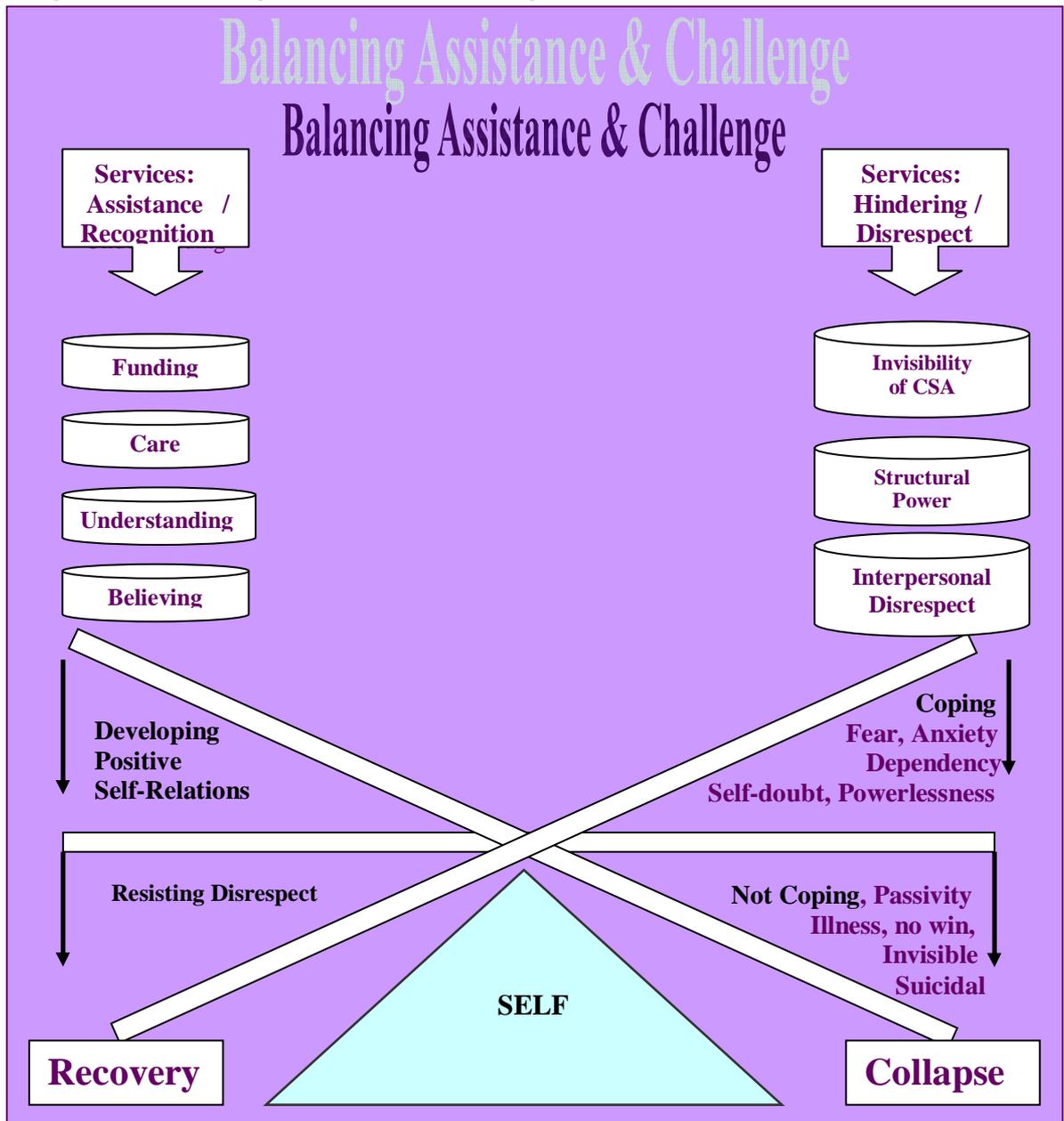
I have used several visual models at different stages of data analysis to improve my understanding of the data. The problem I faced was how to present the data in ways that do justice to the complexity and the non-linear process of the shaping of recovery. The following model in figure 7 demonstrates another step in the analytic process.

Figure 7 How Service Shape Recovery – 8.3.2006



The model in figure 7 showed already the impact disrespect and recognition have on survivors' self-confidence, self-respect, and self-esteem, but it lacked in detail and clarity. It did not show, for example, in which form disrespect was given and why it impacted on survivors' self-relations. What struck me with this model was that, for the first time, I could 'see' that recovery is connected with some form of fighting, and that the ability to fight was linked to receiving support. However, what it did not show was the positive impact of 'unhelpful' experiences through motivating survivors to engage in fighting for their rights. I also wanted to show the backwards and forwards movement of the recovery process, which did not show in figure 7. The following figure 8 demonstrates the next step in the analysis.

Figure 8 Balancing Assistance & Challenge – 26.11.2006



Although the model in figure 8 was an improvement from the previous one and showed a further step in the unpacking of the data, it lacked the sharpness to express the circular dynamics of recognition and disrespect, whereby for example the therapist being caring creates a chain-reaction of improvement in the survivor, respect towards the therapist, caring by the therapist, improvement. It was important for me to demonstrate within my model that survivors are not just passive recipients of care, but that they co-create the circumstances of the recovery process. Using the symbol of a scale to show the movement between helpful and unhelpful interactions was a successful step towards highlighting the non-linear and dynamic nature of the recovery process. I was satisfied that balancing the polarities of recognition and disrespect was the core of the recovery

process. Still, my concern was that interactions were still divided into good and bad and rather uni-directional from service providers towards survivors.

While I reviewed literature I discovered by chance an article about Cambodian refugees with treatment-resistant PTSD and panic attacks. In this article the researchers demonstrated their findings using a circular model that starts with a point of symptom inducing incident that leads to arousal, aggravation of several symptoms, to escalation and panic attacks (Hinton et al., 2005, p. 619). This model gave me the idea to present my data in a similar way. I knew I would need two circles to demonstrate the impact of both recognition and disrespect on the recovery process. I also saw an opportunity to incorporate the actions of survivors that contributed to the maintenance of the cycle of recognition or disrespect. This model is presented in the discussion chapter (page 222) as the final model that shows my understanding of how services impact on the recovery of victims of sexual abuse.

Trustworthiness of the Research

It has been mentioned that to do justice to qualitative research it has to be evaluated with criteria other than those for quantitative research (Guba & Lincoln, 1989; Krefting, 1991). They propose credibility, transferability, dependability, and confirmability as the four main criteria by which a qualitative study should be measured.

Credibility

Credibility of the study is ensured through knowledgeable use of the strategies inherent in qualitative research that allow for accurate representation of the experiences of participants. I have been familiar with qualitative research strategies as this has been my second large study project involving interviewing subjects and representing their experiences in the study's findings. I knew from my previous study that it was important to spend sufficient time with the participants, so that a dependable and reliable identification of the reappearing patterns could take place.

Credibility was also established by seeking feedback from peers and from participating survivors and service providers. In the early stages of the study the research methodology has been tested in a paper presentation that was given at the Annual National Conference of the New Zealand Association of Psychotherapists. The presentation with the title "Love – Rights – Solidarity" explored the usefulness of Honneth's recognition theory in the field of psychotherapy. The audience could relate to the three main categories and a lively discussion started about the ethical implications of

equality in the therapeutic process. One comment was made that psychotherapy is too much concerned with the personal inner world of clients and does not take enough consideration of social contexts and social responsibilities therapists have. Overall, the reactions from the audience were encouraging and supported the choice of theoretical underpinning for this study. Preliminary findings have also been presented and discussed in three research seminars organised by the Faculty of Health and Environmental Sciences at the Auckland University of Technology.

These presentations were very useful because they required me to clarify the preliminary findings and sharpen my thinking around concepts and consequences as well as taking in the questions and suggestions made by the audience. The process of presenting to audiences of peers was also useful in that it demonstrated to me where blind-spots were, as well as indicating directions for further analytic thinking.

At a later stage I presented the findings to participating survivors and service providers. Although both survivors and service providers were surprised with the finding that conflict and resisting conflict is necessary for recovery to take place, both groups were able to confirm that the process of recovery identified in this study fitted their own experiences. I have been given the same feedback by survivors with whom I had a conversation about my study and its findings and who were not participants in this study.

Transferability

Transferability of research findings is established when it is possible to transfer findings from one particular group of study participants to a different group of people with other particularities. For example, a question could be whether the findings of this study could be transferred to persons whose recovery from sexual abuse did not involve therapy or to children recovering from sexual abuse? Can findings be transferred to persons who recover from other stressful circumstances such as the effects of war, natural disaster, illness, and/or mental illness? To assist in this process the participants in this study are described in some detail so readers of this study may form their own conclusion about the relevance of the findings of this study to other groups or to themselves.

Dependability

The method of data gathering, analysis, and interpretation has been described in detail to provide an audit trail. Findings have been examined closely with the supervisors for this research to assure that the procedures have been followed and the findings represent

the data. The supervisors' familiarity and expert knowledge in the health and mental health field enhanced the quality of the research process and the data analysis.

Coding has been extensive and, as already described under the heading 'credibility', colleagues and peers have been consulted to review the findings and participating survivors and service participants have been contacted to assure that the findings represent their experiences of recovery from childhood sexual abuse. I am confident that the analysis in this study reflects participants' experiences and therefore the requirements for dependability have been observed and followed.

Confirmability

The research process has been outlined in detail in order to provide an audit trail, which is understood to be the major technique for establishing confirmability (Guba & Lincoln, 1989; Krefting, 1991). The reader can understand and follow the researcher's decisions so that another researcher could arrive at comparable conclusions given the same data and research context.

Conclusion

This chapter has introduced the researcher, outlined the motivation for conducting this research project, and drawn the link between the researcher's family history of socialist interest and choosing critical theory as a philosophical framework. The personal section ended with a discussion of how the personal biases have impacted on the study and how they have been considered in the analysis. The research process has been detailed step by step to demonstrate how the research developed. Measures that have been put into place to safeguard participants' right to give informed consent have been discussed. The section on data analysis provides an audit trail to enable the reader to follow the cognitive processes that led to the generation of the findings.

The following chapters are dedicated to the presentation of the findings of this research. Chapter Six gives an overview of the findings, presents participants' definition of recovery and presents those experiences that participants identified as being granted recognition.

CHAPTER SIX

RECOVERY AS THE PROCESS OF IDENTITY FORMATION

The journey of recovery for survivors participating in this study has been a journey of pain that over time became hope and towards the end turned into delight. Even though recovery was seen as a lifelong process, a significant milestone was achieved when coping without professional help became possible. It was for many a journey that departed from an experience of brokenness of the self to arrive at a sense of wholeness and peace with one's self. The recovery journey was a journey of transformation at the core of survivors' self-understanding, affecting their self-relations and identity.

How this transformation took place and how services shaped the recovery journey is explored in the following five chapters. Experiences survivors perceived as hindering recovery by initiating a cycle of disrespect are discussed in Chapter Seven as struggling with invisibility of sexual abuse in the public mental health system, in Chapter Eight as struggling with inequality in relationship with ACC, and in Chapter Nine as struggling with the lack of understanding. Chapter Ten discusses experiences survivors perceived as facilitating recovery by initiating a cycle of recognition.

This chapter is dedicated to introducing survivors' perception of what recovery meant for them, how they understood their recovery began, and how they knew recovery had taken place. An overview of this chapter's content is offered in table 10.

Table 8 Chapter Content: Recovery as the Process of Identity Formation

Recovery as the Process of Identity Formation
The Beginning: Self-Recognition
Survivors Define Recovery: The Journey of the Blossoming Self Self-Confidence Through Improvement of Symptoms Self-Confidence Through Improvement of Self-Perceptions and Cognitions Self-Confidence and Self Esteem Through Improvement of Social Functioning Self-Respect Through Improvement of Responsibility and Autonomy
Coping Without Professional Assistance

The Beginning: Self-Recognition

For the journey of recovery to begin participants¹² had to become aware that they had a problem for which help could be available rather than believing they were deficient, crazy, or just odd. The first step towards recovery was giving recognition to their need for care and approaching a health or mental health service provider for help. To do so implied that they gave empathy and care to themselves, even if that recognition through love was given only in its smallest measurement.

I think my recovery started when I first realized that I had a problem. I didn't even know I had a problem. And once I recognized that I did have a problem that started me on the way to recovery. (Helen)

Helen showed that participants had to realise their situation and value themselves enough to approach service providers for help to get their recovery on the way. Yet recognition of one's needs alone may not always have been enough to start recovery.

In knowing that you needed help! Well, knowing that life had to be different, and knowing that we¹³ couldn't live like we were. (Anna)

I think my recovery started the moment I survived, physically survived the rape. That was the same evening. One level of recovery had started then... Even though I had sort of to virtually split myself, for a long time I was very dissociated. But here was something in me enough, even though it was just a very thin thread that told me that I actually wanted to live. And I think that's what I mean that one level of recovery has started because that little thread was there and that kept me going. Yeah, I think actually that's when it started. (Johanna)

The will to live and to live a life worth living was equally important for recovery to start and had become for Anna and Johanna the motivational source to engage with service providers. This will is a reflection of the innate human drive to survive and to be whole, as described by Lewis and his colleagues (2001). Both Anna's and Johanna's account demonstrated how tentative their connection to life had become when their physical integrity was violated through the disrespect of being sexually abused. The damaging impact of sexual abuse is also mentioned by Honneth (1995b) who speaks of torture and rape as causing "a degree of humiliation that impacts more destructively than other forms of disrespect on a person's practical relation-to-self" (p. 132).

¹² The term 'participants' is used from here on for survivors of sexual abuse, who participated in this study.

¹³ Anna used both 'I' and 'we' when she referred to herself in the interviews. She had been diagnosed with Dissociative Identity Disorder (formerly Multiple Personality Disorder). Survivors with that diagnosis often use 'we' instead of 'I'.

I don't know where it came from. I don't know where it came from like give it another go. Because there was nothing left... And we did it again. We rang. We put ourselves out again, I don't know where from ... Do we want to do this again? Is it going to be the same old thing? (Anna)

For Anna the need to live and live in wellness was strong enough to overcome deep seated doubts she had after feeling abandoned and discarded by two previous therapists. It gave her the courage to approach another therapist. Marion described another road to recovery. After disappointing encounters with therapists she described as unhelpful, she embarked on helping herself and studied everything to do with sexual abuse and recovery.

So I think I have to stick to saying that I have read every single book that you can possibly buy. I have studied it, read internet, TV programs, I have done everything that I can do, that they recommend to do... So when saying that my treatment didn't really start until I met my present counsellor, I suppose with myself, I had come a long way. (Marion)

The above examples indicated that participants' recognition of their need for professional help was one pivotal aspect for their recovery to commence. They knew they needed something and they had the determination to look for a therapist who was able to meet that need, even though they may not have been able to name this need.

Survivors Define Recovery: The Journey of the Blossoming Self

In the course of the interviews participants shared their understanding of recovery. They described how they have been helped and supported by service providers in a variety of ways and how that help led to an improvement in their trauma response. The term trauma response is used in this study as the collective name for the commonly known legacies of sexual abuse survivors struggle with (Chapter Three, pages 32-53). They include symptoms, self-perceptions and cognitions along with social functioning the ability to be responsible and autonomous. Using Honneth's (1995b) recognition theory, improvements of symptoms, self-perceptions, and cognitions have been linked to the development of self-structures as described in Chapter Three (pages 44-47) and interpreted as evidence of the development of self-confidence through emotional support and care. Improvements in social functioning have been linked to development of self-confidence and self-esteem because they indicate the development of trust in oneself and others as well as social integration, which Honneth (1995b) assigns to recognition through love and through solidarity. Improvements in responsibility and autonomy have been linked to the development of self-respect because they indicate the

person’s willingness and ability to participate in society as full-fledged member with responsibilities and rights. Table 11 gives an overview of participants’ definition of recovery.

Table 9 Survivors Define Recovery

Survivors Define Recovery
Self-Confidence Through Improvement of Symptoms
Self-Confidence Through Improvement of Self-Perception & Cognition
Self-Confidence Self-Esteem Through Improvement of Social Functioning
Self-Respect Through Improvement of Responsibility & Autonomy

Self-Confidence Through Improvement of Symptoms

The symptoms commonly associated with the legacies of sexual abuse are for example impaired memory processes, impaired emotional regulation and distress tolerance skills, flashbacks, sleep disturbances, and heightened anxiety states. The improvement of these symptoms is understood in this study as leading to the development of self-confidence (table 11). From Honneth’s perspective it demonstrates that the person has been able to move from a rather chaotic internal state to a more balanced and quiet internal state with the help of emotional support and care. Participants saw evidence for progress in their recovery in their increased ability to deal with their emotional states and cope with the intrusive symptoms of post traumatic stress, for example flashbacks, hyper arousal, and hyper vigilance.

I am also starting to remember things. Times are a lot better now. I am putting things into better perspective. Whereas before it was like I shut dates and times and moments out and I actually got mixed up quite a lot with events, what time they took place. And now I am remembering because I want to. So it’s like I can put things in order. And that was part of how I got around things, I jumbled everything up. So the event that I thought was first was actually last. And stuff like that. Now I am actually going through everything to get a better timeline for my events and how they actually took place. So I can be a bit more precise about me. That is coming out of therapy. (Jacob)

Its many things. It's getting to a place where you can function without any problems...I am functioning at a level where you aren't abnormal, not being noticed for your oddities. (Anna)

Jacob mentioned that his inner world and his thought processes were now more organised and less chaotic whereas Anna rejoiced in feeling normal. Both experienced progress in their recovery when psychiatric symptoms lessened and they developed a more positive self-understanding. It allowed them to create a meaningful narrative about their lives, which Cozolino (2002) considers to be important for a coherent sense of self and for one's identity.

I think recovery for me has been to be able to identify what my body is picking up. Being able to listen to my body and respond in a healthy appropriate way. Keep myself safe or to soothe myself when I get distressed. To know where to go to for support. How to look after myself. How to avoid getting into situations where I could be at risk. Like being conscious of what are not safe situations. Being able to stand up for myself and assert myself, and also to protect others. And in particular children, if I see a situation, I like to be able to recognise that. And that is something that once upon a time, I wasn't clear about. And that is dangerous. But I am very clear now, very, very clear. And I have no problem advocating stuff like that. (Marama)

And I can handle quite a lot. I can handle my grief, which is still quite deep sometimes. And you know I am fine now. I know how to ride the ups and downs. And the ups and downs are small now... But I have got, I have got a lot of external and internal resources that I never had before. (Ruth)

Marama and Ruth had a sense of recovery when their psychiatric symptoms decreased and they were confident that they could respond appropriately in a variety of situations that involved strong feelings. Their affect regulation skills and distress tolerance skills have improved and they had more resources at their disposal. This gave them a basic trust in themselves and suggests a significant shift in their ability to exercise self-control. These indications of self-confidence imply the acquisition of self-resources that have been discussed in Chapter Three, pages 44-47 and by Honneth (1995b) as a result of receiving support, care, and age appropriate challenges.

Not until I started to see counsellor that I made any sort of connection whatsoever. And I can clearly see my patterns now...My recovery was a lessening of the panic attacks and having coping mechanisms, knowing that when I have panic attacks I am not going to die. And having had so many and getting over it. And just be able to cope with life. (Helen)

I would say it is the therapeutic relationship and the therapy that recovery has happened under. Instead of just feeling bad by not turning up to certain things I can actually face up to a number of things in a different way. And doing things in a different way. (Cassie)

A major point (of recovery) was when I started working with my counsellor. When the headless running around in different directions stopped and I was kind of getting myself into one direction that was useful. That would have been definitely the major point, where the more focused part of the recovery started... I didn't see myself as victim anymore. The times between panic attacks in public would have lengthened to at that point I didn't had any for about 4 or 5 months. I didn't have night mares anymore. (Johanna)

He (a friend) was pretty supportive but I didn't need him to help me recover. For me to recover I needed myself and the therapist to work together. (Jacob)

Closely linked to the improvement of symptoms and a sense of recovery was participants' relationship with their therapist. Jacob indicated that the support of his friend was important, however for his recovery he needed the therapeutic relationship and what this relationship had to offer. Therapy helped them to understand behavioural patterns, learning to handle situations more effectively that previously caused panic attacks or strong emotions, making connections between disabling symptoms and sexual abuse, and have a sense of direction. Participants' level of functioning increased and with it their sense of control and self-confidence. Following Honneth's (1995b) and Mead's (1934) understanding of identity formation, participants comments indicated that they were able to see themselves through the eyes of their caring therapist and reconcile the therapist's positive view of them with their own self-perception.

Participants mentioned that they knew that recovery was progressing when they noticed that the abuse history had lost its hold over them. In the past they may have been consumed by intrusive post traumatic symptoms such as flashbacks, nightmares, or overwhelming emotions. They had a sense of recovery when they noticed that they had been able to free themselves from the adverse affect of trauma.

Hm, probably the main thing that I noticed over the last few months is that I am not being ruled by the past. I don't have that at every thought or I don't have anymore triggers and anything more like that. I am coping better... And living a life where you know you can make choices and you are not being ruled by previous experiences. (Anna)

Yes absolutely. And I can think about my childhood and all sorts of things that happened and they are just things that happened. I don't get panicked or worried or stressed. I can say I am over it. (Helen)

I was actually looking forward to do things when I left the house. I would plan a future again. I was thinking of what areas of my life I would want to develop more to kind of build on that. Whereas before my focus had been on decreasing of frequency of panic attacks, getting myself out of bed in the morning, functioning as a mother. (Johanna)

Rather than being ruled by their past participants could now make choices based on experiences in the present and their focus could now turn towards the future and the things they wanted to achieve in life. Memories of the past had lost their significance. Just as Herman (1992) described, the incidences of abuse became just one aspect of participants' lives, and not even the most important one. Engaging in therapy has transformed memories of past abuse into 'just another memory' and future prospects started to hold more excitement and promise.

Improving the symptoms signified for all participants a noticeable reversal of the post traumatic legacies that are commonly observed in victims of sexual abuse. These legacies have been explored in Chapter Three (pages 43-50) as dysregulated neurobiological processes, attachment disturbances, and lack of social skills. In the past contaminated thought processes, intrusive symptoms and dysregulated affect have all had a disabling impact on participants. Recognition through love in the form of emotional support and care from their therapist enabled participants to regain a sense of control over themselves and their body. It allowed them to regain self-confidence and thereby contribute to the undoing of the harmful impact of sexual abuse.

Improving Self-Perceptions and Cognitions

Participants made the strongest link between recovery and their ability to see themselves in an increasingly positive light. Their self-perceptions improved and cognitions that were contaminated by the abuse had been revised (table 11). Improving self-perceptions and cognitions are understood in this study as a result of emotional support and care that led to self-confidence. These improvements reflected participants' underlying trust in themselves and confidence that their social environment will meet their emotional and physical needs, which Honneth (1995b) connects with self-confidence.

That all aspects of myself as in the big *SELF* can blossom. That I am capable of realising my potential in all of these areas, just like I have been before. (Johanna)

Oh my god, who was that person. I don't recognise that person at all any more. No. And I am very much more at ease with myself. But though the last four and a half years haven't been easy, it certainly has been a huge turning point. (Anna)

Yeah. With recovery I wanted to feel good about me. To feel changed. Let's say, instead of putting myself down all the time ... recovery for me was just to handle my emotions, to put things better into perspective, and to just, to know me better. And just operate normally. (Jacob)

For participants the outcome of their recovery journey was their restored sense of self-confidence that allowed them to feel good about themselves. For Anna this process was so fundamental that she found it very difficult to identify with the person she was before she embarked on the journey of recovery. Recovery became noticeable by the transformation from the traumatised, negative sense of self to the establishment of a positive sense of identity.

That I like myself. I think to be able to feel that I have as much right as everybody else to say what I want to say, do what I want to do. That if I am in a situation where maybe I am put down or something by somebody, which happens, that I can keep that in perspective, of that is an isolated incident and doesn't necessarily mean that I am a crap person. That I can retain some self-esteem and belief actually that I am an alright person. Not blindly alright, you know, not I am perfect I have no faults. But even with those I am actually as good as anybody else. (Cassie)

Because I actually feel ok enough and healed enough to function peacefully. And I mean I am very happy. I am very, I like who I am, who I have become. I am very confident. (Marama)

Restored self-confidence was reflected in participants' ability to like themselves and to cope with put-downs without the collapse of their identity. The development of self-confidence was reflected in participants' conviction that they could handle their life, that they had re-established a basic trust in themselves, and that they were able to express their needs and wants without fears or anxieties.

Improving Social Functioning

Improving social functioning is understood in this study as a property of self-esteem in Honneth's (1995b) sense as it represents survivors' ability to see their mode of life, their manners, and their beliefs as having positive significance within their community.

The biggest thing for me is that I can go to places socially and work and everywhere I go, I feel that I do fit now. And that I am not broken and that people don't see me broken anymore. And know I can slot into almost any

situation and feel confident enough to pass so to speak. That's a cool feeling.
(Anna)

I (feared) I was always going to be that person living at the bottom of the scale of life and drinking and drugging it out. Just having no life... Recovery for me would be being able to operate with Jo-public, get out and about, do things on my own with happiness. I didn't have many people in my outside life. That is changing now, but before I started therapy I really didn't have many people around me. (Jacob)

Anna and Jacob described how their sense of recovery was linked with noticing an improvement of their social functioning. When they were able to move away from isolation and towards feeling connected to others their quality of life improved. Honneth (1995b) describes subjects' need to be esteemed in a community that shares the same values with the concept of solidarity, which, according to him, is a pre-condition for developing self-esteem.

I would have never done stuff that I am doing now, one day I am at athletics, next I am talking to school teachers, parent interviews, none of that would have been possible. I go to 'Pack and Save' every day, take the kids with me if they want to come. That would just never have happened...I know now that I am capable of things. ... It's like I am out there now willing to try things to feel what would be me. .. Now all these other things, doors are opening up ... I know that at the end of the day I am not going to be packing cans. (Jacob)

...on Saturday night I went to the concert in the park and for a variety of reasons I chose to go on my own. And I did that about 7 years ago and I remember feeling utterly bereft standing in a park full of people and thinking there is not one person who really knows or cares about you at the moment. And on Saturday night I was dancing around and I was walking along the paths and I was absolutely fine being alone, because I knew I had friends. (Sheryl)

Once participants experienced recognition in the form of emotional support and care, their self-confidence grew. This enabled them to try out new ways of behaving, to engage more with people, and gave them the opportunity to feel valued by their peers. Jacob's example shows how his self-confidence grew when he took more responsibility at home and did volunteer work at school and in the athletics club. It helped him to feel recognised by others and his self-esteem increased. Honneth (1995b) states that a person's social worth or standing in the community is very much linked to what he or she can achieve and how useful one's abilities or traits are for "shared praxis" (p. 129). Other participants had similar experiences. Through engaging more with people they experienced being accepted and valued. Thus their self-esteem grew when they felt they fitted in their social environment.

I understand people better. I can actually empathise with people some of the time...I definitely relate to people better, absolutely. And a lot of that comes out my therapist listening to me ad nauseum, other people listening to me in the group, or me listening to them. I find now rather than making snap judgements I am actually listening to what somebody else has to say. I can even quite like them if they say things I don't like. Or things I don't agree with. I can talk to people better. (Helen)

Significant for Helen's recovery was the development of social skills and the increase in her social functioning. Recovery for her showed in developing understanding and empathy for others, even if she did not always agree with their point of view. Honneth (1995b) asserts that important for the building of self-esteem is the ability to have social relations in which the parties esteem each other symmetrically. He sees that as the reciprocal valuing, liking, tolerating, and understanding of one another in one's unique and individual traits, views, or abilities.

Improving Responsibility & Autonomy

Being responsible for making decisions about one's own life and being autonomous is understood in this study as a property of self-respect in Honneth's (1995b) sense, because being morally responsible, being able to participate in important decision making, and having rights and the ability to exercise these rights are all aspects of being a citizen who is equal to others. These qualities all lead to having self-respect.

No being reliant on others, on the state. Doing daily things without any ... (hick-ups) panned out fantastically. Because here I am, four and a bits year later, and we are working full time. Living on our own, we are independent of everything. We can do pretty much everything. (Anna)

Anna has moved from being constantly in crisis, being unable to work, being dependent on high dosages of medication, and feeling unable to survive without therapy, to being able to live without assistance from the government or mental health professionals. The newly gained sense of independence and autonomy indicated to her that she had succeeded in her recovery.

Because it wasn't that I just wanted to be rid of the nightmares and the flashbacks and depression and forcing myself to get out of the house and all of that. I was more than that. That was not how I functioned before. I functioned before as a capable and intelligent person who was happy with her children, who has managed very well with her separation. That's what I was before. And I think to be able to make a full contribution again to our society, that's what full recovery is about. (Johanna)

Johanna explained that for her recovery was more than getting rid of disabling symptoms. Her expectation of recovery was to re-connect with the person she was before the abuse and regain the sense of control she used to have. She recalled how well she functioned prior to being sexually abused, how capable she was, and how positive she felt about herself as a mother and a member of society. Recovery for Johanna was reflected in regaining a sense of autonomy.

I know a shit load about boundaries and how to put them in place, and I feel satisfied and in control. That's it. Absolutely, that's the word that describes it. I am absolutely in control of myself. (Marama)

What I think today has an effect on my future. And I actually really like that feeling of having that control. (Anna)

Being responsible and autonomous meant for Marama and Anna being in control of their inner states and all other aspects of their lives. This notion was shared by other participants as well. Being able to direct their lives away from interferences of the past, of restricting governmental requirements for treatment funding, and of needing to rely on a mental health professional for functioning gave participants a sense of control. This allowed them to respect themselves as fully functioning members of society who were able to make a contribution to society.

Coping Without Professional Assistance

All participants had a clear understanding of the recovery process that began with them realising they needed help and finding a therapist to connect with. They identified recovery as an ongoing process that did not have a certain end but was rather a life-long process. However, there came a time when participants were able to cope without professional assistance (table 10, p. 112).

(I am) Near the end of the course so to speak. I think recovery goes on for ever. Because I also deal with how it impacted on my personality, so yeah, that goes on and on. (June)

I finished my work with my therapist. I think I have always work to do, but I think I need to do it with other people in different settings. I don't think it will ever end. I think it comes in different levels. You know, it's like a spiral, and I just get to the same stuff but at a different level... The shame and things still cycle through occasionally. I suppose at the beginning I had this great idea I would be fixed. (Ruth)

Whereas on one level participants perceived recovery as a life-long process, on another level there was a clear indication that participants knew when they had reached a point in their recovery when they no longer needed assistance from mental health

professionals. Both June and Ruth knew they needed to apply the skills they had acquired in therapy outside of the therapeutic setting for their recovery to progress.

As far as full recovery goes, I don't know whether there is such a thing. It is something that I am never really sure what it is that I am hoping I am ending up like. And I don't think that is something that ever stops. But, I tend to think well, what will I be like? I guess a sense of 'I am OK' is probably the biggest thing out of all of that. (Cassie)

Cassie expressed her awareness that memories, feelings, and other legacies of the historical abuse may never completely disappear but might surface again in the time ahead. Herman (1992) explains that through the processing of traumatic memories the abuse history will have no greater significance than other life events and becomes part of the person's narrative about herself. Being able to feel good about themselves and being able to function in normal day to day activities was a main indicator for all participants that they had progressed enough in their recovery to stop with therapy.

So I have never missed a session when I wanted it. Whereas now the need (for therapy) seems to recede. I don't need it. (Jacob)

So we reached a mutual place the therapist and I where we said this is, now is the time. You know, you've got your wings now, go and fly. And, you know, initially that was, holy shit, but it's been great going out into the real world and testing everything. (Anna)

I had the sense that I was OK enough to go. There was nothing more that I wanted to do. My relationship was the healthiest it had ever been. I felt contained, I felt safe... I didn't need, I literally did not need to come into sessions. I am sure, I could have stayed in therapy for another ten years, but it was like I was OK, I was functioning extremely well. (Marama)

Jacob, Anna, and Marama pointed out how their need for the protective environment of therapy subsided. Instead they wanted to test their ability to function independently, even if that notion caused some anxiety. Another indicator that assistance from mental health professionals was no longer required for recovery was the sense that life waited for them to be lived and therapy was getting in the way of doing so.

But one of the things I always remembered, when I went to the group and I asked how do I know when I don't need to come anymore? I have been told, when there is something that you rather do than come here. And I always remember that. And it got to that point... I found there wasn't the compulsion to go. There were other things that I really wanted to do. And I knew that I could cope if I did those other things and didn't go to therapy. (Helen)

Helen mentioned that she came to a point where she wanted to do other things with her life then going to therapy. This was representative of other participants' experience. Their self-confidence had developed to such an extent that staying dependent on therapy and therapists was rather hindering than facilitating recovery.

All six participants, who had completed therapy by the time the interviews were conducted, initiated the termination of their therapy themselves once they felt they were able to function without professional help. The need to be autonomous and self-reliant was stronger than the need to be taken care of by society, by ACC, or by therapists.

I know I am coming near the end. Or at least not have therapy for a while. I come to another point like, you know, I am getting out of this group because I want to do life. (June)

While participants have been involved in regular therapy their recovery had taken precedence over all other areas in their lives. Once recovery progressed and their need for assistance lessened regular therapy became a disruption to life rather than an enhancement. Participants knew it was time to stop therapy. For their self-confidence, self-respect, and self-esteem to be maintained and grow they now needed and wanted to rely on their own resources and continue the recovery process by themselves.

Conclusion

The recovery from sexual abuse has been explored in this chapter as the process of identity formation by using the lens of recognition theory. This process only started once participants were able to care enough about themselves to approach health or mental health professionals in their search for help. Participants clarified in the interviews that their main concern was the recovery and/or development of those aspects of their self-relations and their identity that had been harmed through sexual abuse.

It has been shown that recovery is more than the absence of symptoms. Although the absence of symptoms indicated to participants that the recovery process was on its way, more important was that they felt good about themselves as persons. They noticed improvements in their symptoms and in their self-perceptions. Using recognition theory, this is explained with an increase of participants' self-confidence. Participants had a sense of self-responsibility and autonomy when they felt they had control over their lives and were able to function without the assistance of the

government or mental health professionals. The improvement of their overall functioning resulted in a sense of self-respect, self-confidence, and self-esteem. Participants were able to re-connect with their community and started seeing themselves as valued members of society. The social skills they have gained enabled them to make new social connections which facilitated the development of self-esteem.

According to Honneth (1995b) recognition theory explains processes of social groups rather than complex developmental processes of individuals. This has certainly been a limitation in this study, as explained in more detail in Chapter Twelve under limitations. However, by using inductive and deductive analysis this limitation has been largely overcome.

The next chapter discusses how participants struggled with the invisibility of sexual abuse when they had contact with public mental health services prior to engaging in ACC funded, abuse-focused therapy.

CHAPTER SEVEN

STRUGGLING WITH INVISIBILITY OF SEXUAL ABUSE

For participants the journey of recovery began with the realisation that they needed help and many initially approached public mental health services. Although they struggled with a wide range of psychiatric disturbances, participants often did not know that their problems were related to experiences of sexual abuse in their past. Instead they thought their problems were due to something that was organically wrong with their mind, something they did wrongly, or they thought wrongly. Not knowing that sexual abuse could have caused the psychiatric disturbances they experienced, they also did not know how to ask for abuse-specific help. This chapter explores how participants struggled with public mental health services. Participants' lack of understanding the origins of their problems was compounded by public mental health services' lack of addressing and processing sexual abuse as a cause of psychiatric disturbances. Table 12 provides an overview of this chapter's content.

Table 10 Chapter Content: Struggling with Invisibility of Sexual Abuse

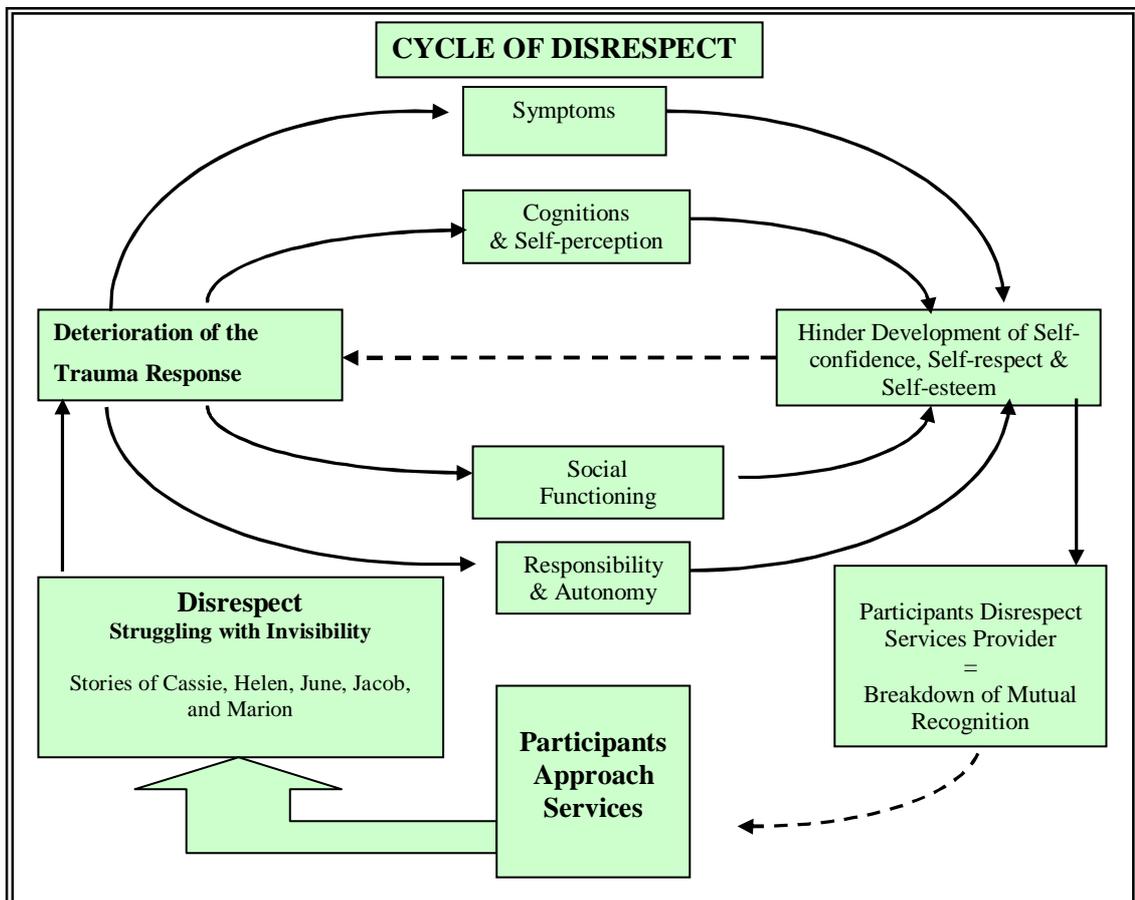
Struggling with Invisibility of Sexual Abuse
Cassie's Story: Feeling Crazy
Helen's Story: Living with Anxiety
June's Story: Lost Years
Jacob's Story: Becoming a Criminal
Marion's Story: Illness and Hopelessness

This chapter demonstrates with the following stories of Cassie, Helen, June, Jacob, and Marion how the recovery from sexual abuse has been severely threatened by public mental health services keeping sexual abuse invisible. The examples will show that participants have not been given recognition through love in the form of emotional

support and care because they did not receive the treatment they needed for symptom reduction.

Instead participants experienced disrespect in the form of the denial of rights. By not being informed that their psychiatric disturbances may have been a result of sexual abuse, participants were denied the right to give informed consent to their treatment, to make an informed choice between using public mental health services or ACC funded therapy, and the right to access ACC compensation for the damage sexual abuse has caused. Helen reported that she was coerced to comply with drug treatments which took away her right to participate in relevant treatment decisions, and Jacob was denied access to social resources that would allow him a minimum standard of living. Being denied these rights led to an escalation of participants' trauma response. Their symptoms, self-perception and cognition, social functioning, and self-responsibility and autonomy declined. This hindered the development of self-confidence, self-respect, and self-esteem, culminating in the breakdown of mutual recognition and the perpetuating cycle of disrespect (figure 9).

Figure 9 Cycle of Disrespect: Struggling with Invisibility of CSA



Honneth (1995b) states that in order to obtain existing rights subjects need to have the means and be given the opportunities to practise the rights legal systems are granting them. Survivors of sexual abuse were denied to obtain the existing right to apply for ACC funding and compensation by the invisibility of sexual abuse by public mental health service providers. The following examples show how prior to engaging in ACC funded abuse-focused therapy participants instead struggled for many years with feeling crazy (Cassie), living with anxiety (Helen), lost years (June), becoming a criminal (Jacob), and illness and hopelessness (Marion). These examples have been chosen because these participants had extended years of dealing with the public mental health system without having their sexual abuse history addressed.

Cassie's Story: Feeling Crazy

Cassie struggled since early adolescents with psychiatric symptoms such as depression, self-harming behaviours, and suicide attempts. Yet, she had not had the awareness or the understanding that her disturbances were linked to her history of being subjected to sexual abuse.

I didn't come out and say hey, I've been sexually abused. That was something that I just took into myself and figured I was just screwed up. You know, that was just me. (Cassie)

Cassie grew up in the 1960s before the feminist movement had pushed the issue of domestic violence and sexual abuse into the public arena. Until then sexual abuse was not discussed in the media but remained a problem individuals struggled with privately. Without being able to link 'being screwed up' to the historical experience of sexual abuse, Cassie saw herself as defective and was unable to convey her treatment needs effectively. This was re-enforced by her doctor's dismissive response to her suicide attempt.

...when I cut my wrist the doctor I was seeing at the time said "Now that was stupid, wasn't it?" and that was the end of it. So there was never any follow through with it. And I mean, I was only 15 or something at that point. And I was too shy and too scared to say anything or try and take it any further.

When Cassie's doctor did not enquire after the reasons for her suicide attempt and called her action stupid, she had not enough self-confidence to take the initiative to explain her action or disclose the abuse by a family member. Not being able to link her distress to the experience of sexual abuse, she did not know the questions to ask that would give her access to professional help. For the following years her doctor's

misrecognition kept her from seeking professional help and led to an escalation of her response to trauma and self-debilitating behaviours.

I had several wrist cuttings and OD's and so on, none of which were bad enough that I was hospitalised or anything. I mean, I never went to the doctor once for a cut. It never came up for me, no matter how bad it was, to see somebody for help with that. I looked after things myself...I never took enough ... it sort of was more of a cry for help. It wasn't a suicide attempt. Although it was, I never knew enough to know how much was required. (Cassie)

This changed a few years later when Cassie developed a severe eating disorder. Again she sought the help of health professionals.

It was about 1984. I became anorexic. And so I was going for treatment ...for the anorexia...I had to fill in a questionnaire about things. By that stage I pretty much knew that a lot of my problems were related to my abuse. And I never talked to anybody about it before. And I just thought, I am going to put it here and just let them...., because I can't do anything. I need somebody else to do something here and help me out. So, without going into a blow by blow account I wrote on this thing that I've been abused by various people, and, ahm, they never took it anywhere. They just carried on with the eating stuff. And I was thinking it's got to be related. Surely that is what we really should be talking about. And they never did. The hospital people never ever took it any further, (Cassie)

After years of passivity Cassie finally found the courage to disclose on the hospital's intake questionnaire that she had been sexually abused. She had hoped that the health professionals would be able to address the sexual abuse during the family meetings they organised. Cassie believed that she was unable to confront her family by herself. Yet her disclosure was not acknowledged at all by the clinical personnel. Instead the focus of the consultations was limited to her disordered eating.

Foucault (2003) asserted that mental health professionals observed, measured, and categorised the visible symptoms, while the symptoms' intensions and the secrets of the causal links were kept invisible. This reductionist view of professionals in the public mental health system allowed for the injustice of sexual abuse to go unrecognised. Cassie's sexual abuse history remained invisible. Honneth (2001) conceptualises invisibility as a social interaction mediated through language and gestures that excludes subjects from being socially integrated. He defines social integration "...as the result of processes of recognition through which subjects are normatively incorporated into society by learning to see themselves as recognised with respect to certain characteristics" (p. 249). The consequences for Cassie were extensive.

...I often came away from the hospital after having been there for ... I think I've been there for 5 months. And at the end of that time I just said I'm not going. I just stop going. It's a waste of time. They are not helping. Nothing is changing. I

don't feel any different. I just won't go anymore...It never seemed to get better, so I totally went the other way. It was just up yours, I don't want to know. I am out of here. In so many respects it not only killed my faith in God it killed my faith in anything improving or getting better. (Cassie)

After months of treatment without making any progress Cassie left the treatment without expressing her disappointment with the hospital team or trying to express her needs more clearly. The disrespect of sexual abuse and years of disrespect through misrecognition by health professionals had silenced her. In return, Cassie had lost all faith and respect in mental health professionals and mutual recognition had broken down (figure 9, page 127). The outcome of the perpetuating cycle of disrespect was a halt in Cassie's recovery.

The common practice of public mental health services to keep sexual abuse invisible is explained through the long history of the medical model (Botella, 1999), the lack of understanding of sexual abuse, the lack of training/education specific to sexual abuse (Cusack, Frueh, & Brady, 2004), and a combination of personal and organisational issues (Lothian & Read, 2002; Wells, 2004). Without receiving recognition of her abuse history by health professionals, Cassie struggled for years.

I mean there were various coping mechanisms that I used. One of them was bulimia, and after my anorexia (I swung to) sort of like anorexic, bulimic, anorexic, bulimic. And the bulimia was sitting there for a long time and then I would have anorexia again. So that was one way.

In the following twenty years Cassie used various coping mechanisms to get by. She understands now after years of therapy that swinging between bulimia and anorexia was her way of coping with the legacies of sexual abuse. Studies suggest strong links between a history of sexual abuse, illnesses, and the use of medical services (Arnow, 2004; Arnow et al., 1999; Kolk, 1994; Kolk, McFarlane, & Hart, 1996; Rothschild, 2000). However, it is impossible to assert that keeping sexual abuse invisible causes serious illness. Yet some writers suggest that the self, deprived of recognition and emotional support, finds through illness a way to ensure that some care is received (Herman, 1992; Rothschild, 2000).

When I was overseas, while things were new and different it was like I am focusing on everything is fine... Then when things start to get not so good I'd go somewhere else...and I am thinking things are getting on top of me and my job is getting me and I can't cope. I would go for six months to Africa because that was something new and different. And then it was like, ok, I go back to England for a while. So every time things got on top of me I'll swap the country. Because as long as things were changing and were different I guess I could put my reason for not having a partner down to being moving because I am travelling. Because

that (not having a partner) was always the thing that got me into the hole.
(Cassie)

With constantly moving between England, Africa, and New Zealand Cassie could find something new and different to distract herself from her problems. She stated in the interview that only after returning to New Zealand and after two failed relationships did she approach the public mental health services again in her quest for help.

I did the initial interview with the person over the phone...He probed whether there was sexual abuse involved and him saying to me 'do you know that you could get funded or subsidised'? That was like a lightning bolt to me. It was like how come nobody ever told me this. You know I was at the eating disorder clinic, I had in desperation when I first got there written out everything. And they knew that. How come nobody there ever said to me, you know, you can get funding for this, you could get counselling. And then when I went to the therapist I ended up with, he charged me full price for the whole time. He never said anything about it either. I mean, how come these people don't tell you. It's this whole 'don't tell her'. It's like some big conspiracy. (Cassie)

Cassie was distressed when she learnt she could have had abuse focused therapy to advance her recovery instead of struggling for over 20 years with disabling psychiatric symptoms. She perceived the silence around sexual abuse and ACC funding as a conspiracy. With the benefit of hindsight, Cassie grieved for time and opportunities lost, for avenues that were not explored, and for financial losses she had.

Yet, 25 years ago the law changes that provided for ACC funding for sexual abuse therapy had just come into effect. More importantly, sexual abuse was just beginning to be discussed both in public and amongst health professionals as a significant cause of mental health problems. The awareness of sexual abuse and the impact it has on a person was in the early stages and could not be compared to today's context.

Helen's Story: Living with Anxiety

Helen grew up in a family environment where child abuse, alcohol and drug abuse were the norm rather than the exception. A succession of violent men stayed with them and, as a result, Helen and her siblings all have different fathers.

I mean our family was involved in a lot of alcohol and as years went by with drugs and, you know, not a lot of nice things. So agencies of any kind were not welcome in our home. And we grew up saying nothing to anybody. And if anybody approached the house, it was 'keep your mouth shut'. And everybody kept their mouth shut. Like, although, we got beaten up and stuff like that, we weren't frightened of getting beaten up. That wasn't it. What we knew was when to keep our mouth shut and when not. There wasn't any reason for agencies to come to the house, because nobody ever said anything. I certainly never said

anything. Not ever. Nobody said anything, nobody went anywhere. And we, we didn't talk to anybody, because there was nothing wrong. Everything was perfectly normal. (Helen)

Helen described that it was not the fear for punishment that kept her from telling the authorities about the circumstances at home. She had already internalised her family's ways of living with violence and abuse as normal and had learnt to keep quiet about them. By the time she had reached adulthood she knew not to talk about her problems but 'get on with it'.

A common theme from interviews was that participants did not link their psychiatric disturbances to their history of sexual abuse. That lack of linking and childhood conditioning of silence and passivity affected their initial encounters with mental health professionals. This passivity, widely discussed in the literature as a common phenomenon frequently observed in victims of interpersonal violence (Herman, 1992; Kolk, 1989; Myhrvold, 2006), may prevent individuals from being effective in seeking professional help and from protecting him or herself from possible future emotional, physical, or sexual attacks (Herman, 1992; Jurist, 1994; Kolk, 1989). Helen gives an example of not being effective in seeking professional help.

It began, with what I recognise now as panic attacks. But I didn't know then. I thought I was really sick. And, you know, it took a long time. It was not just a few days. It took months, probably even years. It just got to the stage where I couldn't leave the house. And I got really, really ill... I couldn't go out, I've got headaches, and I started vomiting. All sorts of things! ...I was also what I see now as really depressed, and I was crying all the time. I was functioning very, very well during the day, with six children, sick father in law... And I said I just can't do this. I can't do this. And I would collapse. I would get unconscious in the bathroom and wake up in the early hours in the morning. (Helen)

Helen grappled for many years with what she now understands were panic attacks. These attacks manifested over time and increased in the severity of the accompanying, physical symptoms. Although she saw a doctor during those years, she was only treated for the variety of symptoms she struggled with. Neither Helen nor her doctor made any connection with possible past abuse. The lack of recognition of sexual abuse by Helen and her doctor has caused a continuing escalation of her trauma response in the form of anxiety attacks and the somatic symptoms she experienced.

Not at that time. I never really thought about it. It never occurred to me. I had no idea. The past and sexual abuse had nothing to do with my life. I have never thought about it. (Helen)

Six of the ten participating survivors did not link their psychiatric disturbances to their history of sexual abuse. They were unaware of the significant role sexual abuse

had in their psychiatric disturbances. It did not occur to participants to talk about their past abuse. They had to wait until they met a health professional who identified their psychiatric disturbances as a possible legacy of sexual abuse and asked them whether they had experienced such abuse.

Helen was 44 years old when her doctor suspected an anxiety disorder and sent her to a clinic that specialised in anxiety disorders. Prior to this referral Helen reported that, although she had periods where she had been 'OK', she also had years where she suffered terribly.

The psychiatrist said to me, is there any history of sexual abuse. And I said yes, and he said can you be more specific, and I said no, not right now. Because I didn't want to talk about what happened then, so I said no, not right now. And nobody ever asked me again. It never got mentioned again, you know. They concentrated on panic attacks, and nobody ever asked. So I just never brought it up, I never thought about it. (Helen)

Like Cassie, Helen had mentioned that she had been sexually abused during her initial interview and the subsequent treatment she received did not take any notice of her abuse history. It focused solely on managing the symptoms of anxiety. Helen's response 'I never thought about it' indicates that she relied on the health professionals to point out the relevance of her sexual abuse history. When that did not happen, she did not think that the abuse was relevant for her treatment.

And I just sat there. I didn't do anything. I did their housework. I cleaned the rooms. I just did that. And they had groups. And you got to see a psychiatrist ever now and again one-on-one, and sexual abuse didn't even come into it... I honestly don't know what it did for me. But I know that I felt comforted by being there during the day...the fact that they weren't freaked out when I have a panic attack... and they dealt with the panic attack, not with why it happened...It's just a panic attack and it will pass. And there is no need for me to explain it all...I think they helped me to control them better...but I don't think I would recommend for somebody to go there, if they really need help. (Helen)

Helen reported that she benefited to some extent from having her anxiety attacks normalised and from learning how to manage the attacks more effectively. However, these attacks did not stop and it took another seven years of struggle until Helen's doctor inquired about the possibility of past sexual abuse and referred her to a therapist who provided abuse-focused therapy. It had taken Helen a long time to accept that her panic attacks and other problems may be linked to her experiences of sexual abuse.

Recognising the sexual abuse thing didn't come until probably about just a few weeks before I first saw my counsellor...Even when we first got into the sexual abuse thing I felt, no, because I always had a problem with people blaming the past all the time. This is your life now. Just get on with it, you know. I can see

now how people are shaken by their past. But I always thought people were making excuses for themselves. (Helen)

The lack of public education about the effects of sexual abuse, childhood conditioning of being silenced, and the misrecognition by health professionals over more than thirty years have contributed to the vicious circle of keeping sexual abuse invisible. Not being fully informed about her condition and the possible causes led over time to an escalation of Helen's trauma response, especially her symptoms and self-perception and cognitions. The cycle of disrespect (figure 9, page 127) initiated by the public mental health service's denial of Helen's right to full information about her condition was maintained by Helen's disappointment about the lack of improvement in the wake of which she became dismissive and disrespectful of the service.

June's Story: Lost Years

June's story very much echoed what has been described by Cassie, Helen, and others. She too struggled for years with 'not feeling right' and having overwhelming urges to harm herself.

Once, when I was in town, I think I just had my second child, and was walking across the Grafton Bridge, and the urge to jump off was so overwhelmingly strong. I walked down town to where my Auntie worked at Lifeline. I walked in there and said I have got to talk to somebody. And I had no idea what that was. (June)

June knew she needed help, but she had no idea what sort of help that had to be. Like other participants she did not link the psychiatric disturbances to the history of sexual abuse. It therefore did not occur to her to disclose this particular part of her history. She was completely unaware of the impact of sexual abuse on her social, psychological, and cognitive functioning.

I never forgot about the sexual abuse. I always remembered it, always in the greatest detail. But I couldn't see the relation between that and my flaws. I thought I had problems because I hadn't worked hard enough, I hadn't been good enough, I hadn't prayed hard enough. I hadn't anything enough. (June)

Without being able to link her problems to the experiences of sexual abuse June, like other participants, perceived her problems as a flaw in her personality. Her self-perception and cognitions were contaminated by the experiences of abuse. June's lack of awareness was re-enforced by health and mental health services that did not pursue taking a detailed personal history that included incidences of abuse.

I always think, if somebody had asked me the right questions, when they put me in the bin (psychiatric ward), you know, 25 years ago. And paid the money and

got it done then, I would have had a better life. So the longer I lived without it, the more it cost the government. (June)

June was bitter that the 'right' questions had not been asked when she stayed in the psychiatric ward of a hospital. It took her another 25 years of struggling with psychiatric disturbances until one doctor inquired after experiences of sexual abuse. Only then had she been informed about ACC funding for abuse focused treatment.

The examples of June, Helen, and Cassie show that the invisibility of sexual abuse in public mental health services can have severe consequences for survivors. It could cause survivors of sexual abuse years of suffering psychiatric disturbances that, with receiving abuse-focused treatment, would not have been necessary. It indicates that the denial of survivors' right to be fully informed about their condition and available treatments led to the cycle of disrespect (figure 9, page 127) in which mutual recognition had broken down and participants' trauma response had escalated and their recovery was hindered.

Jacob's Story: Becoming a Criminal

Jacob's childhood has been a continuous experience of physical, emotional, and sexual abuse. His parents used him and his sisters in their private brothel until they were arrested and sent to jail when he was about 15 years old.

I was hoping that there was something out there when my parents first went to jail when I was 15 or 16, that I could get help from the government for this or that. I tried to. I didn't try to get help for the mental side of it. Back then it was more financial and educational side. But there was none...The first two years when they first went away, I had two attempts to suicide, I felt not needed or wanted, and nobody cared about you. Society certainly didn't! ...you look at other people and talk to other people, everything got me down, the system got me down, because, there is nothing there for me. (Jacob)

Jacob described his struggle after his parents had been sent to jail. Although this meant the abuse had stopped, he now was left without support of an extended family or a place to stay. He had nobody to turn to who would take care of him or guide his actions. He received no recognition for his need for social and financial assistance and became hopeless and suicidal.

I think I was nearly 16, because that's why social welfare then said, you know, we are not going to pay for your School C. You are nearly 16 you can get a job. That's what they said to me. So I had to leave school before I actually finished that year. And that was the year when I was going to finish my school C, but so it couldn't happen and it didn't happen...she (his younger sister) was sent to Bollard, a home for problem children. They live in a house, they get schooling, whatever. They get counselling or psychotherapy help or what ever. (Jacob)

Jacob reported with bitterness that he was sent out into the world to fend for himself while his sister had been helped after their parents had been sent to jail. She had been sent to a home for problem children, was housed, clothed, fed, had schooling, and received counselling. He tried to get financial support from social welfare to finish his schooling and pay for boarding accommodation and food. However, these efforts were unsuccessful. The denial of his right to access social resources in the form of financial assistance or benefit opened the door for a life at the fringe of society.

I didn't really look after myself or coped at all. I did things that would take my mind off the chaos that was created by people not being there, the government or the system just wasn't there for me. So I just felt betrayed and I just felt that I could do what I wanted to do and didn't care about the law. Because it wasn't there for me, so why should I abide by it? So that was the early days of thinking...I drank, drank and drive, just did the things that I did, you know. Let off shotguns, because hey, I could. Even if the law said I couldn't. When was the law there for me?

Jacob described how he sank slowly into a life of drinking, drinking and driving, petty crimes, and later on robbery and drug dealing. He felt ignored by the legal institutions and rebelled against this by ignoring the laws that guide social life.

Jacob's example shows the tragic effects of being caught in the perpetuating cycle of disrespect. In contrast to his sister who received help from social welfare, he felt disrespected through the denial of his right for assistance. He took that as permission to disrespect the laws society is guided by. The breakdown of mutual recognition led to the accumulation of several criminal convictions that, as he explained in the interview, are still affecting him to this day, by for example limiting his career choices.

...Yeah, but I felt I was forced onto it just to survive in the beginning, because I had no money from social welfare. They told me to get a job. I still needed a place to live which I didn't have. I had to really get a job, because living under the bridge wasn't good...Oh, I'd say (I lived under the bridge for) six month. It probably was more like three, when I think about it, but it seemed like an awful long time day by day, when that was happening in your life...

You just fight back. It just wasn't right. I didn't like it and fought back by drinking booze. And to get the money for it I had to be a thief. And later on that wasn't enough because it was too complicated so I sold drugs. And then my criminal record was getting bigger and bigger because I was just drinking and driving and did silly things. (Jacob)

Jacob spent many years being angry with the system. He believed that he should have been helped when his parents were sent to jail. Marginalised and without a voice he became involved with drugs, alcohol, and robbery and accumulated a number of

criminal convictions. Being recognised as a criminal appeared to have been more tolerable for Jacob than being treated as socially invisible and being ignored by social institutions for his specific needs as a survivor of sexual abuse.

Being denied the right for social assistance led, in Jacob's case, to an escalation of self-debilitating behaviours. His recovery and the development of self-confidence, self-respect, and self-esteem was not hindered, it was not even given a chance to start. Honneth (1995b, p. 136) states that the absence of recognition "...would open up a psychological gap within one's personality, into which negative emotional reactions such as shame or rage could step". Without the emotional support of a caring and/or therapeutic relationship Jacobs' rage was turned towards the external world. Unfortunately, Jacob's story is not so unusual. Studies (Boles, 2005) have pointed out that in many instances a history of sexual abuse coincides, especially amongst males, with an increase of criminal activities.

The only help you had was when you had an alcohol problem or ...when you went to court and got done for. Then they sent you of to, ah, what was that place called? Ah, fancy forgetting that, because I went to that several times... Yeah, that's it, it was the probation office. That was about the only help that you could receive. Even when the signs were there that you are a repeat offender on whatever you were doing, alcohol or drugs or whatever. But it was like they never put it together, that, hey, that person might need help. Let's give him counselling. (Jacob)

Jacob reported that he had dealings with a wide range of services such as his school, social welfare, the police, and the courts. Yet he felt that none of the services even attempted helping him to deal with the legacies of sexual abuse. Similar to the mental health system in the previous examples from June, Helen, and Cassie, sexual abuse was ignored by the legal system. With the benefits of hindsight Jacob indicated that counselling might have helped him to leave the criminal path and get his life back on track. However, the judicial system traditionally rectifies transgressions of law with punishment instead of counselling or therapy. The outcome for Jacob was that for many years he did not receive abuse-focused treatment and emotional support and care. He explained that it took him over ten years before he engaged with mental health services for therapy. He had been told about ACC assistance for sexual abuse counselling and was searching for a counsellor. However, he had to learn that finding help was not easy for men.

So, that made me even bitterer towards men and women, because I thought it was a bit unfair that there were places for women and not men. To actually find counselling for me was hard...there was plenty for women but not for men. So I sort of found it hard to get into wanting to help myself at the beginning, because

there were no places out there for men... I think back then, it was like no, it didn't happen to men. And I think everyone's' attitude back then was hey, it doesn't happen, you are lying. (Jacob)

Jacob found that most services were offered for women and he could not find a counsellor who was willing or able to work with him until much later. He was marginalised by stereotyping that saw only females as victims of sexual abuse.

I wanted to be a scientist or somebody in that sort of field. So when you are young and your teenage life is based on that sort of dream, and all comes crashing around you don't really feel like getting off your arse and doing everything a normal person would...If that had panned out back then, I would be somewhere else, instead of trying to get to that other place now. It's like I wasted so many of my years like 18 to 20 years at least have easily been wasted. And it's hard to try to get back that time for me...What's the point. (Jacob)

Jacob saw all his dreams falling apart. He pointed to the social institutions that have denied him recognition of his needs as a young, male victim of sexual abuse and denied him the right to vital help at a time when his future wellbeing was at stake. He was bitter, discouraged, and could not see a point in trying to make something out of his life.

Honneth (1995b) asserts that human integrity is linked with patterns of approval and recognition because of our dependence on others for the forming of positive self-relations. Jacob's experiences are a fitting example of Honneth's thesis that experiences of injustice and disrespect, such as misrecognition through invisibility, can bring a person's identity to a collapse. Services shaped Jacob's recovery by denying him the right to access means for basic living and the right to treatment for the legacies of sexual abuse. A cycle of disrespect (figure 9, page 127) was established that led to the escalation of his self-debilitating behaviours. This diminished his self-relations and prevented recovery to commence.

Marion's Story: Illness and Hopelessness

Marion felt hopeless about the many times she reached out for help and was disappointed. Staying alive became hard work, having to combat feeling rejected, abandoned, and not helped.

There were so many times where it would have been so much easier not to be alive, especially when you go and try to get help...and the people that are supposedly there to help you or the people that you have been directed to, they don't help. Then it's like, well, what am I bothering for? ...you can go through really tough times...I didn't feel I got anywhere with her. I would walk out the door and just think, ha, just wasted another hour. That's how I felt...Yeah. I just felt let down and I just, the whole system I couldn't be bothered with. (Marion)

The lack of effective emotional support and care had a similar effect on her as it had on other participants. Worn down by the disappointments they gave up pursuing their recovery for some years. Being denied recognition through love in the form of emotional support and care Marion was trapped in the cycle of disrespect (figure 9, page 127). She responded to the lack of recognition with disrespecting services and turning away from continuing to seek help. Mutual recognition had broken down. That led to an escalation of her somatic symptoms and self-debilitating behaviours and halted her recovery for many years.

So, I lived, yes I lived for 38 years. But, they haven't, there hasn't been a lot of joy ... Which I put down to I had those problems because I kept everything bottled up. You can't keep it bottled up. And that was why I went when I was 16 to get help, because I didn't want them to be bottled up. I didn't get what I wanted... It [cancer] is not in the family. The doctors were quite mystified, especially at my age. But, and it is quite ironic that the two cancers came out in cervix and breast. I mean, how clever is the brain? (Marion)

Marion understood her struggle with cancer as her body's self-destructive response to her inability to process the emotional pain whenever she approached health professionals for help. Although Marion took responsibility for 'bottling up' her feelings, she implied that she might not have had cancer had she received due recognition and emotionally supportive treatment for dealing with the sexual abuse experiences.

Helen, Cassie, and Marion have experienced years of debilitating illness which they blamed on their history of abuse and the many unsuccessful attempts to get help. This hypothesis is supported by Boscorini (2004) who identified a strong connection between the experiences of trauma, including sexual abuse, and the occurrence of a wide range of physical conditions such as cardiovascular disease, diabetes, gastrointestinal disease, fibromyalgia, chronic fatigue syndrome, musculoskeletal disorders, and other diseases.

Marion's suspicion that her cancer could be connected to the abuse and her inability to process her experiences is echoed by health professionals (Hay, 1999; Heard, 2004) who believe body and mind are linked and affect each other. Hay and Heard are just two of the practitioners who contend that "every cell within your body responds to every single thought you think and every word you speak. Continuous modes of thinking and speaking produce body behaviours and postures and eases or diseases" (Heard, 2004, p. 1) Hay (1999) who explores alternative healing solutions outside of conventional medical practices suggest that cancer is associated with a

person's deep hurt, longstanding resentment, and the harbouring deep secrets of grief that are eating away at the self.

Conclusion

This chapter has described participants' experiences with public mental health services. It came into view that policies and procedures shaped by ideological alignment with the medical model and by limited funding, did not meet the treatment needs of participants. They were treated for symptoms while their history of sexual abuse remained invisible. The disrespect reflected in not attending to participants' traumatic experiences and merely treating symptoms resulted in an escalation of their trauma responses. Although not inquiring about a history of sexual abuse may be common practice for which health professionals in the public mental health services have a number of rationalisations, this practice turned out to be costly and damaging for participants' positive self-relations and identity.

In hindsight participants perceived this as an injustice that denied them access to their consumer right of informed consent. They were not fully informed about their condition and the possible causes which hindered them to make an informed decision about their treatment. The invisibility of sexual abuse also denied participants the opportunity to make an informed choice between using public mental health services or ACC funded therapy and withheld access to ACC compensation for the damage sexual abuse had caused. Instead participants had been treated over many years in the public mental health system for any number of psychiatric disabilities without any or only little progress made. They felt hopeless and discouraged about their struggle, the lack of progress, and their frequent disappointments.

Even though participants' interactions with public mental health services show the asymmetrical power distribution and inequality between service provider and survivors, their main concern was not this inequality but the invisibility of their sexual abuse history. Inequality became participants' main concern in their interactions with ACC. The next chapter discusses how participants struggled with the inequality and the lack of power and control they perceived as they engaged with ACC for funding for their abuse-focused therapy.

CHAPTER EIGHT

STRUGGLING WITH INEQUALITY: SURVIVORS' RELATIONSHIPS WITH ACC

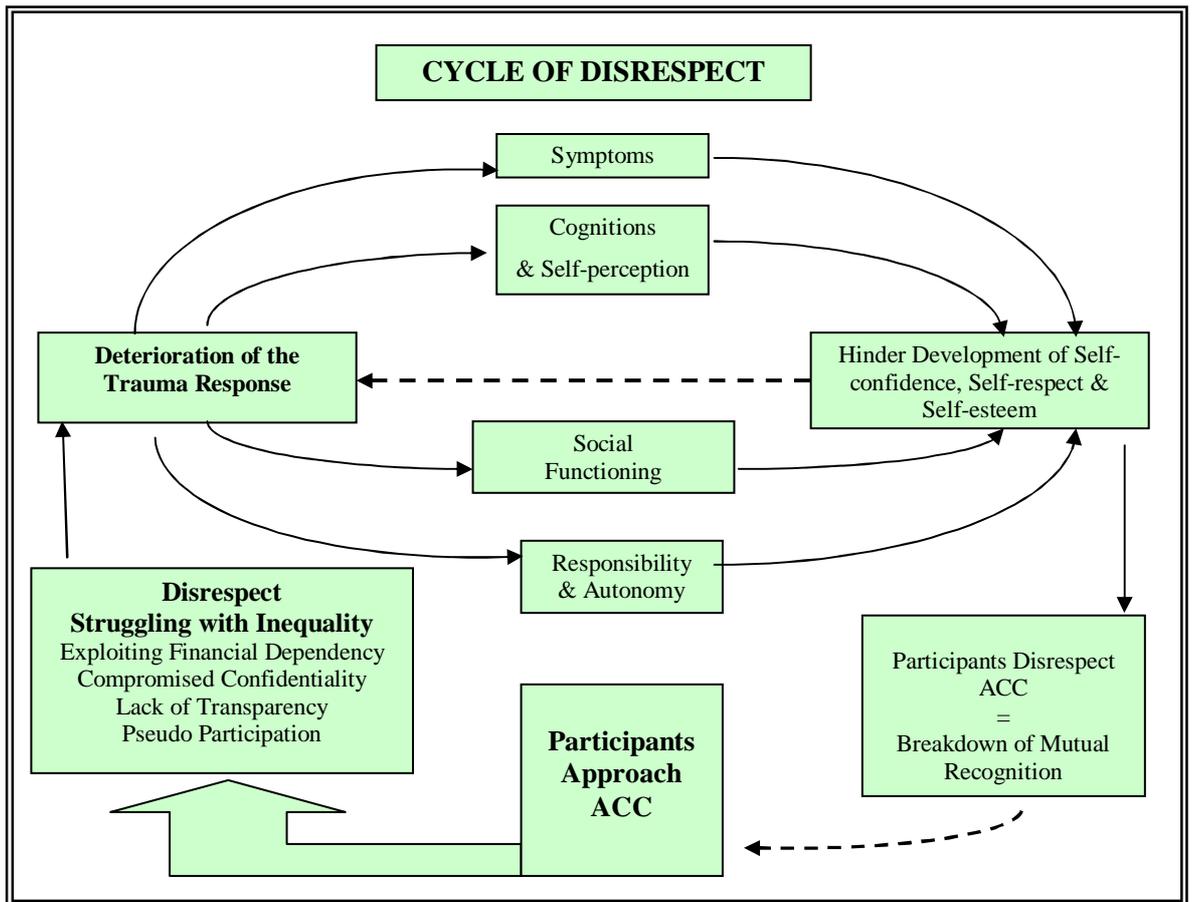
When participants had been informed that they might be eligible to receive abuse focused therapy funded through ACC they felt great relief. The treatment they had received from public mental health services had not resulted in improvements of their psychiatric disturbances and their financial circumstances did not allow them to pay privately for therapy.

In their experiences with public mental health services participants had contact with health professionals who were trained to deal with persons in psychiatric distress and who made the decisions as to what treatment and how much treatment would be provided. This changed considerably when participants engaged with ACC. They now had to deal with administrative staff that had little or no training in dealing with persons in psychiatric distress and they, not the health professional, decided what treatment and how much treatment would be provided. Participants had to learn that ACC funding came conditional to complying with processes they did not anticipate, for which they had been unprepared, in which they had no say, and which left them with a sense of powerlessness.

This chapter discusses how the recovery from sexual abuse has been shaped through processes that reflect the inequality between ACC and participants. Honneth (2003) understands the uneven distribution of power between social groups as asymmetrical recognition relations causing subjects suffering and social deprivation. Participants perceived that the uneven distribution of power between them and ACC became an obstacle to their recovery.

The disrespect they perceived was reflected in their sense of being financially dependent on ACC, having to compromise their confidentiality, struggling with a lack of transparency of processes, and being lulled into a false sense of participation. As a result their trauma response deteriorated and the interactions with ACC hindered the development of their positive self-relations. The following figure 10 gives an overview of this dynamic.

Figure 10 Cycle of Disrespect: Struggling with Inequality



This chapter explores in detail how participants responded to the asymmetrically distributed power reflected in reports, assessments, and reviews and how the mutual recognition between ACC and participants brakes down. It will be traced how this inequality has led to the deterioration of the trauma response (symptoms, cognitions and self-perception, social functioning, and responsibility and autonomy) and how this deterioration impacts on the maintenance and/or acquisition of their positive self-relations. Table 13 provides a visual overview over this chapter’s content.

Table 11 Chapter Content: Struggling with Inequality

Struggling with Inequality
Exploiting Financial Dependency
Compromised Confidentiality
Lack of Transparency
Pseudo Participation
Weekly Compensation Anna's Story Cassie's Story

Financial Dependency

In order to have continuous therapy approved participants had to collaborate with their therapists and needed to give detailed, sensitive information for regular progress reports that had to be submitted after every 20 hours of therapy. These reports were each reviewed by ACC psychologists who then decided whether further treatment is justified or whether an assessment conducted by independent psychologists or psychiatrists is required before funding decisions are made. After each 30 or in some cases 50 hours of therapy every survivor has to attend an independent psychological or psychiatric assessment to have their progress and the effectiveness of the therapeutic relationship reviewed. The relief participants experienced at the beginning of their involvement with ACC turned quickly into feelings of dependency, helplessness, powerlessness, and anger once their therapist had to submit the first report.

Navarro (1986) suggests that health care services reproduce social relations of dominance of the helping agency and subordination of the subjects needing help. This control is possible because patients need the services to meet their basic need for health care. Participants believed that being reliant on ACC for treatment funding gave ACC the power to control the conditions upon which they would grant funding for sexual abuse therapy.

It was very hard in the beginning. And basically the only reason that I went through with the ACC process is because financially we were very cash strapped... If I could have done it without [ACC], I would have, because I suppose it's just again... Because it was like the whole process was about exposing myself to the system and people that I didn't even know. No faces... So I felt actually from the beginning I felt really trapped. An interesting

dynamic, I mean because it's the whole dynamic again of feeling trapped. (Abuse dynamic) Yes, all over again. It's sort of like having to look after somebody else's needs in order to get my needs look after, this sort of thing. (Marama)

Marama explained that she only applied for ACC funding because she was unable to pay for therapy herself. To receive funding she had to comply with ACC's requirement of submitting reports. Marama experienced the exposure of the most intimate details of their lives to a 'face-less' system as intrusive and disrespectful. She described that she felt trapped and exposed and that it reminded her of the abuse dynamics of her childhood.

Yes, I have been forced, in order to get the ongoing care that I needed and wanted, I was being coerced into talking about stuff that is still extremely difficult for me to talk about. And it was humiliating. (Sheryl)

Sheryl also described that they had no other choices but to comply with ACC's requirements for submitting reports because she would otherwise not have been able to afford therapy. She felt humiliated by having to talk about aspects of her abuse that were still difficult for her to face and express. All participants in this study mentioned that they complied with ACC's requirements reluctantly.

It was that condition to tell all. I could not see, and I still don't see the need for it. To this day I found that that was abusive. It felt abusive. (June)

June was unable to see why ACC needed elaborate details of her abuse history for approving her application for funding. Instead, she felt re-abused by having to comply with this requirement.

It got mixed up in a sort of paranoid stew from therapists sitting in the office having a good laugh about me thinking and talking about my private stuff, down to them doing it in Wellington. Well, and there is a part of me that says, hang on, get real. But it's still out there and on paper. To, you know, flattering around the rubbish dump with my name and my abuser's name on. (June)

Without having the process and the rationale for the level of detail required for the reports made clear to her, June became paranoid. She was worried about the confidentiality of the intimate details of her life and imagined people talking and laughing about her 'stuff'. This paranoia interfered with her ability to develop trust towards her therapist and therefore also interfered with her therapy (figure 10, page 142).

With the lack of abuse focused treatment available through public services, participants who want to recover from the legacies of sexual abuse and who are unable to fund therapy privately, have no other choice than turning to ACC for assistance. The

trauma literature (Briere, 2002; Herman, 1992) emphasises that the re-establishment of personal power and autonomy is a main therapeutic aim in the treatment of victims of sexual abuse. These aims have also been indicated by participants in this study as vital to their experience of recovery. Circumstances that conjure up a sense of powerlessness, humiliation, undue exposure, and abuse are the exact opposite to personal power and autonomy. They caused a deterioration of participants' emotional states and tied their perceptions and identities to the victim role. Self-confidence, self-respect, and self-esteem were harmed by the uneven distribution of power and participants' recovery was hindered (figure 10, page 142).

Compromised Confidentiality

The right to confidentiality is a cornerstone of health and mental health services. It is a crucial part of the code of patients' rights (MHC, 1998) and of the code of ACC claimants' rights (ACC, 2003). However, participants in this study had concerns about the level to which ACC is protecting claimants' confidentiality. June's doubts that her confidentiality is adequately protected by ACC were confirmed when she experienced a dreadful breach of her confidentiality.

...one of my letters (from ACC) came, private and confidential, and it was opened. It had been addressed to somewhere in Auckland, and someone had opened it. It gave me a dreadful shock. There was nothing in it that, you know, it said sensitive claims unit, I think I had been accepted for group therapy or something. But it gave me an awful shock. And I mean I rang (ACC) and they were so blasé (*is swallowing hard*). (June)

A letter from ACC was sent to another address in Auckland. That person had opened the letter, saw June's address on the letterhead, and forwarded it on to her. She reported that this shook her deeply. June was equally distressed about ACC's 'blasé' response when she rang them about the incident. By not taking survivors' concerns about confidentiality seriously ACC conveys the message that they do not give noteworthy priority to confidentiality issues. Although claimants' right for confidentiality is clearly outlined in the Code of Claimants' Rights (ACC, 2003), the staff member June dealt with did not seem to be skilled in dealing with her complaint in accordance to the Code.

Most participants doubted that confidentiality is adequately observed in ACC and feared that their needs for privacy and confidentiality might be compromised. This fear is echoed by Edwards (1999, p. 95) who states that "Not only must a patient be concerned about what will become known of them in the present but they must contend

with the possibility that what they say will be on record for the rest of their lives and eventually threaten their future”. Sensitive details about their personal life or their psychiatric disturbances might, for example, interfere with future employment prospects or with unbiased treatment by health services.

And that sort of power dynamic. You don't have that control and parts of my life, a very private part of my life, is held somewhere that I don't believe I have any control over in terms of bringing them back to rest... As if my stuff would go to a Maori house. You see I touch my heart. Its like, it is been received into a whare that follows the tikanga, the honouring of mana... And I am not altogether sure that the ACC structures are that way and I suspect they are not because there are not a lot of places that are, as much as they use Maori words and all the rest of that sort of stuff. So yeah, I would love a Maori unit, I would love to have felt that my stuff is going to a kaupapa Maori sort of place to sit and rest. (Marama)

Marama described the sense of powerlessness she had from not being in control over the way her confidential material is treated. She expressed cultural concerns and was worried that her most private information may not be held in a place that complies with the cultural expectations and needs Maori survivors may have. Even though Marama was very concerned, she was unable to convey her concerns to ACC. Powerlessness, lack of control, and the associated feelings of anger and fear prevailed not just for Marama but were experienced by all participants.

Well, it's almost like the abuse is happening again because it's an authority figure. And you have no control over who sees that form. So it's almost abusive again. It's like a lack of control again. You have no control over who sees this private stuff that supposedly belongs to me, you know, that is my world. So it's almost, yeah, I reckon it almost verges on abuse again. (Ruth)

Ruth expressed that the lack of control evoked in her associations of being abused again. The disclosure of sexual abuse is difficult for most victims. It may be accompanied by strong feelings of fear, shame, or anger and by invoking powerlessness and victimisation could be re-traumatising to victims of sexual abuse (Herman, 1992). As soon as disclosed material leaves the confidential space of therapy, victims have no control over how this material is handled and what conclusions are made by the recipient of the disclosed material.

I always felt very uncomfortable, because ... the therapist had to get a little bit more specific, and that felt, I felt betrayed in a way, in that here I was sharing my story with the therapist, and little bits had to go to another city, to people I didn't know, and that made me feel a little bit sort of dirty, in that like somebody else was having a piece as well. (Anna)

Anna shared that she had a sense of betrayal when her therapist had to be more specific in her reports about the abuse. To have the incidences of her childhood

humiliation described in the reports left her feeling dirty. By feeling dirty Anna indicated that she took responsibility for the abusive acts perpetrated on her. Although the perception of having responsibility for the experienced abuse is a common phenomenon observed in victims (Briere, 2002; Herman, 1992; Ross, 2000) the therapeutic effort is to focus on reversing this belief about oneself and freeing the victims' identity from this undue responsibility. Anna did not report that she was able to share her sense of betrayal with her therapist and work on reversing the belief of responsibility. Instead, as 'bits of her story' left the confidential space of therapy her identity, contaminated by the abuse, had been reaffirmed through her perception of dirtiness.

Anna's example is a good illustration of how the submission of reports might interfere with the recovery process by initiating a cycle of disrespect and hinder recovery (figure 10, page 142). Sperry and Prosen (1998) reflect participants' concerns regarding confidentiality and warn that supplying poorly prepared administrative personnel in managed care organisations with highly sensitive material may ultimately lead to survivors' deterioration because such practice may breach confidentiality and interfere with therapeutic roles and boundaries.

Lack of Transparency

Other obstructions to participants' recovery were dynamics interpreted in this study as 'lack of transparency'. ACC dominated processes for authorisation and re-authorisation for treatment through reviews, assessments, and reports all of which participants' believed they had no control over and were unable to see the usefulness of.

I used to, especially in the early stages go through quite a process. Because what we would do, about by session 17 going through and using the sessions to basically write the report. And it would take me probably two or three sessions on the other side to actually get over it because I would get so stirred up and angry. (Marama)

Marama described that she became so stirred up and angry in the process of preparing for ACC reports that she needed two or three sessions to process the impact the ACC report had on her. Rather than being able to focus in their therapy on building strength and developing healthy ways of conducting their lives, participants were constantly reminded through the reporting process of their humiliation and victimisation through the abuse.

This is emotions, and re-tracking all of the stuff that you have gone through brings up a whole heap of things...I suppose again, they are intrusive. When it's

that ACC day, you don't have any choice. You've got to go through it what you've learnt, how do you think, it's just questions, questions, questions, and questions again. And it's like, I am trying to get better. I try to be the person I suppose that I was born to be. I just wish they'd let me do it. And it's a waste of a whole hour with my counsellor. (Marion)

Marion aired her frustration about not being able to use the precious hour with her therapist for her therapy. She resented the time spent and felt disempowered by having to meet ACC's need for reporting rather than meeting her therapeutic needs. Certainly, attending assessments has been stressful for all participants.

I was just so terribly nervous about going. And I think we spent some time before the appointment just spending time talking about that. Well, it seems, looking back, an extreme waste of time...the stress of the assessments in itself has added to the need for more hours... Sometimes it has felt that we spent an awful lot of time talking about the effect of the ACC interventions on me. And all the way through I had other difficulties to deal with. (Sheryl)

Sheryl expressed resentment for session time wasted for something that she did not perceive was fostering her recovery or advancing her treatment. She explained that she was hindered to talk about more pressing issues she needed to deal with by having to comply with ACC's requirements.

I felt threatened that the support that I had fought for in the first place quite hard, was at the edge of being pulled away from me. And I didn't know how to pay for the support that I felt I still needed. That made me very insecure. Especially in the beginning I felt I didn't allow myself to really get into the session sometimes because I wasn't quite sure how long it would be able to last. And what would I do then? It stopped after a while. But certainly in the beginning that was an issue and it definitely prolonged my recovery, because I held back in order to protect myself, because I didn't know what was going to happen. And that wasn't very useful at all. (Johanna)

Johanna commented on the stress and the fear assessments, reviews, and reports had caused her. Not knowing whether the continuation of her therapy was secured, she was unable to immerse herself fully in the therapeutic process. Both Johanna and Sheryl feared that the continuation of their treatment was in jeopardy. Their lack of being able to control this vital aspect of their therapy led to their need for additional sessions. The literature of managed care (Cary, 2001; Sperry, 1998) informs that reports, reviews, and assessments do not meet survivors' needs and may even lead to a deterioration of clients' condition due to their lack of power and control over their treatment.

At some stage I started counting it, and knowing when it was coming and I got a bit anxious because we would have to do this report again, and yeah... because as I started to get well, I also started to get anxious. Because, so what are they going to expect of me? (June)

June reported that she became anxious when it was time to send another report to ACC. She was unsure of what was expected of her. Helen had a similar reaction.

But then I would get really anxious that if I hadn't done enough, that they would cut me off and then there would be the whole process of, what if they cut me off? I can't afford to come, I got this far, and it seemed to be all the time this was coming up. (Helen)

Not knowing whether ACC would have approved another 20 hours of funding caused Helen great anxiousness. She feared that she might have to discontinue therapy, her source of emotional support and care. Both Helen and June knew that the continuation of their therapy depended on the progress reports so that they continued to receive the financial support. Yet, they believed they had no control over whether these reports would assure continuing funding through ACC.

Participants perceived the evaluation of the reports as being one-sided and non-transparent. They did not know whether they were unwell enough, too well, whether they had worked hard enough in therapy, or whether they were taking too long to recover. They were unable to predict how ACC would respond after each report or assessment. That left them feeling powerless and distressed.

The absolutely worst part of the whole process, I guess, they add and add and add to the feeling that I already had that I was taking too long. You know they allocate sessions for a number of hours and you have to justify why you need more. And the thing is you really don't know why you need more. You just know you are not OK. (Sheryl)

Sheryl explained the worst part was that she had to justify over and over again the need for more hours. It was her perception that the frequent reports and assessments implied that she took too long to recover. The threat that ACC might cut their funding for treatment before they were ready to leave therapy has been felt by all participants.

... and all of a sudden it's me and this ACC lady and I didn't know anything about her. Well, that lady sat in the chair and I find it difficult to speak to strangers on a very personal note. If she had said is there anything that you would like to know about me, I could have asked, well, are you from Auckland, are you married, have you got children? Just a little teensy little bit and then I would have had a feeling of some interaction between us instead of it being her and me, and her assessing me. (Marion)

Marion described her struggle with a recent ACC assessment. Like many victims of sexual abuse she has difficulties talking to a stranger about very personal details. She would have liked a few personal comments from the assessor to put her at ease and feel less objectified. Yet that did not happen. How stressful the interview was for her showed in the strong somatic reaction she had the following day.

And the following day I had a migraine that ‘bed-roomed’ me. They had to get the doctor and I was ‘pethidined’ then. So that seems to be how my body seems to react to things. I thought I was going to die. I had migraines before. I certainly never had a migraine like this. I was sick the entire week. (Marion)

Marion needed several pethidine injections for her strong migraine and was bedridden the entire week. That she was able to participate a few weeks later in the interview with the researcher, who was also a stranger, indicates that her strong somatic reaction had more to do with the significance of the assessment process than with the familiarity of the interviewer.

You know, which really worried me? Measuring my sanity or what it was. They don’t do that when you break a leg. No. People with post traumatic stress disorder are not malingerers. They are not trying to suck the system. Oh, sure, you might get one or two, I don’t know, but I think the majority, nobody wants to go through that. (June)

June felt discriminated and branded a malingerer through the assessment process. Anthony (2003), who has been a main proponent of the recovery movement¹⁴, pointed out that assessments maintain a ‘discriminative wall’ between survivors and service providers. He considers this discriminative wall to be detrimental to recovery because it denies survivors the status of equal citizenship with equal rights and responsibilities.

Whereas progress reports have to be submitted by participants’ therapist after every 20 hours of therapy, psychological or psychiatric assessments are conducted by independent, ACC appointed health professionals that are unknown to the survivor. Ongoing and repeated clinical assessments are meaningful when they are used to inform clinical practice. Ideally, this is a process in which both clinician and survivor collaboratively come to an understanding of the problem at hand and the pathway of the treatment ahead (Rahm, Otte, Bosse, & Ruhe-Hollenbach, 1993).

However, psychological or psychiatric reviews/assessments arranged for by ACC are only available to the therapists who work with the assessed survivors on their request. They are used by ACC for other purposes. The lack of transparency of what the function of assessments is and how they are going to be used by ACC, has given rise to many assumptions and interpretations by participants.

I was just like, no way. And I said to her, this is ACC’s way of actually culling the claimants (attending data assessments). Because I said I bet you, like anything, there must be hundreds of women who are like no way I rather not do

¹⁴ See Chapter Three, the recovery model and public mental health services, page 46

anymore therapy than go through this process...I'd rather die than go through this (assessment), like hell... I mean it all sounds very nice, but underneath it is just a way of reducing the numbers of claimants who are consuming the resources. (Marama)

Marama believed that the main purpose of assessments is to save costs by discouraging survivors to requests further funding for treatment. She felt very strongly about not attending any further assessments or reviews and decided to not apply for further ACC funding. Marama's belief is echoed in the literature about managed care (Ahles, 2002; Beitman, 1998; Coney, 1997; Edward, 1999; Weisgerber, 1999) here it is pointed out that reports, reviews, and assessments have the function to control and monitor the therapist and survivor dyad and save money by discouraging further requests for treatment funding.

ACC's lack of transparency in relation to the use of reports and assessments and the lack of involvement in the decision making process regarding their treatment caused participants significant distress and fears. It left them with a sense of powerlessness and a need for valuable session time to process participants' grievances with ACC. Blum (1992) believes that services limit survivor's ability to influence treatment to maintain the power inequality that exists between service providers and survivors. This power inequality, which Honneth (1995b) identifies as asymmetrical recognition relations, hinders recovery by detrimentally affecting participant's emotional states, and by re-enforcing participants' abuse-based beliefs of not being equal. This obstructed participants' ability to develop positive self-relations and therefore obstructed recovery (figure 10, page 142).

Pseudo Participation

ACC portrays to the public a policy of partnership and participation which is further defined in the 'Code of ACC Claimants' Rights' (ACC, 2002). Here claimants are assured that they have the right to have their views considered (right number 2) which suggests claimants' involvement and consideration. Although participants may have expected to be able to participate in decisions about their treatment, the following examples show how their expectations were disappointed. Instead they felt hopeless, powerless, and frustrated. Figure 10 (page 142) shows that asymmetrical recognition relations led to a deterioration of self-confidence, self-respect, and self-esteem and caused a deterioration of participants' trauma response by detrimentally affecting

symptoms, cognition and self-perception, social functioning, and responsibility and autonomy.

But I had a terrible conversation with the ACC case-manager. She was just awful to me because I made a complaint ... and she said "Well, our call centre people are all trained". Trained to do what? You know, answer a set of phones? ... She was just really rude, and cold, utterly cold. No warmth in the voice at all...I didn't feel like a partner at all. In fact when I went through the code of patient rights, well that's just a load of nonsense. It just hasn't happened like that for me. It just hasn't happened. And there is no way to challenge them (ACC) because they are not listening. (Sheryl)

Sheryl had made a verbal complaint about the treatment she received from the call centre staff and was rudely brushed off by the case-manager she spoke to. She has lost faith in the Code of Claimants' Rights being adhered to by ACC staff. Sheryl's sense of helplessness in getting her point of view across was echoed by Cassie and Jacob.

(With ACC) There is a big sense of helplessness sitting in there. That it doesn't really matter what I think or say or do. I can't, I can't change anything. I can't. (Cassie)

They (ACC) tell you to work with them, say your side to them, but they will never ever use your side to dictate what they are going to do in your healing. They have already made up their mind about the sequence in which things are going to take place, when they are taking place and how...Its like, they control what they (ACC) want you to do. You can't control yourself or the therapy you want. They control everything...while you are going through your healing, the whole idea is to get control of yourself and to get control of your feelings, your thoughts, your ideas, and to get control of your life. But with them it's them controlling it. That's the how I feel, they control it... Yeah, and when I don't sign these things my benefit gets cut immediately. So it's not like a partnership is it? When I don't agree with it I can't change it. So is it a partnership where they make an agreement where there is only one side to it, you have to sign it. If you don't your benefit ceases. You can disagree with it, but hey, it doesn't matter. If you don't sign you don't get your benefit. (Jacob)

Cassie and Jacob had a deep sense of helplessness and powerlessness because they believed that their viewpoint had no weight in decisions that were finally made. Jacob was told by his case manager that his rehabilitation plan would be developed together with ACC. However, he believed that his concerns were not taken into consideration. His case manager had already stipulated the course and conditions of his rehabilitation. Jacob was told he had to sign the agreement or his ACC funding would be discontinued. He felt that ACC controlled everything and that he had no control at all. Jacob believed that lack of control was counter-therapeutic to the recovery process he identified as regaining control over his inner states and over his life.

Lister (2005) describes “...being involved in phoney participation, by people who don’t listen, when things don’t change” as the ultimate disrespect. Participation in one’s recovery is not just to engage in the therapeutic work but also about being listened to and being heard in a democratic space that is governed by mutual recognition and respect (Howard, 2003). This may explain the deep frustration and distress participants expressed about the lack of participation they believe they had in making important treatment decisions. The disrespect reflected in the asymmetrical recognition relation between ACC and participants hindered recovery by impacting detrimentally on participants’ trauma response, causing symptoms, cognitions and self-perceptions, social functioning, and their self-responsibility and autonomy to deteriorate. This obstructed the development of participants’ self-confidence, self-respect, and self-esteem.

Participants described in the interviews how their experiences of feeling disrespected by ACC distressed them deeply and led to the breakdown of mutual recognition. Honneth (1995b) states that mutual recognition is vital for the development and maintenance of self-confidence, self-respect, and self-esteem and forms the basis for subjects to view themselves as autonomous and individualised members of society (Honneth, 1995b). Mutual recognition is therefore a precondition for recovery to proceed.

...there are a lot of people that work for ACC, case-managers and so on. I don’t for a moment, and I could be wrong, I don’t believe for a moment that case-managers are trained in any way. I just feel like when I am talking to my case manager, I am talking to a clerk. And I don’t think they have any understanding of what goes on... I wonder how much gets fobbed off or slips through because I am dealing with somebody who is not a professional, someone who is not trained, even trained in what they are doing. (Cassie)

Cassie had not a lot of faith in her case managers’ qualification or capacity to understand her situation. She felt at times fobbed off and powerless due to the lack of participation in the decision making. Without interactions based on mutual recognition and respect the connections between ACC and participants became strained. Participants perceived that they were not given due recognition by ACC and in turn they did not recognise ACC as an agency that is professional, caring, skilled, and operating within ethical parameters.

...the ACC inspector, I had to tell him about my back. I felt that he had the feeling that I was making things up or I was claiming for things I shouldn’t be allowed to claim for...Not only was he not tactful or in anyway diplomatic, he was very insensitive and quite ignorant as well...He was somebody who, I don’t

even know his name. But he was working in the sensitive claims department. How he got there, I have no idea. He certainly would have not been my choice of person to be there. (Johanna)

Johanna described her interaction with an ACC inspector who she perceived as insensitive, ignorant and tactless. Feeling disrespected by his insinuation that she ‘was making things up’ she quickly discarded him as not fit to be working in the sensitive claims unit. The breakdown of mutual recognition between ACC and claimants has not only been mentioned by participants in this study, but also been discussed in the media “Another claimant has recently written to ACC CEO, Garry Wilson, complaining about the way his staff are abusing and ignoring the law. "You and your staff think you are above the laws of this country and use intimidation, bully tactics, threats and disentitlements. You say that you have not been made aware of complaints, well I am complaining, he wrote” (1943). Claimants feel disrespected by ACC and in return disrespect ACC. Jacob provides another example of this dynamic.

Useless...they don't even consider you to be a part of society. It's like you are tainted... Because at the moment with ACC it's like I am a burden. That's how I feel. I am a burden to them and society because I am taking. And yet I am taking only because I need help. And I want to get the help. They are trying to make out that they are doing you a favour, when in actual fact they should not look at it that way. There are rights that are there for me, because I paid for them anyway as a taxpayer and an ACC-levy-payer.... Instead they make you feel like you are ripping them off and that you are not trying to get help and that you are not doing the work. (Jacob)

Jacob perceived ACC's actions as disrespectful. He felt that ACC treated him badly because he used ACC resources for his recovery. Even though he believed that he had the right to ask for their assistance, the way he felt treated left him with bitterness and critical about ACC. He felt that he was not given due recognition and, in return, did not extend due recognition to ACC. The breakdown of mutual recognition signified the disrespect between ACC and participants that lead to an escalation of participants' psychiatric disturbances. It hindered recovery through the detrimental impact it had on participants' self-confidence, self-respect, and self-esteem (figure 10, page 142).

Weekly Compensation

Weekly compensation for loss of earnings (weekly compensation) is given an extra section because it is a complex issue. Although not directly related to treatment that facilitates recovery from sexual abuse, weekly compensation provides survivors with their weekly income to cover living expenses. To be able to pay for one's rent,

mortgages, groceries, power, petrol, and other living expenses has a great significance in a person's life. Maslow (2002c, p. 2) asserted that basic human needs such as housing, food, sleep, and safety have to be satisfied first before psychological needs can be addressed. Receiving weekly compensation that provides the funds for meeting these basic human needs has a vital part in the shaping of recovery from sexual abuse. It might provide the foundation that allows a person to start and/or remain on the recovery journey.

Victims of sexual abuse can apply for weekly compensation when they are in paid employment and become unable to continue working due to the legacies of sexual abuse. ACC requires a medical and a psychiatric assessment to ascertain that sexual abuse is the cause for the inability to continue working. Once that is given survivors, who qualify for weekly compensation, receive 80% of the income they earned before they had to stop working.

Weekly compensation makes up 33% of ACC's total expenditures for sexual abuse claims (table 5, page 73), which is the second largest sum after costs for ACC's administration of sexual abuse claims. To protect their financial interest and to ascertain progress in recovery in relation to survivor's rehabilitation plan, ACC requires frequent medical and psychiatric assessments of survivors. The following two stories of Anna and Cassie explore how applying for and being on weekly compensation and meeting the increased demands of ACC impacted on both participants and shaped their recovery.

Anna's Story

Anna applied for weekly compensation when she was about to embark on a particularly intense and difficult phase in her therapy. For years she had struggled at her workplace and hoped she could focus more fully on her therapy if work stresses were eliminated.

We did apply for it, and it was an absolute nightmare... So we had to endure a session with a psychiatrist, and it was one that ACC did recommend. That was on their list. I feel angry, because the report that the psychiatrist wrote wasn't in favour of our application... there were these insinuations that we were lying... ACC would come back and say, well, we will need to test for malingering and factitious disorder, based on what? Based on 90 minutes with a psychiatrist, not the x number of years previously in the system? That was shattering!...I was being re-victimised again. Put in a situation where we weren't believed. We had to go and have tests, psychological tests and we had to wait months for reports, not knowing what the outcome was. (Anna)

Once Anna had applied for weekly compensation she felt trapped in a nightmare. Rather than having stress reduced, her application caused her even more

distress. The psychiatric assessment implied that she was simulating her symptoms of severe dissociation and ACC requested several psychological tests to determine whether she was malingering or not. Being disbelieved discounted years of struggle with the emotional and physical pain she experienced as a result of being sexually abused and being suspected for lying and malingering was an insult and an attack on her integrity.

(ACC should have listened to) my therapist who would know us better. Some psychiatrist from 90 minutes discussion, or my therapist who we worked with for over two years at that stage. It was ridiculous. It was like we were like little ants, trampled.

Anna was distressed that ACC would go with the findings of a 90 minute psychiatric assessment and not consider her therapist's assessment of her condition and her needs. It is interesting to note that Anna had received ACC funding for therapy for several years. Thus numerous reports must have been submitted by her therapist without any suspicions or doubts about her condition arising. That this changed immediately after she applied for weekly compensation and ACC sent her to one of their contracted psychiatrists is a dubious coincidence. Anna is joined by numerous ACC claimants whose applications have been declined following assessments by ACC appointed clinicians. Howard (2002b) described this practice as "Claimants in 2002 are not getting treatment and rehabilitation and claimants are still referred to ACC medical "hit men" who seem to be in for the fast ACC buck to write favourable reports for it".

The denial of recognition through love in the form of emotional support and care had shattered Anna and caused an escalation of her psychiatric disturbances she described as crippling in the following quote.

Fortunately we were very lucky to have my therapist there who was committed as I said before and we were able to talk to her and go through the whole range of emotions with the whole thing, and the impact it was having on us. It was like, it was almost crippling. (Anna)

Anna described that she was able to rely on her therapist to be on her side in this difficult time of being disbelieved by ACC. She was able to balance the disrespect from ACC and ACC appointed assessors with the recognition she received from her therapist. This enabled her to cope, even if coping was very difficult.

You know they help out financially, but it comes with a catch, you know, that's what it feels like. And the catch is that we now own you... We say x number of reports have to be written. We say who we think your treatment should be by. Not by my therapist, by somebody else. We say who you are going to see, we say what tests you undergo... They are abusing their power... That was shattering, because we had got to a stage with my therapist where we were feeling safe, trusting, and all that sort of thing. And then all of a sudden there was this thing bigger than life, and it was ruling our life.

Anna felt abused by the demands ACC put on her. They even wanted her to stop with her therapist, who had been her lifeline for three years, and continue with a therapist of their choice. She felt disempowered, humiliated, and very fearful that her therapy would be in jeopardy. After years of mistrusting people she had finally found a therapist she could trust. After years of ineffective therapy she finally noticed that she was feeling safe and able to trust.

And again from somewhere deep it came, that you deserve better... We had a number of discussions on how to handle it. And we came down to either we wait for them to decide on our future or we do it. We make the difference. And it was a very good step. And we cut them loose. We said no, we do not deserve to be treated in this way... I am furious, absolutely furious. And I still would love to walk into ACC, into the sensitive claims unit, and speak to a couple of people... They had the power and I had to take it back because otherwise I was headed down the wrong way. And it has been a huge relief cutting them free.
(Anna)

Anna had a deep sense that she deserved to be treated. She was no longer prepared to let ACC determine her future and took back the control that she had lost by applying for weekly compensation. That she was able to do so implied that her self-confidence and her self-respect had grown strong enough through the emotional support and care she had received from her therapist. Her identity was no longer that of a victim.

ACC never responded to me or to my therapist. And that just was like ... it just proved to me that they didn't care. They didn't acknowledge it by phone call, email, nothing. No nothing. And that was just like, well, yeah, they don't care about you. They don't ring because they don't have to. They've got another one off their books, they don't have to subsidise another person. They can save some money. It does hurt, it does hurt. I sometimes think I'd love to ring them up and say, why didn't you. But then I don't want to go back to that, hearing the same old crap. I mean, not even to acknowledge the letter. Acknowledge that you are no longer on their books or system. Nothing! I mean that, that's like you didn't even exist. (Anna)

Anna was shaken to the core for being treated as if she did not exist. She was completely ignored by ACC after she had complained to them about their treatment of her and stated that she would no longer require ACC funding. She took that as a confirmation that ACC did not care about the people and only cared about getting claimants off their books to save money. Anna knew that ACC had received her letter because they did not insist on her attending the assessment they required. For a while she considered to ring ACC up and question them about their lack of recognition. She decided against ringing them up because she did not want to be exposed to the same accusations and justifications she had been given over the past twelve months. Her need

to protect herself from continuing disrespect outweighed her need to express her anger and hurt.

The contract is now between my therapist and me and they are no longer pulling the strings. It has empowered me. And I think it so could have easily gone the other way with ACC...If I hadn't taken back the power, I'd be a mess...I know I wouldn't be where I am now because if I had continued to let them control me like that, I would have gone back repeating the whole cycle of my childhood, of being told what to do, of being directed in one way, their way. (Anna)

Being able to stand up for her rights and resist disrespect from ACC has empowered Anna. Resisting disrespect became possible because she had built positive self-relations. She demonstrated by her ability to resist disrespect that she had strengthened her self-confidence and self-respect during the course of her recovery journey. This was possible by the relation of mutual recognition between her and her therapist. By balancing the disrespect from ACC with the recognition she received, she found that the recognition side of the scale outweighed the disrespect side. The endpoint of professional assistance for her recovery is in her grasp.

Anna's story is an example of the extensive mending of a person's self-relations that needs to take place before victims of sexual abuse are able to assert their rights and resist disrespect. Prior to engaging in abuse focused therapy the psychological impact of abuse affected her ability to respond assertively to forms of disrespect. Only after years of therapy that exposed her to emotional support and care was Anna able to act on her feelings of being disrespected and remove herself from an environment she perceived as abusive.

Cassie's Story

When Cassie first applied for weekly compensation ACC had declined her claim. However, Cassie was able to enlist the support of her doctor and her therapist to face the dispute tribunal. She won her case and had been on weekly compensation for some years now.

So how can we be in partnership when ACC at the end of the day have the control? They are the employer. Effectively they decide to fire me when I am not doing what they want...I don't feel that I have any power. I think when I was still working and I wasn't on compensation I felt I had some power because effectively I was paying for my therapy. Ok, it was subsidised, whereas with the compensation they suddenly have ownership of me. All of a sudden they can pull my strings. (Cassie)

Cassie described the lack of power she had in relation to ACC and felt that her dependency on weekly compensation forced her to comply with ACC's requirements. These requirements, however, caused her significant distress.

Why do I have to keep proving that something has gone wrong for me? That I have been abused? Why do I have to keep fighting this way, keep proving every time it has happened? When all the time it puts doubt in my mind that the reason I am so screwed is because of the abuse, you know. (Cassie)

Cassie questioned why she had to go through the many assessments to prove that she was still entitled to the compensation she received. She reported that the constant requests to justify that she is not able to go back to work caused her to doubt that her psychiatric problems were a legacy of the experienced sexual abuse. She did not see that she had a choice. ACC was not only funding her therapy but was also her only source of income for living costs.

But the hoops you have got to jump through to get what you are entitled in are just too much. I was at a point where they said you have got to have an independent medical assessment, another data, another psychiatric assessment. You know they want all these things and they want all these different people to do them...And you don't know whether, they have all got different criteria. Yeah, I mean, it's all too hard, too hard...And in some respect I feel weak because I need this. (Cassie)

Cassie felt worn out by the constant demands from ACC for ongoing assessments. She described the stress of 'hoop jumping' for recognition and funding as too hard. Although she felt weak for needing ACC compensation, she saw no way out of this dependency. Without ACC she believed that she would not be able to afford therapy and without therapy she would not be able to recover.

Holtgrewe (2001, p. 2) elaborated on the tension between existing relations of recognition such as the ACC legislation that regulates entitlements for sexual abuse therapy and the misrecognition embodied in the requirements imposed by systems to access these entitlements. This tension not only indicates the infringements on subjects' autonomy, it also prevents the development of self-respect. Yet self-respect does not just develop by having one's rights recognised. She stated that what is required is often "...a certain amount of non-conformism for which in turn recognition is sought and claimed". She referred to resisting circumstances that are perceived as disrespect. Cassie had not yet built enough positive self-relations of self-confidence and self-respect to counter-balance and resist ACC's disrespect in the form of intrusive and disabling requirements.

The ACC side in many ways made me feel that I am cheating... that I am not allowed this, that I am getting something that I shouldn't. And part of that is my own shit. (Cassie)

Cassie believed that the ACC processes implied that she was cheating. Her tentative acknowledgment of her own contribution to that feeling may be the first step towards becoming aware of her critical self-judgement regarding receiving weekly compensation. At present she projects her self-criticism onto ACC.

What it does do is that some of our sessions will be taken up purely with my fear of what will happen to me if ACC pull out. And there will be whole sessions where I am dealing with coping with panic and ... and I mean I have panic attacks and stuff like that. What would I do? So dealing with panic attacks, dealing with anxiety, there will be sessions quite wasted... Well part of me just thought to give up. And because the financial pressure was so large for me that give up was a big give up...I was suicidal...because I can't live. I can't live. I can't really see a point in living. I haven't got that energy to fight. (Cassie)

Fear, anxiety, or even panic attacks have been mentioned frequently by participants in relation to reports, reviews, and assessments. Cassie could not see how she would survive without weekly compensation. Her dependency was so overwhelmingly strong, that she even considered taking her life. Such crippling dependency confirms concerns that have been raised by Newman (2006) about the destructive effect of long-term welfare dependency. As long as Cassie was frightened of losing ACC compensation and freeing herself from that dependency, her recovery was under threat or certainly slowed down.

There are constant things that are coming in to say we don't want you on it, get off, get off, get off. So there is the fear all the time that they are going to throw me out before I am ready...But there is this huge fear all the time that the time is going to be a problem. (Cassie)

Unlike Anna who was able to free herself from ACC's control over her life and thus progressed towards recovery, Cassie was still locked in her fear of losing the financial support without which she felt unable to survive. Her overwhelming sense of dependency indicates that, even after years of therapy, the emotional support and care from her therapist has not been able to strengthen her self-relations enough for her to resist disrespect. Her functioning was still dominated by tolerating dependency and disrespect in which self-doubt and self-criticism prevailed.

Conclusion

This chapter has described participants' experiences with ACC. It showed that policies and procedures shaped by ACC's need for control, accountability, and containment of expenditures, clashed with the treatment needs of participants. Participants felt shamed, blamed, fearful, angry, and/or powerless and believed their recovery from childhood sexual abuse was inhibited by systemic requirements they saw as evidence of the uneven distribution of power between them and ACC. Participants struggled with inequality reflected in their experiences of financial dependency, compromised confidentiality, lack of transparency, and pseudo participation, and when they applied for weekly compensation. The emotional distress caused by this struggle led to an escalation of participants' trauma response. Participants' symptoms, self-perception and cognitions, social functioning, and their sense of self-responsibility and autonomy deteriorated. Not only did this deterioration negatively affected the development of positive self-relations, it also led to participants' negative view of ACC. The outcome has been a breakdown of mutual recognition relations between ACC and participants and a perpetuation of the cycle of disrespect in which recovery is hindered.

The discussion of weekly compensation for loss of earnings showed with Anna's example that resisting the disrespect involved in applying for weekly compensation had helped her to grow her sense of identity, regain control over her life, and advance her recovery. Cassie's example illustrated how remaining on weekly compensation and submitting to ACC's requirements caused her feelings of crippling dependency and inhibited her recovery.

The next section explores interpersonal disrespect by examining how participants struggled in interactions with service providers that were perceived as providers lacking understanding of what the treatment needs for survivors of sexual abuse are.

CHAPTER NINE

STRUGGLING WITH LACK OF UNDERSTANDING

The previous two chapters have explored participants' experiences with larger systems. Perceived disrespect that hindered their recovery from the legacies of sexual abuse was linked to procedures and policies that had evolved over time. This chapter explores intersubjective processes that were not based on following policies and procedures but rather reflected service providers' lack of understanding participants' limited ability to cope in a variety of treatment situations. Table 14 gives an overview over this chapter.

Table 12 Chapter Content: Struggling with not Understanding

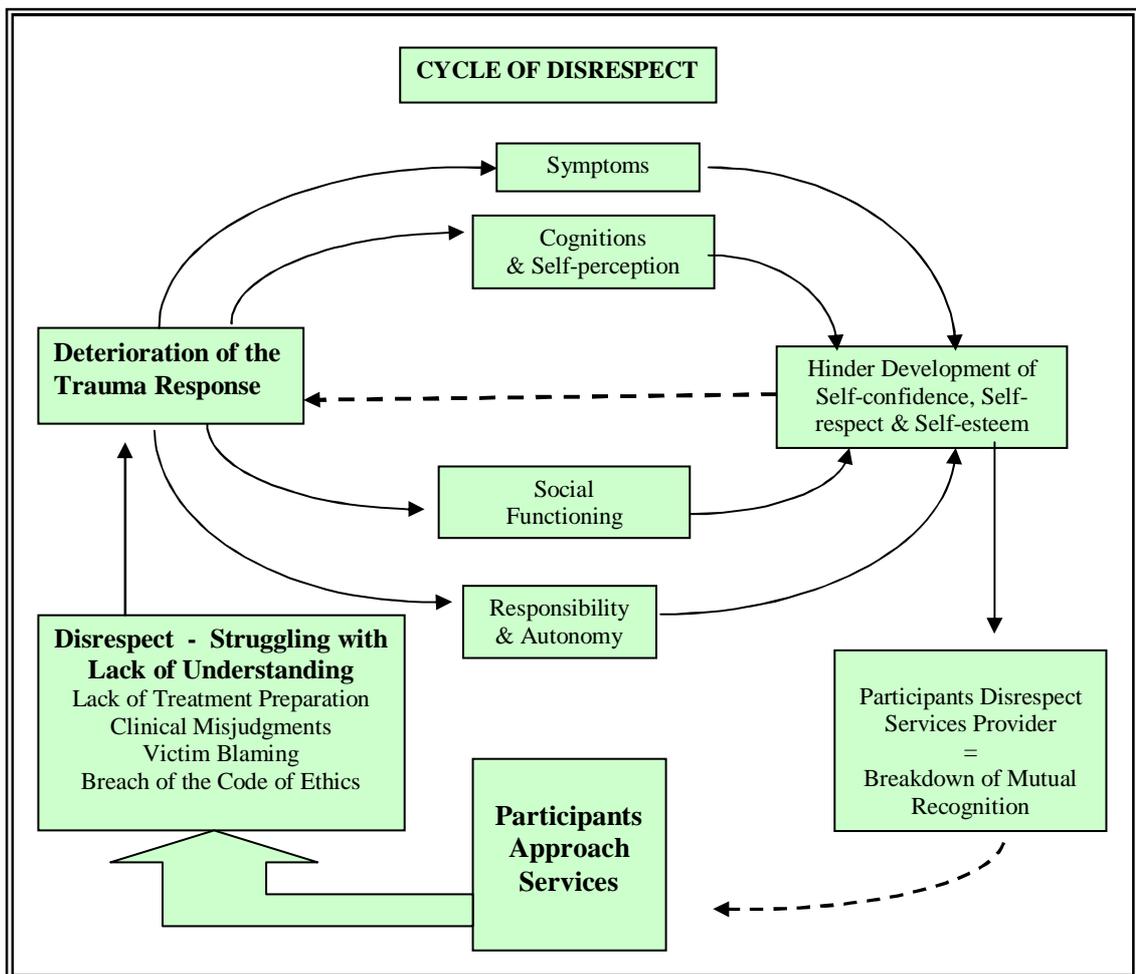
Struggling with Lack of Understanding
Lack of Treatment Preparation Inaccurate Information Mismanagement of Therapy Termination
Clinical Misjudgements
Victim Blaming
Breach of the Code of Ethics

It has been mentioned in Chapter Three (page 43-46) how experiences in therapy directly influence the shaping of a person's neuro-biological structures. It is shown in this chapter how this influence is not just caused by the problems discussed but also by the care and respect reflected in the way health professionals have addressed and/or approached participants. Therapy aims to provide experiences that symbolise a 'safe emergency', meaning that survivors are exposed to the un-integrated material that causes the psychiatric disturbances and avoidant behaviours while providing them with the tools and nurturance with which to integrate the experiences (Briere, 2002; Courtois, 1999; Herman, 1992; Kluft, 1993; Putnam, 1989).

While successful therapy strives to provide an enhanced environment in which recovery may occur (Chapter Four, page 68), interventions that lacked support and nurturance have shown in this study to be detrimental to participants' recovery. Instead

they caused a deterioration of participants' trauma response (figure 11) by negatively impacting on participants symptoms, cognitions and self-perceptions, social functioning, and/or on their ability to take responsibility and be autonomous. As a result the development of positive self-relations was hindered and participants disrespected the service provider involved in the detrimental interactions. This breakdown in mutual recognition was a symptom of a perpetuating cycle of disrespect that hindered the recovery from sexual abuse.

Figure 11 The Cycle of Disrespect: Struggling with not Understanding



The following interactions discussed in this chapter, although painful and distressing for participants, may not have been due to service providers' ill intention. They may simply have been a reflection of the complexity and difficulty of all communications in human encounters. They may have been the consequence of not understanding trauma dynamics, misjudging needs, unreal expectations, empathic failures, or thoughtlessness.

Lack of Treatment Preparation

Most experts in the trauma field¹⁵ (Briere, 2002; Herman, 1992) agree that the initial stage of therapy needs to prepare survivors for the therapeutic work ahead of them. Such preparation will help them to have some sense of direction and control in a potentially bewildering process. The preparation stage of treatment therefore focuses on the establishment of safety, the development of trust, and on the establishment of a functioning working alliance.

Inaccurate Information

To give accurate information about the conditions under which treatment will take place is one way to prepare survivors and create a safe environment for the therapeutic work. Giving accurate information at the beginning of therapy also means to respect survivors not only in their neediness and their right to receive emotional support and care, but also in their competencies and their right to be respected as equal partners in the contractual encounter called therapy. Survivors may be hurting, but that does not automatically mean they are incapable of making sensible decisions about their treatment. The following example described how insufficient preparation disabled Sheryl from becoming a collaborative, equal partner in her therapy.

Never thinking for a moment that I would be going more than a dozen times. I thought I just went along, told what happened, and that was the end of it. Every thing would be fine. I had no inkling at all of the complexity of what was going on for me. I just didn't have any idea. I didn't even know why I was going to counselling. And so to come up with goals (for ACC) and that sort of thing was just impossible. I didn't even have an idea what counselling was at that stage... And then, when it did take that long and longer and longer, I saw that as there is something wrong with me. So I was feeling as though I am not doing this right. Even though I was being reassured that what was happening was the way it was suppose to happen and it was fine. And then having to go and justify myself to somebody else. That was truly terrible. (Sheryl)

Sheryl described that she had no comprehension of the complexity of her problem and for how long she would have to attend therapy. She did not know what counselling was or why she attended counselling. When she was required to state goals for her therapy, she was unable to do so. The establishment of the therapeutic alliance that is based on the collaborative efforts of both therapist and client was insufficient and

¹⁵ The term 'trauma' is used in this study in relation to extremely stressful or life-threatening events in a person's life that cause significant emotional or psychological injury. Often, survivors of trauma are diagnosed with post-traumatic-stress disorder.

Sheryl did not know what she could expect of the treatment and what would be expected of her in return. Instead, she became upset with ACC for asking information of her that she was not willing or able to provide. She became insecure and distressed. Her psychiatric symptoms escalated and hindered the development of self-confidence and self-respect. The progress of her recovery had been obstructed (figure 11, page 163). Not being given accurate information was also difficult for Johanna.

One of the things that I was told was that, when and if I decided to go to the police, because at that point I didn't want to do that, somebody from Rape Crisis would be available to go with me and would make sure that at any point I wanted to stop the process, that that would be possible. That turned out later to not be the case...That was also quite hard, because I sort of had relied on information from them and then it turned out to be wrong...at that point I didn't trust anybody anymore. I hadn't been very trusting beforehand, but that really was the last straw for me...Because everywhere I turned I felt let down.
(Johanna)

Based on the information Johanna had been given she assumed that she could initiate the prosecution of her attackers once she felt stronger. She was also told that she could stop the process should she get overwhelmed. That turned out not to be the case and Johanna lost all trust in people. By not being accurately informed, disrespect was shown to Sheryl and Johanna by lack of recognition in relation to their need for emotional support and care. Inaccurate information deprived Sheryl and Johanna from re-gaining a sense of control and self-agency, the foundations on which self-confidence and self-respect could be built.

The following section shows how unprepared participants have been for therapy and for the conditions under which therapy had to take place when their therapist terminated the therapy. This lack of accurate information had a devastating impact on some participants.

Mismanagement of Terminations

An important part of preparing survivors for the therapy ahead is outlining therapists' limits and the consequences if these limits are over stepped. Such preparation signals that the therapist respects the survivor's adult-capacity to operate within these limits. The following examples show how the lack of being prepared for the therapist's limits hindered participants' recovery when therapy was terminated.

We became suicidal ... And she couldn't handle it. We had an incident where we overdosed and then went to see her in the hope of dying there. Strange! ...The psychologist then said that's too much. You are too much! I am going to refer

you to community mental health. And they made an appointment within two to three weeks. (Anna)

When Anna attempted suicide her therapist decided not to work with her anymore and transferred her to community mental health services. Without being prepared for her therapist's limits and informed about the consequences of becoming suicidal, she felt abandoned and punished. Although being prepared for her therapist's limits might not have changed the course of events, the lack of cognitive respect prevented Anna to find out whether she could have controlled her suicidal urges and worked within these limits.

The establishment of healthy attachment patterns is an integral part of recovery from sexual abuse (Briere, 2002). Anna's attempt to die in her therapist's presence could be an indication that she had formed some attachment to her therapist. Instead of understanding Anna's suicide attempt as a significant therapeutic event that could provide information about her abuse history, the therapist told Anna she was 'too much' for her. After Anna had worked for five years with her next therapist at community mental health services she was faced with another termination.

After the first psychologist palmed us off we started seeing the psychiatrist. From the beginning it was like it will only be a matter of time until you pass us on. And all the reassurances were given (by the psychiatrist) that no, this will not be until you say so...And towards the end, not knowing that it was the end, we started to discuss a little bit more about the abuse. And there it was, bang. I can't see you anymore...we thought what's the point. What is the point of trying to get better? You might as well just curl up and die. You know, and the old messages, that no one will like you and no one will want you, all that sort of stuff, that was just like, yeah, I tried... because it was just before Christmas and how we got through that Christmas I don't know...we sank very low then. And another option was to go and see somebody else, and it was like NO, we can't put ourselves through that ... (Anna)

Anna, who had been disillusioned by the first therapist's termination of therapy, had been reassured by her next therapist that she would work with Anna until it was Anna's own wish to stop therapy. This reassurance allowed Anna to open up and enter more deeply into her abuse experiences. When Anna had to learn that the information given was inaccurate and her therapist terminated the therapy Anna was pushed to the limits of her coping skills. Her self-confidence was harmed and old messages, given by her abusive family of origin, that nobody will ever want her, like her, or help her were re-enforced and she was close to losing her will to live. To start with another therapist appeared impossible at that time. The progress of Anna's recovery had been hindered (figure 11, page 163).

Frerichs (2000, p 209) concluded in her study about the therapeutic experiences of survivors with Dissociative Identity Disorder that the termination of the therapeutic relationship by the health professional is always difficult for survivors and is usually accompanied by a loss of trust, the loss of courage to engage with a new therapist, and a strong sense of abandonment and hopelessness. Anna was unable to prepare for this termination because the therapist made promises she was unable to keep. Instead of being a collaborative partner in the decision making around the termination and its time frame Anna had no participation in how the termination would best be conducted. She was powerless and had no participation in the decision making process. Anna was so distraught that her psychiatric disturbances escalated and she became suicidal. Her self-confidence, self-respect, and self-esteem had been harmed and recovery had been hindered.

...I started to see this woman who was actually a trained psychiatrist. And she was incredible. She cost me a fortune, and I had to travel to x-town¹⁶ to see her. And she got married and left the country...As I saw the psychiatrist, I suppose I felt like I was making steps, but she went away and I was left in no-man's land. Of course they start things slowly and they don't tell you why they are going down that channel. And then they go away and you are half way down that channel. And you don't know what is going to be at the end of it. So I never felt that I had accomplished anything...my psychiatrist, if she didn't get married and shifted, we would have gotten somewhere in x-town...It was only months. Only just a couple of months. (Marion)

Marion reported her experience with a psychiatrist who terminated the therapy after two months because she got married and moved to a different country. Marion thought that the psychiatrist was very skilled and helped her in small measures to progress. However, when the psychiatrist terminated therapy so unexpectedly, Marion felt she was left in no-mans-land.

Although the psychiatrist must have known that she is going to get married and about to leave the country, she did not inform Marion about her limited availability but was willing to see Marion for as long as she could for a substantial fee. By withholding such vital information the psychiatrist showed lack of cognitive respect and took away Marion's right to make an informed decision whether she wanted to engage in short term therapy. Instead, Marion's expectation to be able to resolve her issues was abruptly disappointed. She was denied recognition through emotional support and care as well as the respect as an equal citizen who is capable of making meaningful decisions for herself. Marion did not express any resentment about this mismanaged termination, but

¹⁶ Name of town changed to assure confidentiality

her disillusionment became apparent in the fact that it took her many years before she was able or willing to put her trust again in a therapist. Her recovery came to a halt (figure 11, page 163).

The following example shows that survivors are not harmed when they are able to play a vital part in making the decision to terminate therapy.

I saw her for 8 months...It wasn't working. When I was going to switch to my therapist I went to her and said, my therapist said to me, I might be able to work with your counsellor, we might be able to work together. You come and do some action work¹⁷ with me and keep working with her. So when I spoke to my counsellor, she said na na na na na, I am sorry, I don't know anything about it (action work) and she was not willing to go. So I said OK, that's it as far as she and I are concerned. I want to work differently. I want to work with action... Well, she asked me to come back for two sessions and I did. But, you know, I would rather not have at that time. You know, it wasn't actually up to me to sort out her feelings about it. I said, look, I have seen the way he works, and I want to work differently. But she didn't agree to that. She said oh we are just getting something. And I thought maybe, but it's not useful for me to be here. (Ruth)

While Ruth was with her therapist she had the opportunity to see another therapist doing some action work in a group setting. She had the sense that just sitting in a room and talking was not working for her and was impressed by the other therapist's skills and the possibilities of group work. When she approached her therapist to work in combination with the group therapist, her therapist was unwilling to do so. Instead, she dismissed Ruth's strong interest in group work and tried to persuade her not to change therapists. Although this showed some lack of cognitive respect, Ruth had enough self-confidence to express her preference for working the other therapist. Instead of feeling rejected or abandoned she felt empowered by her decision.

Ruth's example shows that participants were empowered rather than harmed when they participated in the decision to terminate therapy or change therapists. Being able to have a vital part in making treatment decisions strengthened their self-confidence and their self-respect and thereby facilitated the progress of their recovery.

Clinical Misjudgements

An important part of the initial phase of therapy is to help survivors to gain the skills necessary for dealing with the emotions and distress that accompany the revisiting of traumatic memories. Briere (2002) uses the metaphor of the therapeutic window that describes the parameters of safe therapy. He claims that too much exposure to traumatic

¹⁷ Modality substituted to assure confidentiality

material may exceed survivors' ability to cope and create a psychiatric emergency and too little exposure to trauma may not be effective and survivors may not experience progress in their recovery. The following examples show clinical misjudgements that have exposed participants to traumatic material before they had acquired the skills to cope with the feelings this exposure evoked (figure 11, p 163).

So I put my trust in her in thinking, well she knows what she is doing. And then she tried to put me into a group of women, and I was by far the youngest. And they were all sitting there, sort of reminiscing as such of their past experiences...And I went back to my counsellor and said, look, I really don't want to go to that. I walked away feeling worse than what I did when I went in. Because, not only did I have all mine (problems), I had all theirs as well. And fathers that have been sexually abusing their children. And you know, I was only 16 and I was really naïve, and I just felt sick to my stomach. So anyway it sort of just fizzled out and I stopped seeing her. (Marion)

Marion's therapist misjudged Marion's therapeutic needs by sending her to a group of adult survivors of sexual abuse. Marion became overwhelmed when she listened to abuse stories that often involved sexual abuse perpetrated by their fathers. Burdened by these stories she often left the group meetings feeling worse than she had before. Marion had not yet learnt the coping skills needed to accommodate this level of sexual abuse disclosure. She reported that she lost trust in her therapist and stopped going to her for treatment. Her recovery came to a halt.

Well after so many years all of a sudden there was this stranger who we saw once a week for 50 minutes. And we were disclosing the very personal ... it was very difficult for us to be feeling, all of a sudden feeling things. All the different feelings, mobbed by them! You know like feelings running at you all the time. And then it was like, ok, see you in a week's time we've had our 50 minutes. And it was like, oh my god, what are we doing with everything in between? And it just opened up things that we didn't know what to do with...We became suicidal while seeing her, quite badly suicidal (Anna).

Anna described how she struggled at the start of her therapy to cope with the flood of feelings as she started to disclose more personal details. She deteriorated quickly and became suicidal. Her therapist had made the clinical error to encourage disclosure before Anna had acquired sufficient skills to regulate her emotions and tolerate the distress they caused. She did not receive the emotional support and care she needed to contain her distress and develop her self-confidence.

Therapists inexperienced in working with a victim of sexual abuse can underestimate the time and effort needed for establishing trust and safety. This inexperience can lead to therapeutic errors that can have a devastating result. Wheelock (2000) outlines the vulnerability that can be expected in the work with sexual abuse.

...the individual with immature and fragile defences and poor ego functioning is more likely to respond to an empathic invitation to explore feelings by losing a sense of self-other boundaries and regressing to a more primitive level of functioning. In these cases a few sessions of psychotherapy are likely to stir up strong dependency longings, chaotic emotions, and, ultimately, feelings of intense vulnerability rather than empowerment.

Another clinical error was reported by June. She had been released from the psychiatric hospital under the condition that she attended an out-patient group program that was using psychodrama¹⁸ as a way of processing problems.

At (x program), one 'very wise' lady picked me with the sexual abuse and then blew it in the middle of this 'great' psycho drama and said, 'did you enjoy that?' And I thought 'stop', 'stop'. It was nearly out. This fucking psychodrama therapist! And I stopped. And I thought nobody is going to get it. I'll never go this far again. (June)

June reported that during the psychodrama the drama-therapist had the inkling that she may have been sexually abused. She was shocked by the provocative question 'did you enjoy that'? June was not ready to disclose the abuse and her psychological defences went up. She stopped participating in the psychodrama and was determined not to disclose to anyone what had happened to her. She stayed away from mental health professionals for many years.

Like Anna and Marion, June did not have the resources to cope with the disclosure of her experiences of sexual abuse and did not have the holding of a trusting therapeutic relationship that would provide emotional support and care. The unexpected, premature, and tactless comment of the psychodrama therapist foreclosed any further exploration of her sexual abuse experience. Her recovery could have started there with a more skilful intervention, but it was halted before it begun (figure 11, p. 163).

Participants also described clinical errors by service providers in the form of lacking care and understanding for the needs of victims of sexual abuse.

I felt really guilty about being there anyway, you know, and they weren't out rightly saying you don't deserve to be here. But they certainly made it perfectly clear that they don't like overdosed people. And then they have a psych. person come and see you. And then, it's like, well, look here is a taxi chit, and it was at night it was after ten o'clock at night! See you later. It's like you are thrown out in the dark again. (Anna)

Anna described how she was treated at the hospital after an attempted suicide. She perceived the treatment she received by the hospital staff as hostile and punitive. Instead

¹⁸ Psychodrama is a therapeutic modality that uses actions methods in the form of drama to explore problems people may have. Developed by J.L Moreno. See J.L. Moreno, 1987, Psychodrama Vol. 1, Springer Publishing Company

of being cared for she was sent home by taxi in the middle of the night. She had an equally disturbing experience at another time when she was again admitted for attempted suicide.

I think the first time we went (x Unit) we were getting 24 hour care with somebody who cant be more than an arm's length away from you, even going to the toilet, which was humiliating... How could it be beneficial being a sexual abuse victim going into the public hospital psychiatric wing and sleeping in corridors or in rooms of two or three people? How could that at all be beneficial? It's not. For sexual abuse victims? It's horrendous! (Anna)

Anna described how she has been on close watch for 24 hours and even had to go to the toilet with the nurse at her side. She describes the horror of having to sleep in corridors or in rooms with other people who were psychotic. Anna was adamant that such circumstances are totally inappropriate for victims of sexual abuse. June had a similar experience.

They zonged me out with this medication. And I did not like it. I did not like being in there with people coming in like on reprimand, the druggies. And there were people fornicating at the end of their beds there, it was utter shock for me. I mean we are talking convent girl plus, you know. And I said I want out of here. (June)

When June was sent to the psychiatric hospital she was heavily medicated. She did not feel safe amongst the many psychiatric patients, some of whom were fornicating in plain view of her. June and Anna did not feel that the hospital made allowances for the needs of victims of sexual abuse, for example their need for sensitivity, privacy, or safe accommodation.

All participants have commented on the disrespect experienced in a variety of health care settings through the attitudes and in the lack of emotional support and care of health care personnel towards victims of trauma. It has conveyed to them that their needs are not seen as important and that they are not worthy to be respected. Participants believed that the injustice of the sexual abuse had been re-enforced through the injustice of the treatment they received.

Instead of experiencing an improvement of their psychiatric disturbances as a result of seeking help from professionals, the interventions described here led to an escalation of participants' trauma response by affecting negatively their symptoms, self-perception and cognitions, social functioning, and self-responsibility and autonomy. The development of their self-confidence and self-respect was hindered and recovery was obstructed.

Clinical misjudgements were also made in the context of assessments. The following two examples show a lack of understanding of sexual abuse and a lack of sensitivity to the issues victims of sexual abuse struggle with.

I wonder if he had any experience in sexual abuse at all because the wording of his report implied that the abuse wasn't actually abuse because I had agreed to it...as an eight year old. (Cassie)

Cassie reported that she had to see a male psychiatrist for an assessment for ACC. She doubted that he had an understanding of sexual abuse because he implied that she was not sexually abused but had consented to the sexual activities with an adult family member. He totally dismissed that she was only eight years old. By condoning the paedophiliac actions of Cassie's abusers the psychiatrist not only condoned the injustice of the abuse, he also threatened months of therapeutic work that had focused on convincing her that children are never to be blamed for the sexual transgression of adults.

She (assessor) didn't seem to have any idea that this would be difficult for me. She'd ask me questions that I wouldn't even ask someone that I have known for months. Just direct questions. As though I should be able to talk about those things to a total stranger. I was just sort of speechless. It almost felt like another violation. And it does actually. It is not too strong a word... the whole process felt undermining of the work and humiliating to me personally. (Sheryl)

Sheryl commented on the assessors' lack of understanding that she struggled with talking about intimate issues. She felt violated by the direct questions the assessor asked her and mentioned that they undermined the work with her therapist and humiliated her. The assessor misjudged the clinical situation by not taking Sheryl's vulnerability into consideration. Spending some time putting Sheryl at ease and involving her actively in the assessment process could have strengthened her self-agency and given her a sense of self-confidence and self-respect. Sheryl's experience with service providers being insensitive to the vulnerabilities of victims of sexual abuse was not an isolated incident.

That was horrendous. And I was told that my concentration span was only about 4 minutes and the average person's was 40, 45 minutes. That I obviously have difficulty with the windows. And that I would need to learn to fully concentrate. And it was like, how can you expect me to do that, when all these people are walking up and down and they can see me? (Anna)

Anna felt that her therapist ridiculed her attention span. The room the therapist used had a large window that opened to the hallway and exposed her to all the people, patients and clinicians, who constantly passed by. She was distracted by these comings and goings and felt that her need for privacy and confidentiality was violated. Instead of

receiving emotional support and care Anna felt blamed. The same therapist also demonstrated in other ways the lack of understanding of the vulnerabilities of victims of sexual abuse.

Initially we were just medicated. And when we discussed the sexual abuse, we had some bad times and ended up in the hospital through obviously not being ready enough or whatever to talk about it. So it was more skills, trying to learn some skills to, yeah, like, the psychiatrist said go for a run in the forest. And go throw pebbles in the ocean... Well, the nearest forest was ..., no it wasn't really helpful... I don't have that many good memories. I don't have that, my psychiatrist was ok, but we were still doing the same thing (behaviours of self-harm). Life hasn't really changed much other than doing it a little bit more sleepily. (Anna)

Anna reported that her treatment has mainly focused on dispensing medication. As soon as she started talking about the sexual abuse she deteriorated and became suicidal. Her therapist responded to that deterioration with suggesting superficial distraction techniques for emotional regulation. Anna explained that neither the medication nor the skills helped her in this difficult time. She still engaged in self-harming behaviours, albeit more sleepily.

Anna's experiences within the public health system have been shared by other survivors as well (Wells, 2004). Wells described how rather than engaging in abuse focused therapy and listening to survivors' stories of abuse and pain, the emphasis in public mental health services is on medicating the pain away followed by marginally effective suggestions and advice. Anna stayed for many years in the mental health system and lost hope of ever recovering because 'nothing changed'. Treatment that erodes hope jeopardises recovery because hope is the backbone of recovery (Anthony, 1993). Withholding of emotional support and care in a time of need signals to survivors that they are not worthy of care. It thereby forms a negative sense of identity and hinders recovery (figure 11, p. 163).

Whereas clinical misjudgements can occur because therapists, just like other people, are only human and sometimes just don't get it right, the following section 'victim blaming' discusses interactions that were perceived as intentionally hurtful acts based on discrimination and perceived disregard for the victims.

Victim Blaming

Victims of sexual abuse commonly make meaning out of their experience by assigning blame and responsibility to themselves. Not only do they feel they could have prevented or stopped the abuse, they also might feel they should be able to cope with the

consequences better and 'put the experience behind' them. This is mirrored by their immediate environment and by society who become resentful of being reminded that safety and predictability is at best tenuous and fluctuate between compassion, blame, feelings of revenge, and responsibility (Kolk & McFarlane, 1996).

In the section 'victim blaming' interactions are discussed that have been perceived by participants as hurtful because they felt blamed, judged, mistrusted, and discriminated. These experiences, in line with Honneth's framework of recognition theory, represent the withholding of legal recognition form of cognitive respect which has been identified by Honneth (1995b) as instrumental for the development of self-respect (table 2, p. 20).

I feel they (ACC and WINZ) don't trust me to say when this is done and finished. And I am quite capable of doing that. And I will... Well, I am on sickness benefit, and that, you know, you haven't got, you are not the full life on sickness benefit. You are not fully responsible. That's their attitude. (June)

June interpreted the attitudes of staff at ACC and WINZ as a sign of mistrust in her ability to be fully responsible. She was adamant that she could be trusted to indicate when she no longer needed governmental support for her therapy. Marion described a similar experience.

And then at the end of it she said that she agreed with my counsellor that I probably would have to go for another couple of years to set everything right. And its almost, I felt like I was someone on the dole and they came into our room to make sure that I was supposed to be on the dole. That's what I felt like... I felt like maybe I was telling lies and I was getting my counsellor's help for \$40 instead of \$90 and that she was here to test me, and that something had happened to me and that I should be allowed to be here. (Marion)

Marion had been reassured by the assessor that she would need probably two more years before she could leave therapy. Still she had the impression that the purpose of the assessment was to establish whether she was entitled to receive ACC funding for therapy. She felt blamed that she might be telling lies to assure ACC's financial support. Other participants had similar perceptions. They believed that the emphasis of ACC reports and assessments was on justifying the need for further funding. This evoked in participants the impression that they were mistrusted and that their integrity was questioned.

Participants perceived they were blamed and not respected to make moral decisions. Honneth (1995b) explained that not only the withholding of legal rights but also implicit messages that one is not equal to others and is not being granted equal moral rights deprives a person of the cognitive regard for their status of moral

responsibility. The above examples showed that participants were very sensitive to the perceived lack of cognitive respect and reacted with distress. Whether participants' perceptions of blame were indeed correct or just imagined, they still responded with distress and hurt feelings. It harmed their positive self-relations and thereby hindered their recovery.

And they, they just didn't listen to what I was telling them and what my doctor was telling them...I didn't believe what came from my case managers outlining what happened last year, the series of events. The total misinterpretation of everything that happened. ... It makes me feel guilty all the time that I am asking for something that I shouldn't be having. Something [money] I wasn't entitled to. They were kindly giving me their money. That's what it feels like. Well, I felt very angry at times. Yeah, very, very upset. Very frequently! ... And so they just ended up mucking me around and in the end I just gave up. I just couldn't cope with fighting them any longer. So I never had funding for that. I paid for it. (Sheryl)

Sheryl felt very angry and upset. She was blamed asking for money she was not entitled to, although she had a specialist's report confirming that the treatment she requested was directly related to her abuse. Sheryl's self-respect was so bruised by this disrespect that she stopped asking for financial assistance. She paid for her treatment herself. The perception of being blamed and mistrusted by ACC led to feelings of hurt, anger, and indignation. This was also the case for Jacob as the next example shows.

Lousy, pretty lousy! I was untrustworthy, they didn't trust me, you know, they thought I was a liar. I felt frustrated and I felt hurt that I was not going, I was just going to be who I was. I was always going to be that person living at the bottom of the scale of life and drinking and drugging it out. Just having no life... I started thinking more about seeking help. The opportunity came up for help when we finally put our parents away (prison) in 91 or whenever it was. And then it was a money factor. Someone told me I could get money from ACC because of what happened, and then I thought that might actually be a chance to get back something from the system. And then a whole new fight started with that then. The whole disbelief that I have been sexually abused by ACC. No one believing me. (Jacob)

Jacob reported that his case manager did not believe that he was sexually abused. He was frustrated and hurt by the implication that he was lying about the events in his childhood. Not only was that a devastating insult for him, he also feared he would miss out on the opportunity to get his life back on track. Honneth (1995b) states that the denial of recognition can cause the collapse of a person's identity. This threat became noticeable in Jacob's statement that he feared he would always be a person who lived at the bottom of the scale. Fortunately he had received recognition in the form of cognitive respect through the court procedures, when his parents pleaded guilty and were sent to jail for many years for the abuse they had perpetrated on him and his sisters. His

identity did not collapse. He was able to resist ACC's disrespect and fight for his right for compensation and for treatment funding.

Whereas the examples so far described victim blaming in the form of mistrust and suspicion, Sheryl reported a more direct and blatant form of victim blaming.

They (police) actually told me off, because for going where I went (to the park). They said you shouldn't be playing there...It was my fault, and they said I was stupid. It was a stupid thing to do. And I mean it was terrible... The person was sent to court...It was never mentioned again from that day...No I wasn't seen by anybody. I never talked about it to anybody. (Sheryl)

After she had been raped at the age of seven in a public park in bright daylight, the police scolded her for playing there. They told her that she was stupid for doing so and that it was her fault that she had been raped. The rape was never again mentioned by her parents or by her. She never received any psychological help after the rape and never talked to anybody about it. Because she had never received any recognition for the injustice of the rape, she had internalised the blame and felt responsible for having been raped. It set her up for a lifelong struggle with disabling psychiatric symptoms, low self-respect, and low self-confidence. Only forty years later, after her daughter had a similar experience and Sheryl's coping systems collapsed, did it occur to her to reach out for professional help. She had lost forty years of quality of life by the poor and uncaring way her childhood experiences of sexual abuse had been handled by the police.

An even more subtle form of victim blaming had been identified by some participants in the injustice they perceived when they saw how they were treated compared to other accident victims.

I get really angry when I see like the All Blacks, you know, they get every broken toe nail attended to. And they go out and chose to do these things. You know, I had no choice at all in what happened to me. (Sheryl)

Sheryl expressed strong feelings of anger about how easy famous sports persons receive treatment. She made the point that she had no choice in what happened to her while, for example the All Blacks expose themselves knowingly to the dangers of suffering injuries. Yet they receive ACC funding for their treatment without having to endure the humiliating processes she had to endure.

The sickening part for me is that the person that did this to me is in drug rehabilitation and totally 100 % government funded and he has to go and has the injections and the drugs are given to him. Because he couldn't go off, it would kill him. Yeah, the whole world just seems a little bit wrong. All his help is free. (Marion)

Marion had a strong sense of injustice when she learnt that her abuser received treatment that was fully funded by the government whereas she had to comply with stressful and humiliating processes as well as having to pay for part of her treatment. What Marion overlooked was that she had the choice to use public mental health services instead of ACC funded therapy.

But now I am beginning to think, why don't they go and get it off the buggers who did this. I don't have to feel guilty! They could go and get it. And I happily sign for them to do that. But of course it would be hard to prove and anything. But that is another issue...they are not held responsible. No absolutely not. I live with the constant gripe inside me that they have gone on to have very, very successful lives. I don't know, I can't really say whether they are happy or not, but they are not struggling financially. And even if they struggle emotionally, they can afford the best. I don't know. It's not fair. And I am not going to feel guilty for ACC paying thousands on me. (June)

June commented on the injustice in the ACC legislation that allows perpetrators of sexual abuse to go unpunished. She feels that current law is to the advantage of sexual perpetrators who slip through the fingers of justice and are not held responsible. While she has struggled for decades emotionally and financially and not been able to live up to her potential, her abusers have led very successful lives.

Victim blaming shaped the process of recovery from sexual abuse by evoking in participants an intense sense of injustice that led to strong feelings of distress, or, as seen in Sheryl's case, even prevented the beginning of recovery. This distress was reflected in participants' deterioration of their overall functioning that harmed the development of positive self-relations and hindered recovery (figure 11, p. 163). Feelings of humiliation and re-victimisation were also evoked when therapists overstepped professional boundaries and became involved with participants.

Breach of the Code of Ethics

In the context of this study 'breach of the Code of Ethics' describes how therapists violated participants' physical integrity. Honneth (1995b, 2003) described rape as total disrespect of a person's right to receive recognition through love in the form of emotional support and care. He explained that the denial of recognition through love is harmful to a person's physical integrity and detrimental to the development of positive self-relations and identity.

Because of the strong emotions and attachment needs that arise for survivors in the therapeutic relationship, health professionals are required to maintain strict professional boundaries to avoid the exploitation of survivors. All codes of professional

conduct and ethics for mental health professionals explicitly prohibit sexual involvement with survivors.

When I first went to see him [therapist] I certainly wasn't thinking about him in relationship terms. It was just somebody that has been supportive and I was going to see him. It then went real quick which I was very happy about, it was wonderful. I mean it was only since I talked to various people like my counsellor that I can see otherwise. But, at the time I thought it was great... I think it rocked me a lot harder than if he [therapist] had just been some guy. He had always been somebody who had always been so accepting of me, so OK with me. And now suddenly I wasn't? And I guess it reinforced the notion or this belief that I have that my only use to a male is for sex. So after we had sex, that was it. He didn't want me anymore. (Cassie)

Cassie described how happy she was when her therapist started a relationship with her. First he had been so wonderful and accepting. This changed very quickly once they had sex. He withdrew from her. She explained that the break-up rocked her much harder than if it had been 'just some guy' and not her therapist. Pope (2001) explains that the violation of boundaries by health professionals through seduction is confusing for clients, may evoke psychiatric emergency, and may be detrimental to the recovery from sexual abuse. He stated that sexual contact between psychotherapists and their clients is exploitation and never acceptable. Pope's study (2001) found that this sexual transgression of boundaries by service providers is linked to mental health problems comparable to those victims of incest exhibited.

Sexual abuse leaves victims with an understanding of love and care that is associated with sexual acts. When seeking professional help they easily confuse being cared for with being loved in a sexual way. The task of therapy then is for the survivor to distinguish between these two forms of love and learn to set appropriate boundaries. Herman (1992) explained therapy as a labour of love and collaborative commitment. She emphasises that therapeutic relationship is not a love affair or a social relationship even though all the passions of human attachment may be evoked. Cassie's therapist had let her down by exploiting her need to be loved for the gratification of his desires. Rather than having the opportunity to work therapeutically with her need for love Cassie had been re-traumatised by the re-enactment of her childhood violations. Her self-confidence was harmed and she blamed herself for the violation, just as she did for the violation in her childhood. Her self-relations were harmed and recovery had been hindered (figure 11, p. 163). This was similar in the following example, although the therapist did not become sexually involved with the participant. He only talked about his sexual attraction for her.

But, I suppose he thought that he was getting too close. And I thought, here I am, going to a professional for advice, and I have got a man who says he can't give it to me because he is getting too close to me, and... I was 26 or 27 or something. And that 'all the men are the same type' of stigma came in. Because I just thought, gosh, I'd go to him to try and fix up this shit, and he is a shit-head as well. Well, maybe not so bad because then he walked away... I felt like I have just spent six months with you, what a waste of time. (Marion)

Marion had been with her therapist for six months. He told her that he could no longer see her because he was getting too close to her. She was very angry and labelled him a 'shit-head', although she gave him credit for walking away from the therapeutic relationship rather than exploiting his position. Marion felt that she had wasted six months. This experience left her mistrusting of service providers, disheartened, and hopeless. She stayed away from therapy for many years which put her recovery on hold and prolonged her suffering.

Marion's therapist had disclosed his attraction to her rather than using supervision to gain a professional understanding of his feelings and use them therapeutically to aid Marion's therapy. Even though he could be recommended for not acting on his feelings, Marion was left devastated. Dalenberg's study (2000) has shown that often these disclosures evoke strong negative responses and should only be made if they are dictated by clients' needs and serve the recovery process. The therapists' breach of the code of ethics shaped the recovery by re-traumatising participants through the re-enactment of the sexual violation of adult-child boundaries in childhood and by eroding participants' trust in themselves and in therapists. It hindered recovery by reinforcing abuse-based beliefs, leading to the deterioration of participants' trauma response, and hindering the development of positive self-relations (figure 11, p. 163).

Conclusion

This chapter explored how participants struggled with what they perceived was the lack of understanding of their treatment needs by some health professionals. Rather than receiving support and care, they described feeling harmed by poor preparation of the therapeutic work ahead, by clinical misjudgements, by victim blaming, and therapists' breaching the code of ethics. Whether incidences they interpreted as a lack of understanding occurred intentional or unintentional, whether they did occur at all or were due to participants' misinterpretation of their interaction with service providers, they always caused distress. This distress led to the deterioration of participants' trauma response, inhibited the development of positive self-relations, and resulted in a perpetuating cycle of disrespect in which recovery was hindered.

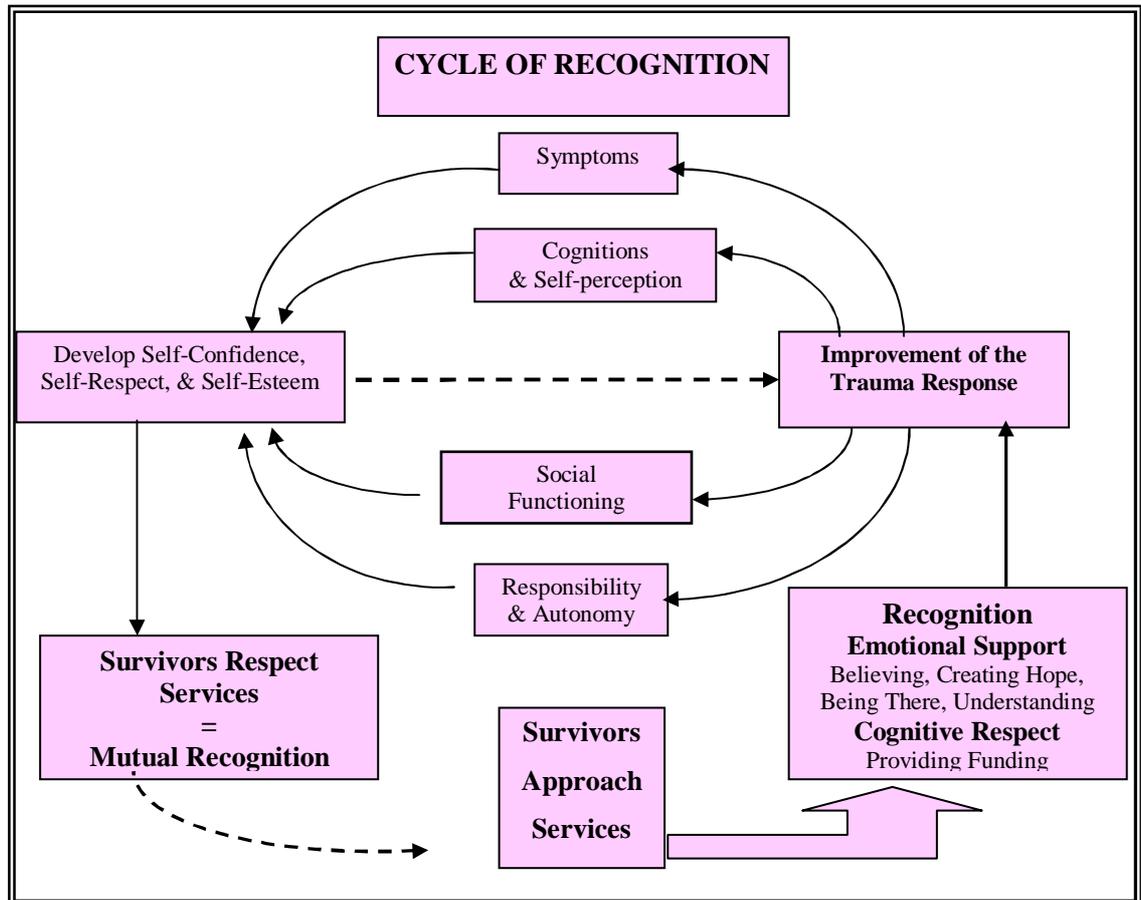
The following chapter explores interactions participants claimed have helped them to progress on their recovery journey and describe the process that allowed them to finally resist disrespect.

CHAPTER TEN

START FEELING LIKE A HUMAN BEING

When participants started in abuse-focused therapy they began to notice progress in their recovery from sexual abuse. As soon as they received emotional support and care and cognitive respect, they observed an improvement of their trauma response inasmuch as their psychiatric symptoms diminished, their cognitions and self-perceptions became less contaminated by the abuse, their social functioning improved, and their sense of responsibility and autonomy grew. This led to an increased sense of self-confidence, self-respect, and self-esteem and informed them that they had grown stronger as persons. The reciprocal re-enforcing dynamic started between their positive self-relations and the improvement of their trauma response. Figure 12 provides an overview of the dynamics discussed in this chapter.

Figure 12 Cycle of Recognition: Start Feeling Like a Human Being



The recognition participants received through the emotional support and care and the cognitive respect by their therapists and/or by ACC enabled them to increasingly cope with experiences of disrespect. They may have experienced disrespect from their own therapists, from ACC, or from other health professionals that were also involved in their recovery. Participants valued the support and care given by their therapists and the mutual recognition that resulted from that, soon led to a self-re-enforcing cycle of recognition.

This chapter explores the incidences and circumstances that describe the above mentioned dynamics that were facilitative of participants' recovery from sexual abuse. It will trace the path that led from participants' improvement to their ability to stand up for themselves and finally resist disrespect altogether. The following table 15 gives an overview over the content and structure of this chapter that shows how participants started feeling like human beings.

Table 13 Chapter Content: Start Feeling Like a Human Being

Start Feeling Like a Human Being
Receiving Cognitive Respect: ACC Funding for Treatment
Receiving Emotional Support and Care Through Therapy Finding the Right Therapist Believing Creating Hope Being There Understanding
Resisting Disrespect Confronting Authorities Maintaining Integrity of the Psyche
Conclusion

Receiving Cognitive Respect: ACC Funding for Treatment

Participants described governmental funding for the treatment of mental injury due to the experience of sexual abuse as a vital source of recognition for their recovery to begin. Receiving cognitive respect through ACC funding for therapy elicited from all participants gratitude and relief because without that funding, they might not have had the therapy that led to their recovery. Honneth (1995b) posits that recognition in the

form of the granting of rights is the expression of cognitive respect. By being given cognitive respect subjects are respected as equal, autonomous, entitled to society's consideration and to accessing social resources. Being granted legal rights enables subjects to respect themselves because they are respected by others.

And she (social worker) said to me you might be able to get ACC funding...And the feeling was a surge of utter relief. That I would be able to get that help! If they hadn't funded the treatment it wouldn't have happened. (Sheryl)

Sheryl was relieved when she was informed about the possibility to get ACC funding for her therapy. She had not been aware of ACC funding for sexually abused persons and mentioned that without ACC funding she would not have been able to afford to pay for her treatment.

I have got to say ACC was wonderful in the respect that one of my biggest limitations about going to therapy have been I could not afford to do that...Absolutely, absolutely ...I do have to say, if it hadn't been for ACC I would have been in a mess. (Cassie)

Oh, hugely. I would not have had it. I would not have had the therapy that I did have without ACC. I could not have afforded it. It is mostly based around finances. I could not have afforded it. It is as simple as that. (Helen)

Cassie and Helen were in the same situation as Sheryl. Indeed, nine out of ten participants mentioned that they would not have been able to pay for their therapy themselves. Not only would they have been in 'a mess', two participants even wondered whether they would still be alive as Anna's example showed.

They (ACC) financially assisted me with subsidising counselling, which was beneficial...No, no, [I would not be able to afford it]. No, I haven't thought about it like that, but yeah that's, yeah...Imagine that. Would I still be alive? (Anna)

All participants acknowledged the importance of ACC funding for their recovery. Being granted legal recognition has been pivotal for recovery to commence and has been in some cases life saving. Participants' initial response has been one of relief and gratitude and they were able to give recognition to ACC for its important role in their recovery. However, the mutual recognition between ACC and participants was short-lived. The circumstances involved in securing ACC-approval for continuous funding left participants with bitterness. So much that Jacob and Cassie had difficulty acknowledging ACC's assistance.

They are paying my way. That's it really. They are paying for this counselling. (Jacob)

ACC has also influenced my recovery in allowing me the time-out I needed. So, you know, I have to acknowledge that. I don't like necessarily the way it had turned out, but I have to acknowledge they had been a huge factor in allowing me time to do this. (Cassie)

Although Helen and Marama would not have been able to pay for their therapy themselves, they needed some convincing from others before they were willing to give up their independence and apply for funding for therapy through ACC.

Yes. I don't think I would have done it at all without them (ACC). And I think my doctor was really good that he persuaded me ... I was a little bit reluctant, because I don't like people paying for me for anything. I mean right even now, money is power... And I felt that will give them power over my life, what I could do, where I could go, all of these things. And they would know what I am doing with my life. If it ever got interesting. And I didn't want anybody to have that power over me at all. So he actually persuaded me to go and talk about it first (Helen)

Well, I am incredibly grateful for the opportunity to have the financial support to carry on with my therapy. Without a doubt, without a doubt! It took quite some convincing for me to be willing to accept it. (Marama)

Helen and Marama articulated the reluctance that some survivors may have with becoming dependent on the government for assistance. Herman (1992) pointed out that being in control and having a sense of power is vital for victims' recovery. In contrast, dependency may easily evoke memories of having been dependent on people in the past that subsequently inflicted pain (Herman, 1992). On the other side, society's general idealisation of independence may render people that are dependent on governmental financial assistance to feel stigmatised and devalued. It has been described by McFarlane and van der Kolk (1996) that they may be seen as threatening the social fabric by not being self-reliant and instead living off 'the strong'.

Although some participants may have been reluctant to accept help through the government the data from this study suggests that legal recognition expressed through governmental funding for abuse-focused therapy has been a significant factor in the shaping of recovery from sexual abuse. Honneth (1995b) states that cognitive respect, the public recognition of a person as a bearer of rights, is vital for the development of self-respect. Funding for sexual abuse treatment through ACC symbolises recognition for the criminal act that has been perpetrated and that victims have the right to apply for governmental assistance to overcome the legacies of this criminal act. Not only gives ACC victims of sexual abuse access to public funding for treatment they may otherwise not be able to finance, by indicating that victims had been wronged it also may have a therapeutic affect in counteracting cognitive distortions such as self-blame.

Receiving Emotional Support and Care Through Therapy

Recognition theory (Honneth, 1995b) considers emotional support and care as the form in which recognition through love is provided (table 3, page 27). Recognition through love is essential for the development of a person's self and the formation of identity because emotional support and care represent intersubjective dynamics that assist people in building a positive understanding of themselves and in developing self-confidence (Honneth, 1995b). Emotional support and care have been depicted in the literature as crucial for human relationships and as a pre-conditions for human community (Engster, 2004; Honneth, 1995b; Mead, 1934; Noddings, 1984). Emotional support and care have also been identified by participants as the main agent that facilitated recovery.

Participants reported that once they had found the right therapist who believed in them, had hope for their recovery, understood them and was there for them, they felt supported and cared for.

Finding the right therapist

Recovery, according to participants, started to advance only once they felt they had met the right therapist who helped them to deal with the legacies of sexual abuse and provided emotional support and care.

The very beginning? Meeting my therapist! Finally meeting ... someone who was skilled, someone who knew about the specifics and who understood, someone who was committed and who was strong. All those things. And it was like Hallelujah...Finding the right match for our particular needs and trusting that we could handle everything. (Anna)

The first thing that comes to my head is my therapist. Because I had attempted before and it was her and who she is, somehow, I could trust. Not completely, but enough to get started. (June)

The examples from Anna and June demonstrate the significance of finding the right therapist. They had a sense that they had succeeded in the quest when they felt their therapist's skills matched their needs and they could go about developing trust in the therapist and in their own ability to cope with the tasks of recovery.

Participants often spoke about 'finding the right therapist'. To be 'right', therapists needed to be skilled and knowledgeable about the specific needs of survivors with a history of sexual abuse and needed to be able to establish a good relationship. It was most important for their recovery that they felt a fit, a connection, with their

therapist. Thus being the 'right' therapist was not just about therapists' skill level, but also about being recognised by participants as being skilled in the field of sexual abuse and, more importantly, being skilled in establishing a human connection.

To be perceived as 'right' required therapists to care about participants, to respect them, and to provide emotional support. Once participants were able to recognise these qualities in therapists, the mutual recognition between participants and therapists fuelled and facilitated the recovery process. The same emphasis can be found in the literature (Miller et al, 2000; Herman, 1992; Briere, 2002; Cozolino, 2002; Lewis et al, 2001) which highlights the importance of the relationship between therapist and survivor for positive outcome. Ruth knew she found the right therapist when she attended a group therapy session and saw the therapist working with another person. She felt that his approach and his way of working was what she wanted and needed for her own therapy.

I wish that was me, I want to do some work like this. And he said I'll stay for another hour, can you stay? And I was so frightened I ran, I said no I can't, I can't, I can't stay. So then I had the courage and I rang him in that week and I started working with him. So, that was the beginning really. (Ruth)

I want you to say that my recovery never really started until I saw my present counsellor. I think in retrospect, when you go to see a counsellor and that doesn't work, it puts you back. Definitely!... Yeah, there needs to be a group of people that are maybe studied or people go and analyse them and they say yes, these people can look after people who have been sexually abused, and these people can't... People have to get to the right person... they might not have a doctor like I've got. They could just have a doctor that says, oh, you'll be right, take these tablets. So how can you police something like that? (Marion)

Marion stated that her recovery started only after she had found the right counsellor. She shared in the interview that she had started with several therapists. She did not feel they understood her needs or were knowledgeable about sexual abuse. She emphasised strongly the need for victims of sexual abuse to find the 'right' therapist with understanding and skills in the area of recovery from sexual abuse. Herman (1992, p. 133) came to the same conclusion in her research and stated "In the words of an incest survivor, 'Good therapists were those who really validated my experience and helped me to control my behaviour rather than trying to control me'".

'Finding the right therapist' indicates how recognition through love in the form of emotional support is indispensable for recovery. This seems to be confirmed by all other participants. Prior to the beginning of their recovery and in the absence of

emotional support participants had been close to giving up the will to live and some even attempted to end their lives. However, once participants had found the right therapist and were able to establish mutual recognition, their recovery proceeded through the emotional support and care given in the form of believing, creating hope, being there, and understanding.

Believing

'Believing' is a property of emotional support and care in Honneth's (1995b) sense because it signals the therapist's trust in the participant's reality that his or her physical integrity has been violated by the experience of sexual abuse. This trust led to participants trusting themselves and developing self-confidence.

...that people actually believed that it did take place. That's what I needed to hear that people believed it took place... You see, I think back then, it was like, no it didn't happen to men. And I think every ones' attitude back then was hey, it doesn't happen, you are lying. (Jacob)

Jacob emphasised how important it was for him that people gave him recognition as a victim of sexual abuse by believing and acknowledging what happened to him. He mentioned that, years ago when he started his recovery, the fact that males are sexually abused as well as females was less known. For recovery to commence and for his self-confidence and self-respect to develop Jacob needed people to believe that, maybe, he was not just a bad boy, but rather bad things had happened to him.

I think my counsellor's acknowledgement that it actually did happen to me.... when I first started to talk to her, she seemed to be quite affected by it. And I am thinking, what is your problem? Because I actually didn't feel bad myself. And I thought why does she feel bad? And that took a long time, and then I started to think, I feel weird. (Helen)

Helen reported how important her therapist's acknowledgement and congruent emotional reaction to her experiences of abuse helped her to start feeling the destructive impact of the abuse as well. Her therapist provided recognition through love with her emotional expression that demonstrated that she was emotionally affected and cared about Helen. Helen's ability for sensing and expressing her emotions re-developed in response to that recognition.

It is not unusual for victims of sexual abuse to dissociate from their feelings in order to cope and not feel the emotional impact of the abuse (Briere, 2002; Herman, 1992). By expressing the congruent emotions about an abusive incident, such as sadness, shock, or anger, therapists facilitate the softening of the defensive coping

strategy and victims become increasingly sensitised to experience a wider range of emotions. Honneth (1995b) claims that emotions such as hurt, anger, or rage inform subjects that injustice has occurred. These emotions then become the motivational source for resisting disrespect and the development of self-confidence. Thus being able to feel her emotions about the incidences of abuse enabled Helen to become more fully aware that injustice had occurred. Her therapist's recognition facilitated the reversal of the trauma response of dissociation and helped her to improve her cognitions by evaluating the impact of the abuse more accurately.

Cassie gave another example that demonstrated the importance of recognition through love when she was asked what had the biggest impact on her recovery.

The fact that somebody would actually believe in me! Who absolute believes I am not defective. Who absolutely believes that I can have a life worth living. Who holds that belief when I don't have it? Who actually, I believe, cares about me and likes me with no ulterior motive. (Cassie)

Cassie's example showed the importance of her therapist believing in her and holding the hope for recovery for as long as she did not have that belief herself. Receiving recognition by being cared for and having the therapist believing in her had been, according to Cassie, the most important aspect that facilitated recovery.

Creating Hope

'Creating Hope' is understood in this study as a property of self-confidence in Honneth's (1995b) sense because hope signifies a person's growing trust in him or herself and in the environment, which Honneth relates to having received recognition through love. Hope as the main stay of recovery has not only been discussed in the context of the recovery model in Chapter Four (pages 56-58) but also been identified by participants as vital for their recovery.

Counselling, how that helped? My God! Hope. Hope... You know there are so many things that come when I think what did counselling give me. And it starts off you have hope, and then everything mushrooms from there... A person, who's, like if you have a kids colouring-in set, you have got a person in there, you start to get filled in, you start to get colour in your life. And you start feeling like a human being. (Anna)

Anna described how counselling had given her hope which has been the starting point from which her recovery unfolded. Receiving recognition through love in the form of emotional support and care from her therapist improved her overall functioning and her life became increasingly more colourful and worth living. Her self-perception

improved, she started feeling 'like a human being', and her self-confidence developed. By recognising therapy and therefore her therapist as so fundamental to her recovery Anna created a dynamic of mutual recognition in which recovery became possible. Other participants mentioned as well that over the course of therapy their sense of identity had been transformed by developing hope and internalising the caring actions of their therapist.

It (teacher liking me) made me feel that maybe I am not as bad as I think I am. Maybe there is something in there that is worth looking at. Maybe there is something that people could like. And it wasn't a 'yes there is something', it was a 'maybe there might be something'. It was more of a, I guess, seed of hope than a confidence. (Cassie)

Cassie reported how the emotional support and care of a teacher installed in her the hope that she could be a lovable person. Her comment shows that not just therapists but all persons who play a significant role in victim's lives are vital for the development of hope and subsequently self-confidence. It demonstrates that recognition through love that is inherent in social support facilitated an improvement in her self-perception and positively impacted on her recovery.

It (counsellor's care) makes me think that there is a possibility that I can like myself that I can get where I want to get to. Because without that I wouldn't be here. Without that I would give up. It stops me giving up. It stops me opting out. Opting out of life altogether. I am sure I said that last time, if it wasn't for my counsellor I wouldn't be here. I wouldn't still be around, you know. (Cassie)

Cassie also described how her therapist's continuous emotional support and care gave her the hope that she could like herself and could succeed in her recovery. She believed it prevented her from giving up and following the impulses to end her life. By giving recognition to the important role her therapist had in her recovery Cassie established a dynamic of mutual recognition in which her recovery was able to proceed.

It has been suggested that the caring of a significant other has a soothing impact on persons who are in a state of heightened emotional dysregulation (Cozolino, 2002; Lewis, Amini, & Lannon, 2001). They explain that the presence of a person who exudes calmness and care assists in creating those neuro pathways that are needed for survivors to self-regulate their inner states. These neuro-biological processes that lead to affect regulation are discussed in depth in Chapter Three (pages 44-47) as being facilitated by therapists' ability to be affectively attuned and able to resonate with survivors' minds. Thus through receiving emotional support and care Cassie was able to improve her trauma response and her self-perception.

Being There

'Being There' is understood in this study as a property of recognition through love in Honneth's (1995b) sense because it demonstrates how helpful participants viewed the active way in which emotional support and care was provided by their health professional.

It was life saving really. Because I was just so confused with what was happening in my head at that stage. I was just utterly, utterly overwhelmed. I was just going through the motions of every day. I mean I was, I couldn't concentrate, I thought I was losing my mind really. It was just terrible. Yes, their advice and their support was life saving. (Sheryl)

Sheryl reported how important the help was that she received from her daughter's social worker before she had found a therapist for herself. Every time she brought her daughter, who had just survived a trauma herself, for sessions, the social worker put some time aside to attend to Sheryl as well.

Rape Crisis, they were really good in that they started to put things in place that made me feel, gave me the things that felt that I was in control. Even though it was the faintest of notion! (Johanna)

Johanna was very thankful for the support she received from Rape Crisis. Knowing they were there for her helped Johanna in this difficult time. While she was still under the shock from the attack, the helpful advice helped Johanna to regain a sense of control. Sheryl and Johanna perceived the emotional support and care as helpful which led to an improvement of their trauma response, especially their symptoms and self-perceptions. When Sheryl and Johanna gave recognition to the services they were involved with a dynamic of mutual recognition was established that led to an improvement of their overall functioning.

Because my doctor was so supportive along with my counsellor I felt I was absolutely entitled to this. I guess it was more their belief than mine when I applied for it. And that's the same with the weekly compensation. (Cassie)

Cassie felt empowered by her therapist and her doctor when she hesitated applying for ACC funding. The reassurance she received from them enabled her to believe in her entitlements and persevere with her application even when ACC disputed her claim. It was the tangible support given by her doctor and therapist that led to the improvement of her self-perception and self-confidence. She was able to balance the perceived disrespect from ACC with the recognition she received and fight ACC for her entitlements.

Receiving recognition through love in the form of emotional support and care gave participants the reassurance that they are not alone when facing difficult times and stressful circumstances. Knowing that they could rely on the support of their therapist enabled them to face internal and external challenges they might have avoided without the support.

... in all the dives that I was going through, you know, all the holes that I was going into, I wasn't on my own, there was somebody...I could hang on to my next session. Whereas when there is nothing out there and there is no prospect of anything, that's just, you know, Oh no, I can't do this. (Cassie)

Cassie realised that she was not alone on her recovery journey. She felt comforted knowing that her therapist was on her side. That helped her to contain her internal stress states in between sessions. Therapy and her therapist had become the transitional object she used for self-soothing between sessions. In psychodynamic literature (Honneth, 2003) transitional objects, in this case the therapist and therapy, are seen to convey a sense of safety and protection and bridge the time of separation between sessions. This was similar for Anna.

... it gave us a chance to rest. And it gave us a tool, mentally and, oh my God, and gather our many thoughts, and, yeah... It has released a lot of pain, it has, and by doing that it has allowed the space for other things to grow. Researcher: Like? Anna: A self! (Anna)

Anna spoke about how therapy has been the oasis in which she could quieten down her inner chaos, engage in the release of emotional pain and experience the growth of her identity. Her therapist had been able to create the environment she needed to proceed with her recovery. The emotional support and care that Anna and Cassie had received from their therapists resulted in an improvement of their trauma response whereby their symptoms declined and their self-perception improved. This allowed for their self-confidence to develop.

But we had our therapist, and she had shown in a number of ways how committed she was to our journey as well, regardless of what direction it takes. And that was huge... and we were able to talk to her and go through the whole range of emotions with the whole thing, and the impact it was having on us, like it was almost crippling. (Anna)

Like Cassie descried earlier, Anna felt that she was not alone anymore. She had found a therapist who was willing to walk alongside her in the pursuit of recovery. When Anna felt harmed by ACC's responses to her application for weekly compensation for earnings, she was able to utilise her therapists' emotional support to

get through this difficult time. Other participants indicated that they felt the presence of care most intensely when service providers would show care and emotional support through actions that exceeded the commonly held notions of health professionals' responsibilities.

He said he didn't want them (x team¹⁹) to become involved. He talked to me afterwards about this and said, once they become involved, you get caught up in all sorts of things, its best to keep them out of it. He said, I come and see you every few hours and he gave me medication. (Helen)

Helen reported how prior to finding a therapist, her doctor would rather take on the extra work of crisis care than referring her to the community crisis team. That allowed her to stay with the health professional she was familiar with and whom she trusted instead of having to cope with unfamiliar health professionals.

But there are things that she does for me outside of those times, the fact that I can e-mail her. She doesn't need to but she does it anyway. That is giving me some belief that I am not totally unlovable and horrible. That someone I care about very much actually cares. (Cassie)

Cassie's stated that having the tangible after session support from her therapist had a great impact on her recovery. The voluntary act by her psychotherapist enabled Cassie to question life-long, abuse based beliefs about her worth and her identity. It was this demonstration of care and support that helped her to penetrate the mistrust and negative self-perception she had for years.

...so one of the first things was that it was not just about the one hour sessions but he was available on the phone 24 hours seven days a week. Now, that's almost unheard of. Very unusual! But when I first met him I was in my suicidal phase. I probably wouldn't have made it through that time. He went away for 5 weeks on holiday and he rang from all over the place, just every three or four days. The holding! And I wouldn't have made it [without it]. (Ruth)

When Ruth had a suicidal phase her therapist gave her emotional support and care by interrupting his holidays and reassuring her of his support. Ruth was certain that this demonstration of care kept her alive at a time when she felt overwhelmed and unable to cope.

These experiences represented a level of care and availability that is usually outside of normal therapeutic practice and usually outside of therapists' capacity to sustain over an extended time. Yet the above examples showed that the willingness of

¹⁹ The name of the service provider is substituted to assure confidentiality.

health professionals to suspend their own needs and provide containment and increase clients' safety has helped participants to progress with their recovery.

Because by saying goodbye to ACC, I would think in most circumstances it would mean that your therapist would say, ok I am not getting subsidised by ACC, so pay the full fee. I am just incredibly fortunate that my therapist hasn't said that yet. Because it still is expensive, you know... Even though I do feel empowered I do feel sad and I feel angry that it went the way it did. (Anna)

You see, my therapist was very good. He just took the \$ 44 that WINZ was giving me. So he reduced his fee, because he wanted to finish off with me...But he was very good, you know, because now I am just paying \$ 44 which is not his fee. His fees are hundred bucks an hour. So he is taking the loss actually, just so that we can finish off. (Ruth)

Anna and Ruth felt supported by their therapists when they decided to stop being funded by ACC for their treatment. Their therapists showed emotional support and care by negotiating a lower than usual fee so that both could finish their therapy. In both cases the therapists have demonstrated support willingly even though it impinged on their own financial interests.

This section has given examples that illustrated that services shaped recovery by health professionals 'being there', giving emotional support and tangible practical support. While participants experiences recognition through love they were also able to give recognition back to their therapist. A cycle of mutual recognition was established that allowed participants' overall functioning to improve and resulted in the development of positive self-relations.

Understanding

In this study 'Understanding' has been vital for recovery to proceed. It is conceptualised as another property of recognition through love (table 2, p. 20) because understanding sexual abuse, the impact it has on victims and the specific treatment needs victims may have is essential for providing effective emotional support and care.

...they [case managers] don't really have any understanding of what is going on with it. They don't really know where their client's are at. ...with (case manager²⁰) I never felt like that. With (case manager) I actually felt like he had an idea of what is going on. He seemed, I don't know whether he was trained or not, I have no idea what his background was, but he appeared to me to be much more qualified dealing with clients than for example the case manager I have now... he was very good...I always got the feeling from (case manager) that he was very much on my side and he was trying to help, (Cassie)

²⁰ The case manager's name has been substituted to assure confidentiality.

Cassie did not believe that ACC case managers in general have a good enough understanding of the needs of sexually abused persons. Yet she reports of interactions with one ACC case manager by whom she felt understood and supported. When she perceived him as helpful and 'on her side' she felt recognised by him. This enabled her to recognise him by respecting and valuing him. Thus a state of mutual recognition was achieved in which, according to Honneth (1995b) the formation of a positive identity can take place.

I didn't start anything properly before I had a trained, committed, therapist. Somehow I always had a sense of a lot of professionalism with my therapist, and especially with the after hour support. (June)

June perceived that service providers would be unable to respond effectively to her needs without understanding the struggles she went through. She indicated that her therapist's ability to understand her and her needs led to the emotional support she needed when she was offered after hours support.

According to participants, providing services effectively would require of therapists a general understanding of trauma and its effects on a person and, most of all, an understanding of the specific needs and treatment requirements of victims of sexual abuse. When participants perceived their therapist as being skilled with sound professional understanding and knowledge they were able to develop a sense of safety and trust in the health professional and in the process of recovery.

That's when I knew he could stand strong you see, and neutral and not collude with me. So that was the other defining moment. That's when I thought, oh, this guy is good. That was a fantastic moment actually, that was a really good moment knowing that he would not collude. Because I knew I needed someone incredibly strong to stand against. (Ruth)

Ruth needed to know that her therapist was neutral and would not collude with her. That increased her trust in his abilities and his competency and assured her that she had engaged with the right therapist. She felt safe.

I think somebody else caring, somebody empathising and caring without wanting to go fix it. They don't want to kill that person, they don't want to do any of those things, they just want to empathise with me. And it is just the action of telling it and somebody else understanding it... Nobody, all these people, they didn't hunt me down and get the adult. They just got the little girl that was available. So it could have been me, it could have been any little girl, but it wasn't the adult. And that helped, that helped a lot. It would have still happened to any little girl that was there. Not just me. And I think overall, that was probably the biggest thing... To understand and be given the skills to know that I didn't really have a choice. Those things helped. Not to feel that it was all my fault. (Helen)

As Helen told her story and her therapist understood what happened to her, she was able to understand herself and her life-history in a new way. Abuse based beliefs and self-evaluations about her identity were investigated and new understandings were explored. It helped her to realise that what happened to her as a child was not her fault. Helen remembered that as a pivotal part of her recovery. The emotional support and care she received improved her self-perceptions and she was able to revise abuse based cognitions of being responsible for the abuse. This was similar for Anna.

I saw people out there that were just going to hurt you...everyone was going to somehow inflict pain and that would either be physical or other... How I am with my community now? Because I am not ruled by the past anymore, I don't have those beliefs about people anymore. (Anna)

As the result of the experienced sexual abuse Anna had been mistrusting of people and avoided all social situations, which left her isolated for many years. Victims of abuse often develop a variety of abuse-based beliefs that subsequently hinder them to lead a normal life (Briere, 2002). These are contaminated cognitions about the world around them, about people, and about themselves. These beliefs needed to be revisited, explored, and subjected to new interpretations and new understandings. Participants reported that they were able to do so in the therapeutic relationship. Improving their cognitions became an important catalyst for their recovery.

'Understanding' has been an important aspect of recognition through love. When participants perceived that they were understood they were able to extend recognition to their therapist and/or other health professionals. Only then was a dynamic of mutual recognition established in which they experienced an improvement of their psychiatric disturbances that led to the development of positive self-relations and recovery (figure 12, page 181).

Resisting Disrespect

The first part of this chapter has explored how receiving funding from ACC, finding the right therapist, believing, creating hope, being there, and understanding created a dynamic cycle of recognition through which participants' were able to diminish their trauma response and strengthen their positive self-relation. The more participants were able to internalise the recognition they received, the more they were able to put up resistance to interactions they interpreted as acts of injustice. Honneth (1995b) proposed that strong emotions such as shame, rage, or hurt constitute emotional knowledge that informs subjects that an act of disrespect has occurred. His concept of the moral

development of society is based on marginalised groups resisting disrespect and struggling for recognition through either confronting authorities or engaging in efforts to maintain the integrity of their psyche. Through such resistance marginalised groups demand from society to become more inclusive and recognise their normative claims for recognition (Honneth, 1995b).

The remainder of this chapter explores how participants' emotions of hurt, anger, and rage compelled them to engage in the struggle for recognition and resist further marginalisation or injustice. They did so in two distinct ways. They confronted authorities and actively engaged in conflict or they resisted disrespect more passively to maintain their integrity by removing themselves from an environment that could expose them to further disrespect.

Confronting Authorities

Participants' ability to confront authorities is evidence that they have been able to leave behind the traditional victim position with its distorted abuse-based beliefs of self-blame and helplessness (Herman, 1992). This process has been a gradual development of participants' positive self-relations that took place in response to the being supported and receiving care, being respected, and being valued by their therapists. The first part of this chapter explored how these characteristics of abuse-focused therapy enabled the development of self-confidence, self-respect, and self-esteem that allowed participants to resist actions of disrespect.

(I made) threats of going to Holmes or Fair Go. I was really yelling at them (ACC) about my rights, because it's my right to be on the benefit because I had a mental break-down! (Jacob)

Jacob had strong feelings of rage because he was left without income for several months over Christmas due to delayed processing at ACC. He felt he was denied the ability to provide for the basic needs of his family. He felt humiliated and the associated rage and propelled him to rebel and threaten to publicly humiliate ACC.

I was trying to fight to keep my counselling and to be paid and be looked after while I was seeking help. So I wasn't actually spending the time healing the problem at hand, but more getting help to get me through the week because of ACC and the system. I still have to fight now, but I can handle it a little bit better...And at the same time you have to lift that little bit higher to get past the stuff that they throw in front of you. (Jacob)

Jacob described how the continuous struggle with ACC had strengthened him and enabled him to handle the confrontations better. He had to 'lift higher' to overcome the obstacles he perceived ACC had put in his way.

Later on when I was getting stronger and when I thought back about what happened, I think it made me quite harder, which is sort of a paradox. And it worked in my case, possibly because I have sort of a fighting nature and was prepared to do it. Possibly also because I had the kids so I had a goal to live for. (Johanna)

Johanna also believed that her struggle with ACC had hardened her. She commented on the paradox that having to fight for her rights had strengthened her. Johanna explained that with her fighting nature and with having her children as a goal to live for. The examples of Jacob and Johanna showed that participants may become emotionally stronger and harden up when they have to fight for their rights and resist acts of disrespect.

... the last time I did argue with them actually, I did win. And that surprised me. And I wonder if it was only because I got a lawyer on my side. And if it had been just me, I don't think I would have won it. It was only the thought of having a lawyer challenging them that I think they gave in... I just said that my lawyer would be present and my doctor and my therapist. (Cassie)

Cassie reported that the support of her therapist, her doctor, and her lawyer enabled her to stand up to ACC and challenge their decision to refuse her weekly compensation for loss of earnings. Cassie's example demonstrated that participants were willing to fight for their rights when emotional support was available and their positive self-relations had become stronger. Participants' recovery from sexual abuse had been shaped by balancing the disrespect they perceived in the asymmetrical distribution of power between them and service providers with the recognition they had received. In most cases the recognition came from participants' therapists, but, as Cassie's example showed, recognition received from her lawyer and her doctor had also strengthened her self-confidence.

This is in contrast to approximately 20 years earlier. Cassie had engaged with a specialist service but did not have the emotional support and care of abuse-focused therapy (Chapter Seven, pages 128-131). Without access to recognition she was unable to balance the disrespect she perceived by the hospital only treating her for the eating disorder and ignoring her history of sexual abuse. She had been unable to overcome her inhibitions and verbalise her discontent with the treatment. She gave up by no longer attending treatment at the hospital.

Honneth (1995b) declared that subjects learn about their strength and developing identity only through resisting infringement on their integrity or dignity. Participants showed that they realised that they had become more self-confident by being able to respond more assertively in conflict situations whereas prior to therapy they may have given up and not engage in asserting their rights. This is highlighted with Marion's example.

I can see things like, I growled at my husband the other day. And we have been married for a dozen years and I never raised my voice to him. Taking my boss to court, hitting that head on...And that was, yeah, that was so hard. Travelling, I would never get into planes, because of this claustrophobic thing being stuck. My grandmother passed away...And I could go by myself [by plane] to the funeral. (Marion)

Marion learnt about who she is, about her particular preferences and strengths by resisting infringements on her positive self-relations. She noticed infringements from authorities such as her demanding husband, a disrespectful employer, and a personal fear that all threatened her self-confidence and self-respect.

When Jacob, Cassie, and Marion experienced a growing sense of self-confidence, an improvement in their functioning, and when they felt reassured of emotional support, they were able to start taking risks and confront authorities such as ACC, an employer, or the husband. Being able to do so gave them a sense of self-confidence and self-respect that signalled to them that their recovery is progressing well. However, confronting institutions such as ACC has been difficult for participants. Only Jacob and Cassie directly confronted ACC. Their ability to engage in direct confrontation with ACC may have been due to the fact that they fought for the continuity of weekly compensation, their only source for their living costs. Thus for Jacob and Cassie the stakes have been higher than for other participants.

Maintaining Integrity of the Psyche

Although most participants did not confront ACC directly, they found more passive ways to maintain the integrity of their psyche by avoiding situations that had the potential of exposing them to disrespect. Whereas in the early stages of their recovery they had strong emotional reactions to disrespect and their psychiatric disturbances escalated, they now had developed strong enough positive self-relations and chose not to engage with ACC.

And then what happened was that I got a letter one day saying that the case worker changed and it changed to a man. I went through such a huge process

with that...I never ever contacted them after that. I was livid. Absolutely livid! How dare they put a man in...and I suppose to some degree, the only way I resolved it was by not contacting them for anything. So I wouldn't ask for any kind of help, any clarification, nothing. (Marama)

Marama was shocked when she realised that she was assigned to a male case manager. She echoed the sentiments of a large number of women who find it intolerable to have a male working on their case because most have experienced being sexually abused by a man in authority. She maintained her psychological integrity by refusing to contact ACC for any assistance at all.

And so they just ended up mucking me around and in the end I just gave up. I just couldn't cope with fighting them any longer. So I never had funding for that. I paid for it myself. (Sheryl)

Sheryl too responded to the disrespect she perceived by avoiding any contact or asking for any additional services. She rather paid for the treatment she needed herself. Although Sheryl and Marama missed out on funding for services they may have been entitled to by refusing to contact ACC, it appears that it was more important for them to avoid any contact that could expose them to further disrespect. As recovery proceeded, participants were able to resist being treated disrespectfully by ACC by not applying for further funding through ACC for their treatment. Some participants continued therapy and paid for their treatment themselves, others were able to stop therapy altogether.

Cutting loose and taking back my power had been invaluable and I think I would have done it even without this experience. But it may not have happened until later. And it wouldn't have left me with such a sour taste in the mouth. (Anna)

When Anna felt abused and treated unfairly by ACC staff she sent ACC a letter renouncing any further wish for funding through ACC. Her strong conviction that she deserved to be treated better showed how much her self-confidence and self-respect had developed. Anna was not the only participant that left ACC-funded therapy because the requirements for re-authorisation of treatment funding harmed their personal integrity and dignity. Five (5) of the ten (10) participants decided not to re-apply for ACC funding. Their self-relations had grown enough and they removed themselves from a system they felt was abusive. By balancing disrespect with recognition participants did not collapse into crisis or unmanageable distress. Instead, participants were able to maintain their integrity by distancing themselves from a system they perceived demonstrated to them the unequal distribution of power.

Now I, left ACC funding when it did run out, I didn't apply for anymore...I had three years or so with ACC. It was allocated. Ah, I had to go for a psychiatric

assessment and I didn't want to do that. I think that's when I said I am not going to do that. (Ruth)

Ruth decided not to apply for further funding when her allocated hours ran out. She did not want to attend another assessment and arranged with her therapist to pay privately to continue her therapy. This was similar for Johanna.

And when those hours were up and they said we could have another assessment I decided that I didn't want to have our case by ACC anymore. I didn't want to go through another assessor. I didn't want to open up to anybody else again. And I felt that even though I had not fully recovered at that point I didn't want to be labelled a victim anymore... And that was important for my recovery too, because it shifted the focus from victim to potential, to achieve my potential. (Johanna)

After Johanna had been told that she needed to attend another assessment, she decided not to continue with treatment under ACC funding. She was not willing to open herself up to another person. Even though Johanna had not fully recovered, she felt she was labelled a victim by continuing therapy under the umbrella of ACC. Rather than focusing on the victimisation of her past she wanted to concentrate on achieving her potential.

... I wanted to (quit ACC) because I thought then that my issues were no longer so much about sexual abuse but about abandonment and some other things. So I thought, well, that isn't really ACC. So it was my choice. (June)

June, who struggled from the beginning with the need to give sensitive and detailed information to ACC in the progress reports, stopped applying for further funding as soon as she had the impression that the focus of her therapy had changed away from sexual abuse towards other issues. June's example showed that it was against her moral standards to exploit the availability of ACC funding for therapy. Her recovery had advanced to the point that she rather experienced her autonomy and take responsibility for the future course of her recovery.

All five participants who stopped ACC funded treatment refused to comply with further restrictions to their autonomy and self-responsibility. They needed to be independent from assessments and ACC and take the course of their recovery into their own hands. To be autonomous and respected as equal partners in interactions took precedence over being taken care of financially by the government. "...the endurance of legal under-privileging necessarily leads to a crippling feeling of social shame, from which one can be liberated only through active protest and resistance" (Honneth, 1995b, p. 121). Participants liberated themselves from the under-privileging that was reflected in ACC's demands for compliance with procedures they perceived as a threat to their

positive self-relations and therefore their recovery. They were able to balance the disrespect they endured with the recognition they received and expressed their resistance to the unequal distribution of power by leaving ACC funded treatment. However, a counter example was given by Helen that may indicate the necessity for resistance from a different perspective. Helen had no struggles or experiences of disrespect from any services involved in her abuse-focused treatment.

I didn't have anything that was not helpful...they (ACC) didn't create any problems or dramas for me. They funded my therapy and funded several other things as well...There was never a problem. If my counsellor had any problems with ACC she dealt with them herself. So maybe I was shielded from that. Because at times she told me she had been contacted by ACC. And I had total faith that she would sort it out. And she did. The problem wasn't passed onto me. I never once directly dealt with ACC. (Helen)

Helen was shielded by her therapist from any contact with ACC and subsequently did not have to fight any perceived injustices or intrusions. Helen has evaluated her therapist protection and care as helpful and positive for her recovery.

It made a huge difference that I had no personal contact with the day to day dealings of ACC and funding. (Researcher: And you got better?) Yes. Yes I did. Yes I still have severe panic attacks. ...when I went to Australia, the two or three weeks were just awful. Horrible! I got them very badly. But I have been very, very lucky with my new partner. There are no secrets, it's nothing, it's, I feel loved. You are not a panic attack, it's just something that happens now and again and we just deal with it. (Helen)

Helen reported that her self-understanding, her overall functioning, and her social skills have improved. Helen left therapy when her therapist went into retirement although she still suffered from the severe panic attacks that had led her to approach services in the first place. This indicates that an important aspect of her recovery had not yet taken place. Her reoccurring panic attacks may have been an escalation of the trauma response indicating that the disrespect of her sexual abuse experiences could still, on occasion, interrupt her life.

Even though Helen would have had plenty of opportunity to challenge incidences of disrespect in her day to day life, challenging the authority from which care is expected and hoped for, may have been the crucial step in recovery. From a psychodynamic perspective the authority from which care is expected may represent transferentially the person that was expected in the past to provide care and which instead inflicted abuse.

Seen in this light, the protectiveness of Helen's therapist may have made it unnecessary for her to resist disrespect in a vital transference relationship and may

have prevented an important aspect of the sexual abuse trauma to be resolved. Helen did not have the experience of being hardened or having to lift herself higher to the extent Jacob and Johanna reported at the beginning of this chapter.

Conclusion

This chapter explored how participants perceived that services facilitated their recovery through recognition. Although therapists' have been singled out as the most significant facilitators of participants' recovery, support, care, and respect from other service providers such as teachers, social workers, Rape Crisis, doctors, and ACC case managers has also contributed to participants' recovery. Therapists have consistently and reliably assisted participants in their recovery by believing, creating hope, being there, and understanding. In return, participants gave recognition to service providers and thereby co-established a dynamic of mutual recognition. A perpetuating cycle of recognition was created in which the development of positive self-relations could take place and recovery could progress.

Even though experiences of disrespect were painful and distressing, they also strengthened and hardened participants. By being able to resist acts of disrespect by either engaging in conflict and confronting authorities or by removing themselves from an environment in which they felt victimised, participants realised that recovery had taken place. It is therefore concluded that both recognition and disrespect are facilitative of recovery. Receiving recognition is vital for the development of positive self-relations such as self-confidence, self-respect, and self-esteem. Disrespect is also facilitative as it brought into participants' awareness that they have grown strong enough to protect themselves from further victimisation. Thus recovery has been a process of balancing the internalisation of recognition with resisting disrespect. Participants were no longer victims of their past but could understand themselves now as equal and autonomous members of society. They started to feel like a human being.

The following chapter explores the reactions of service providers who were asked how they perceived they shaped the recovery of victims of sexual abuse.

CHAPTER ELEVEN

WALKING ALONGSIDE SURVIVORS

Although the main focus of this study was to give voice to the experiences of survivors of sexual abuse, service providers were also interviewed. The aim was to be able to balance and compare participants' perceptions with providers' views of the recovery process. The hope was to get answers for the questions posed in the introduction of this study (page 2), whether assumptions, expectations, and experiences of survivors differ from service providers' views.

This chapter explores participating service providers' perceptions of how services shape the recovery of victims of sexual abuse. To begin participating service providers define recovery. This is followed by brief discussion of how ACC defines their role in the recovery from sexual abuse. Then attention is given to the therapeutic relationship followed by participating service providers' experience of working with ACC funded survivors of sexual abuse. The chapter ends with the presentation of participating service providers' view of how public mental health services shape the recovery from sexual abuse. Table 16 gives an overview of this chapter's content.

Table 14 Chapter Content: Walking Alongside Survivors

Walking Alongside Survivors
Therapists Define Recovery
ACC Defines Their Role
The Therapeutic Relationship
Working Under ACC Funding The Breakdown of Mutual Recognition Limiting Working with ACC Funded Survivors
Working In Public Mental Health

Therapists Define Recovery

One question at the beginning of this study was whether service providers and survivors had a complementary understanding of recovery or whether the disappointment with service providers as expressed by the participants in the interviews, was due to a difference in understanding the nature of recovery.

Recovery for me is when someone gets to the stage where they have a productive live which means they handle work and their day to day living and have relationships of whatever sort, and also be able to deal with the complexities, the disappointments, and the pleasures that occur in life without disintegration and decompensation, where they could become depressed or suicidal or self-harm. (Brenda)

... that enough ego-strength grows to actually manage the traumas and crises that life presents them. So that they don't get re-activated into the same space they were in, that regressed abused state...It is also learning to manage the sexual abuse and the body processes so that the sexual abuse is not running the show. It is understood, it is managed. It will never not be there but it is on a manageable level. (Lisa)

Brenda and Lisa explained recovery as the point in time when survivors are able to function in their day to day life and when they are able to manage distress without entering into a state of psychological crisis. This view corresponded with survivors' understanding who stated that for them recovery constituted improvement of their trauma response in the form of less symptoms, positive self-perceptions and cognitions, improved social functioning, and the ability to responsible and autonomous (Chapter Six, pages 114-122).

These findings are supported by Cozolino (2002) who described the ability to regulate one's inner states as a function of the self to enable a person to successfully navigate social and occupational tasks. Thus the establishment of positive self-relations of self-confidence, self-respect, and self-esteem, the main expressions of a healthy self, have been indicative of recovery. Participants also affirmed the notion from the recovery literature (Chapter Four, pages 57-59) that recovery is a very personal experience that cannot be generalised over all persons in recovery (Anthony, 2000).

It's different for each person. Important is what is recovery for them. Some may want to do a very little piece of work for them to have a sense of recovery. (Esther)

For one particular client I work with recovery is to be able to live within the 24 hour residential program. All their needs are taken care of... therapy would actually not change anything for them regarding independent functioning. So their level of recovery would be learning some basic skills and have relationships within the confines of what they can have. (Brenda)

Esther and Brenda agreed that the process of recovery is different for each person. Esther shared from her experience that some survivors may not have dealt with all the abuse issues. They may have a sense of recovery even though they have only done a little piece of therapeutic work. Brenda expanded on Esther's example, illustrating that recovery for some survivors may mean that they have acquired the basic living skills and relationship skills needed to live in a residential program. Participants in this study also demonstrated an awareness of the importance of resistance for survivors' recovery.

I think one of the most important moments was when they (survivors) have enough courage to be able to bring whatever it is in the relationship between the client and me and they being able to confront me. They have never been able to confront the abuser. That initial step! That is the bit that I really encourage them to be able to do. (Lisa)

Lisa highlighted that survivors need to be able to express their disappointments about their therapists. These disappointments may be due to an empathic failure or not meeting survivors' expectations. By doing so Lisa used current incidences to encourage survivors' negative transference from the perpetrator to the therapist. Wolf defines transferences as 'the manifestations in the clinical analytic situation of distorted archaic needs and the defences against them that were acquired during childhood in interactions with the earliest selfobjects²¹'. By encouraging the negative transference Lisa aimed to access needs and disappointments from the abuse experience the survivor has hitherto not been able to express. Thus therapy becomes the training field for survivors who were not able to confront their abusers. They can 'practice' on their therapists how to resist perceived disrespect and thereby reverse an aspect of their experience of victimisation. Kate expands in the following quote on the recovery from sexual abuse.

They (clients) come home to themselves and they know they are home. That's when they have recovered. For once they are coming home and know they are the ruler of their own house. That's when they have done most of their work and then they have the energy to fight ACC. Then they can stand their ground with them. And that is actually when clients' come off ACC. Then they claim back their life and take responsibility. (Kate)

Kate stated that survivors know that they have recovered when they felt confident enough to confront their therapist without fearing that they will lose the important emotional support and care. Kate used the metaphor of coming home to oneself and being the ruler of one's own house. The acquired self-confidence and self-respect then enabled survivors to confront ACC and, eventually, come off ACC. At that

²¹ Wolf defines self-object as the presence of others (objects), who provide experiences (selfobject experiences) that evoke the emergence and maintenance of the self. The abbreviated term for selfobject experiences is selfobject. (Wolf, p. 11).

point survivors are able to take control over their lives and take responsibility for their future direction.

Participants in this study were therapists who had years of experience in working with victims of sexual abuse. Their training background and their intimate involvement in the therapeutic process gave them a deep understanding of survivors' processes and needs. Other service providers with less close and frequent contact with victims of sexual abuse, for example doctors or crisis workers, may have a different perception of the recovery process. To interview them was outside of the scope of this study and would be an area for further research.

ACC Defines Their Role

After participating survivors and service providers had commented on the impact ACC had on the recovery from sexual abuse, the researcher had hoped to be able to interview some case managers to enable them to state their point of view. However, this was declined with the comment that

...staffs are not clinicians and would not be in a position to comment on sexual abuse recovery. (Grace)

Grace, a senior ACC staff member, was willing to comment on how ACC might shape the recovery from sexual abuse.

...ACC staff has no impact on claimants' recovery...our role is facilitating and funding rehabilitation services rather than to provide services. (Grace)

Grace stated that ACC does not perceive that they have an impact on claimants' recovery. Instead, she emphasised that ACC is not a service provider. They only facilitate and fund rehabilitation services. ACC perceived that facilitating and funding rehabilitation services is not providing services to survivors of sexual abuse. This belief could confirm participating survivors' perception that ACC's interest is in controlling government expenditures rather than serving survivors of sexual abuse through sensitive case management. How ACC is going to justify that making decisions about funding and rehabilitation is not having an impact on survivors of sexual abuse is, however, altogether unclear.

It appears that a number of very important questions have not been discussed amongst health professionals and ACC that clarify the specific role ACC has in the treatment of victims of sexual abuse. ACC's position of having no impact on the recovery from sexual abuse is in strong contrast to the experiences participating survivor had expressed in Chapter Eight (pages 141-161) and participating service

providers, who offer abuse-focused therapy under ACC funding, mentioned in the following sections in this chapter. When Grace was asked to comment on the dissatisfaction and injustice that survivors expressed about the attitudes of staff and the procedures and policies enforced by ACC she countered that "...the last consumer survey showed 81% satisfaction rate". (Grace) Grace did not indicate on what data the satisfaction rate was measured or how representative the survey was of survivors of sexual abuse.

Grace's comment indicated that ACC is not aware of how deeply survivors are affected by their interactions with ACC. The lack of awareness amongst some groups of service providers about the impact they have on survivors has been discussed by Campbell (2005) who identified in her research that social systems personnel often underestimated the impact their actions have on victims of sexual abuse. Grace's response demonstrated Campbell's findings that personnel without clinical background struggle to understand the impact they have on survivors.

...the only barriers for claimants' recovery are accessibility to treatment and lack of clear guidelines for the most appropriate treatment and the length of treatment. (Grace)

Rather than understanding the importance of the interpersonal relationships between ACC and claimants, Grace refers to issues of access and treatment. She stated that survivors' recovery is hindered due to the difficulty they have of finding ACC approved therapists and due to the lack of guidelines for most appropriate treatment and length of treatment. However, the tension between ACC and the therapists (see Chapter Four, pages 67-70) has led to an exodus of counsellors willing to work with ACC funded survivors as Mitchell (2005) emphasises in the following quote.

"...the exact numbers of counsellors opting out of ACC was not known, but it was the experienced practitioners who were leaving. They are saying 'no more'. There is too much paperwork, too many requirements and restrictions, and too much inflexibility. What's more, we get paid a pittance" (Mitchell, 2005).

The tension between counsellors and ACC is further explored in this study in the section 'working under ACC funding' in this chapter. Grace's view that ACC's actions have no impact on survivors may be explained by Armstrong (2005) who stated that workers in large institutions become de-individualised through multiple bureaucratic layers and the division of work processes. This de-individualisation process combined with economic dependency creates a workforce that is motivated away from service

users' needs and towards 'robotic' compliance, suspended conscience, and reduced moral and personal responsibility.

The Therapeutic Relationship

Survivors of sexual abuse have been abused in the context of interpersonal relationships. Therefore recovery also has to take place within the context of a significant relationship (Herman, 1992). Throughout the study it has been emphasised that the experience of recovery was linked to the establishment of positive self-relations, which only can be developed in interpersonal relationships that are based on mutual recognition (Herman, 1992; Pearlman & Saakvitne, 1995). This makes the therapeutic relationship an important tool in the recovery process. Participating service providers have confirmed the importance of the therapeutic relationship for recovery from sexual abuse.

Crucial is the quality of the relationship between me and the client...usually the transference relationship is very maternal and there is the requirement for me to take the mother-role and re-parent and re-do a lot of the mothering deficits as well as working through the trauma. (Lisa)

Lisa made the important observation that initially the therapeutic relationship had a maternal quality and needed to address the developmental deficits that were due to the lack of care and support in survivors' childhoods. Briere (2002) called the task of re-doing developmental deficits through taking on the mothering role the building of self-resources. He emphasised that creating self-understanding, decontaminating abuse based beliefs, and establishing emotion-regulation and distress tolerance skills, thus the establishment of self-confidence and self-respect, needs to be given priority before survivors are able to engage safely in trauma processing.

The therapist-role is very complex. It goes from being warm and soft, to being able to hear their story and not getting afraid. Walk alongside them through thick and thin and being able to go with them into the house of horrors. Be real, be human, and for them to be able to see that you can hold what they bring into the room. (Marie)

In the interviews all participating service providers emphasised the need for therapists to be caring, understanding, believing, and able to walk alongside survivors when they revisit the horrors of their past. As Marie stated, it requires the therapist to be real and to be human. These qualities refer to therapists' position of the nurturer whereas survivors were the recipients of nurturing. However, this dynamic closely mirrors the mother-child relationship and may not do justice to survivors' adult capacities of being capable, autonomous, and responsible. Whilst survivors receive

recognition through love in the form of emotional support and care from their therapists, it appears less emphasis may have been given on providing cognitive respect.

Not only may survivors miss out on experiences that assist the development of self-respect, therapists' primary focus on providing recognition through love might create undue dependency of survivors and lead to helplessness, as the example of Helen (page 201) indicates. As discussed in Chapter Three (pages 44-47), the development of neural processing networks that integrate affective states, sensations, behaviours, and consciousness into functional cortical circuits depends on the provision of stage-appropriate challenges in the presence of support and care. June, a participating survivor explains in the following quote how important stage-appropriate challenges are and receiving predominantly support and care missed an important aspect of her recovery.

I want to say something that I have discovered that is really important...The only thing I struggled with, I want to tell you counsellors this...my idea of atonement, which I kept bringing up, was discounted. Do you know how important that is, to atone, to have confession? Do you know how important that was for someone like me, to find some way of working out my guilt for the things that I did do wrong? I couldn't just say in my head, ah well, you were young, you were abused etc. That wasn't enough. And it was discounted. And I have discovered I do need to atone, in my own simple way...I know I was at fault. It didn't matter whether I had full knowledge or anything else (about being abused). There were some things I felt truly guilty for and I needed to atone. Some things I can only work out in atonement. (June)

June had the need to take responsibility for the things that she did do wrong in her life. She stated clearly that she did not need nurturing in this phase of her recovery but needed to be held accountable for the lapses in her moral conduct. Her therapists' well meant attitude of being nurturing rather than acknowledging June's responsibility in her wrong-doings hindered the development of June's self-respect and therefore impeded her recovery.

Participating service providers were not only challenged to weigh up emotional support and care with cognitive respect, they also needed to find strategies to cope with survivors' post traumatic symptoms and other forms of psychopathology.

Dealing with dissociation in the sessions is really hard for me and my body feels it very strongly. Sometimes it is so strong that I need a lot of energy not to leave my body as well. (Lisa)

Lisa described the tiring effect on her body when she worked with highly dissociative clients. The literature (2003) identified this dynamic as vicarious

traumatisation through which the trauma of survivors affects therapists physical and psychological functioning.

It's difficult when the clients never had a really trusting relationship to develop a relationship in therapy then becomes so much hard work. They may be in a place where they have to be so much in control that they manipulate the therapist and want to make her into a puppet, or not wanting to get well and rather stay sick and be looked after. That's hard work. (Marie)

Marie explained how hard it is to develop a therapeutic relationship with clients who never had a trusting relationship in their lives. She observed that survivors may become controlling or manipulative rather than develop trust towards their therapist.

Very difficult is it when the client works with the attachment to the perpetrator. That work takes a lot of trust. It is extremely painful for the client and I need all my skills for holding and containing the client. (Kate)

Kate expanded on Marie's comments when she talked about the attachment to the perpetrator²². Being mistrusted and needing all the therapeutic skills available to hold and contain survivors' distress when they start exploring their feelings towards the abuser was hard work for Kate.

When practicing deep trauma work therapists not only have to be concerned about the emotional and physical safety of survivors, they are also exposed vicarious traumatisation. Wacker (2003) identified in her research that trauma always affects the therapist. How badly the therapist is affected depends on her resources and skills she has at her disposal to deal with the impact survivors' trauma has on her. Service providers and staff who do not receive regular supervision and address issues of vicarious traumatisation are likely to experience adverse affects such as symptoms of PTSD, exhaustion, hostility, compassion fatigue, stress related illness, or burn out that may lead to engaging with survivors resentfully or with hostility.

These negative symptoms of vicarious traumatisation could have a detrimental impact on the shaping of recovery. Service providers' inability to offer recognition through love might be interpreted as disrespect and therefore lead to an escalation of psychiatric disturbances rather than to an improvement of survivors' overall functioning.

In the following section participants expressed how these difficulties had been compounded when they experienced interferences and disrespect by ACC in addition to the stressors of the therapeutic work.

²² Attachment to the perpetrator is discussed in depths in Chapter Three, pages 71-74. In order to preserve the attachment bond to the perpetrating significant family member, survivors project their mistrust onto therapists and others in their environment.

Working Under ACC Funding

Honneth (1995b) stated that a moral society is only possible when social actors extend recognition to each other, thus granting each other mutual recognition. This section explores how the breakdown of reciprocal or mutual recognition between participating service providers and ACC impacted on participants' identity and the recovery of survivors in their care.

The Breakdown of Mutual Recognition

To achieve mutual recognition partners in interactions are required to extend to each other recognition in the form of emotional support and care (recognition through love), cognitive respect (the granting of rights) and social esteem (solidarity) (Honneth, 1995b). Lisa mentioned how difficult it was to establish relationships with ACC case managers based on recognition because of frequent staff changes at ACC.

The connection with ACC is not happening. You can't build a relationship with case managers. They change all the time. (Lisa)

Last year I had one case-manager that was actually supportive. He seemed to have a sense of what is happening in therapy and what clients and therapists need. But these case-managers don't last long. Whether they (case managers) are too lenient, or they burn out, I don't know. (Kate)

Kate expanded on Lisa's observation. It was her experience that some case managers demonstrated an understanding of the therapeutic process and of the needs of clients and therapists. Kate also noticed that these case managers get replaced and wondered whether that might be due to burn-out or whether they were removed from their position because they became too lenient with survivors.

I said, but get out your contract, let's go through it. No, No, No, we require this now. So, they switched the rules, which made me absolutely furious that they switched the rules. They wouldn't approve within the time they were meant to approve. So now we sent in a referral and I think they were to approve within 2 weeks unless they asked for more information. They didn't! And yet they expected us on our end to cross the "T's" and dot the "I's". If we did one thing out of place, then we didn't get paid for the group work. There is one set of rules for them and another set of rules for us. It was crazy making stuff (Ruth)

Ruth, who was interviewed as a participating survivor, reported of an incident with ACC that occurred while she assisted her therapist in the administrative tasks of organising a therapy group. She expressed a considerable amount of frustration about ACC changing the rules of approval to accommodate their administrative difficulties without consulting or informing group therapists. This had a detrimental impact on

clients because the commencement of the therapy group was threatened. Ruth described her sense of injustice about the different standards that were applied for ACC and for therapists as ‘crazy making stuff’.

The above three examples are representative of the tension that arises for professionals that work in the service industry. Holtgrewe (2001) described that tension with the struggle service workers have following organisational requirements for professionalism, predictability, and standardisation of processes while at the same time needing to adhere to norms of care by accommodating the needs of survivors and restore their autonomy. The above examples demonstrated that at this tension point misrecognition occurred and mutual recognition broke down.

A pervasive theme in the interviews has been the sense of helplessness and victimisation participating service providers experienced in their interactions with ACC. Disrespect perceived by participating service providers led to them disrespecting ACC in turn and mutual recognition broke down.

I feel so undervalued by ACC. I have done all this hard work and they don't pay. We are bloody robots sitting in the chair and they (ACC) push the button, breaking down the whole therapeutic process. (Marie)

Marie expressed her sense of powerlessness in relation to ACC and perceived that ACC's actions interfere significantly with the therapeutic process. She repeated Ruth's observation that ACC used the dominant position they have as funding provider to refuse to pay for her services.

ACC is brutal in their dealings with clients and disrespectful in their dealings with me... ..someone (ACC) is looking over our shoulder and makes decisions...it is intrusive and I fear it might retraumatise the client...I hold much better sexually abused clients that are not ACC funded. I don't have an authority that tells me "that is it, you don't get more hours". I know I don't open a can of worms and then have to stop working with the client because the funding runs out. Two to three sexually abused clients that are not ACC funded take me as much energy as one ACC funded client. It is another authority that creates stress. (Kate)

It was Kate's perception that ACC is brutal in their dealings with survivors and disrespectful towards her. She pointed out that the way ACC used its authority was intrusive and might be retraumatizing for survivors. Kate stated that a survivor funded by ACC caused her at least twice as much stress than survivors that are not funded by ACC. Without ACC involvement she was able to conduct her work without having to comply with requirements that are in conflict with her ethical standards of care.

Kate's perception of disrespect from ACC has been mirrored in many articles in the managed care literature (Blum, 1992; Edward, 1999; Karon, 1995; Sperry, 1998; Wineburgh, 1998) that discussed the disrespect from funding agencies towards therapists. These writers concluded that the requirements and procedures necessary for authorisation or reauthorisation of funding are forms of power and control that threaten the therapeutic relationship and imply disrespect of the professional integrity of therapists. Participating survivors also have interpreted ACC's requirements and procedures as disrespect towards providers.

How can somebody who sees me for one hour have a better knowledge of where I am at than my doctor and my therapist, who have been dealing with me for the last 4 years? I find that incredibly insulting that, insulting to them (counsellors), that they are not deemed professional enough to make those judgements.
(Cassie)

Cassie, a participating survivor, believed that ACC's lack of trust in therapists is insulting and infers a lack of trust in therapists' capability to make valid clinical judgements. Edward (1999) described the exposure of survivors to doubts about their therapists' skills and integrity as a grave interference with the therapeutic relationship. Survivors with a history of sexual abuse need to be able to see their therapist as strong and capable, especially if their caregivers in childhood had lacked these qualities. Therapists need to be able to model personal power and autonomy for the reparative therapy process to unfold and "...the therapist without power, although he could do little harm, would also have little ability to help the patient" (Chodoff, 1996, p. 300).

I had to write a report for one of my very difficult and traumatised clients and ACC sent it back with the comment 'unacceptable'. I couldn't believe it. They could have said could you expand on this... or could you clarify that... I was so stunned and humiliated. (Alexandra)

Alexandra had a caseload that consisted only of clients that were funded by ACC. This made her completely dependent on ACC for her income. She was shocked and felt humiliated when she received a report back with the comment 'unacceptable'. Alexandra's distress implied that she felt disrespected in her right of being treated as a responsible therapist with whom ACC could engage collaboratively for the best health-outcome of the survivor in her care. Her quote also indicated that her self-esteem was harmed by the implied devaluing of her capabilities as a clinician. Like all therapists who work with victims of sexual abuse, Alexandra is vulnerable to secondary or vicarious traumatisation through client's traumatic material. A recent New Zealand research of vicarious traumatisation of therapists (Wacker, 2003) stated that signs of vicarious traumatisation of therapists due to client's traumatic material are accentuated

and heightened by additional primary traumatisation due to either disrespect from ACC, the organisation one works for, or through one's colleagues. That Alexandra suffered from such primary traumatisation was still noticeable at the time of conducting the interview that took place shortly after the incident with ACC. She was upset, had difficulty to express herself, and her language was vague and unspecific, all signs that victims of sexual abuse might display as well.

One of my supervisees only works with ACC clients and is almost burning out. She sees herself as a marionette and ACC is pulling the strings. She is constantly writing reports. There is often no time left in supervision to attend to her clients or to herself. (Kate)

Kate described the circumstances of one of her supervisees who saw herself as a puppet on a string, without any control while ACC is pulling her strings. Instead of using supervision to disseminate the effects survivors' trauma had on her or discuss client's issues, Kate's supervisee needed to spend that valuable time to meet ACC's requirements for report writing.

Just as participating survivors struggled with not being able to have influence over the funding for their treatment and the conditions attached to it, participating service providers struggled similarly with their sense of having no power and control in their work with ACC funded survivors.

...especially at the beginning the clinical needs of the client are not to do paperwork, to write reports, and to go places where they are not ready to go to yet...I need more time with ACC clients at the beginning to develop trust. There are so much more intrusions. Does it strengthen them? No, it comes too early. They have to deal with inappropriate stuff too early. (Kate)

Even though Kate indicated that she was not opposed to writing reports, she questioned that ACC understands the importance of timing of writing reports. She was concerned that survivors' clinical needs for settling down and developing trust had to be disregarded in favour of doing paperwork for ACC. Kate also indicated that the difficulty of working with ACC funded survivors is not just in feeling disrespected by ACC as professionals, but also in the therapeutic responsibility they have to keep survivors safe. To maintain safety service providers often have additional work, such as after hour telephone support or liaising with crisis services when their clients struggle with exaggerated psychiatric symptoms, heightened distress, or become suicidal due to the impact of ACC's interaction on them.

A big obstacle is when clients start and we need to write two reports in the first 4 weeks with very detailed information about the abuse and their lives. The therapeutic relationship is still developing in that time and its strength is limited

regarding the ability to hold the client...clients then have to hold on until they hear whether they are accepted while feeling doubts about being believed. It's like a speed bump and the client moves away from me. (Marie)

Marie also questioned the appropriateness of writing detailed reports at the very early stage of therapy even though survivors, who usually start therapy because they are in considerable distress, may have pressing therapeutic needs. However, in the first four hours of therapy information has to be gathered for a cover determination report (ACC form 290, Appendix J) about survivor's history (personal and medical), the specifics of the abuse (being touched, fondled, penetrated, oral, vaginal, anal, or being forced to do that to the perpetrator, the level of threat involved), the specifics of the abuse circumstances (date, location, frequency, perpetrator's gender, age, and relationship to victim), diagnosis, symptoms, consequences of abuse, treatment requirements (specific goals, how they will be measured, which treatment modality will be used, how long it will take to achieve the goal), criminal convictions of survivor, alcohol or drug abuse, and whether any other agencies are involved.

Marie described the submission of detailed reports at this early stage of therapy, when a solid therapeutic relationship has not yet been established, as a speed-bump that interfered with survivors' ability to engage therapeutically with her. Survivor data in this study (Chapter Eight, pages 141-161) underlines Marie's concerns by describing how much survivors struggle with issues of dependency, confidentiality, lack of transparency, and powerlessness in relation to submitting reports. Participants were in agreement that, whilst early report writing serves ACC's interest for oversight and control, this is not in the interest of survivors' whose needs at that point time are rather the establishment of survivor safety, the development of the therapeutic relationship, and the building of trust.

"When I think what does it cost? I think it actually cost time and what ACC is trying to do is save time and save money for paying for hours. I think it actually creates the opposite. It's unwise! (Kate)

Kate believed that ACC's insistence of writing detailed reports at the beginning of therapy is unwise and an economically unsound decision because survivors' stirred-up emotions and distress evoked by the reports needed therapeutic attention. As this happens usually before emotion regulation skills and distress tolerance skills are developed, additional session time is needed that might not have been necessary if the focus had been more survivor needs. How participants dealt with the tension caused by their need to provide therapeutic services for the survivors in their care and the perceived disrespect from ACC and is described in the following section.

Limiting Working with ACC Funded Survivors

While it is impossible for therapists to avoid vicarious traumatisation through the contact and intense work with traumatised services users participants have described how they avoided the accumulation of traumatisation through ACC.

I have to limit ACC clients because work is so heavy. I need a balance between ACC clients and non ACC clients in order to stay well and keep enjoying my work. (Brenda)

Brenda described that she looked after her well-being by limiting the number of ACC funded services users she worked with. By doing so she limited the stress and avoided burnout that could occur through ACC's disrespect of survivors and therapists. Kate also restricted the number of ACC funded survivors she was willing to work with. She explained her decision in the following.

They (ACC) are the higher authority who set down rules and I have to meet their requirements to not sabotage the funding for the clients. So that puts me into a dependant position too. So I am not in my autonomy...I need respect in order to work, and there is no respect coming from ACC. (Kate)

By restricting the number of ACC funded survivors in her case-load Kate solved her problem with exaggerated stress she believed was imposed by ACC's requirements. Kate mentioned that she felt she had to comply with requirements so that she did not sabotage survivors' funding. This placed her in the position of powerlessness and dependency and limited her autonomy. All other participating service providers have used the strategy of limiting working with ACC funded survivors to minimise stress and disrespect they were exposed to. Their strategies for resisting disrespect mirrored those utilised by participating survivors discussed in Chapter Ten (195-202). Rather than resisting disrespect in a more outspoken and political way, they aimed to maintain the integrity of their psyche by balancing their economical need for generating an income with the level to which they exposed themselves to interactions of disrespect.

Unfortunately, this passive resistance does little more than maintaining the status quo and ultimately benefits only ACC because the more service providers and survivors withdraw from ACC in 'silent protest', the more likely a saving in expenditures occurs. Without more outspoken and public resistance ACC might not be pushed to revise their procedures and attitudes. Whilst therapists have the choice whether to accept ACC funded survivors or not, survivors may end up finding it more and more difficult to find experienced and capable therapists to assist in their recovery from sexual abuse. They might end up suffering for therapists' passivity.

Working In Public Mental Health Services

In Chapter Seven (pages 126-140) the stories of five participating survivors described that the treatment they received focused predominantly on their symptoms and psychiatric disturbances while their history of sexual abuse was ignored and remained invisible. Participating service providers commented on their view of how public mental health services shape recovery from sexual abuse.

Private practice is probably the only area where I have the freedom to define how I work with sexual abuse and commit to the longer term whereas working in an agency, sexual abuse is a box that at best is ticked and then it depends what psychopathology the client comes under as to what service they get. Whereas in another agency I worked for it was almost negated, any sexual abuse. "We don't deal with that here...there is no co-morbidity and no other issues, only the particular psychopathological symptom". (Brenda)

Brenda explained that she did not have the freedom in public mental health services to decide how and for how long she works with victims of sexual abuse. She mentioned that freedom existed for her only in her private practice. Brenda confirmed participating survivors' experiences discussed in Chapter Seven (pages 126-140) stating that sexual abuse was in some agencies totally ignored and in others just briefly acknowledged. In her experiences treatment focused then solely on the psychopathological symptoms.

So a lot of the time I had to hide the work that I did if it related to anything other than that particularly identified psychopathology. I got to the stage where the first ten minutes of a session we met the agencies requirements to talk about the identified psychopathology and for the rest we explored the impact of abuse on the person's life. So it was sort of the secret therapy that you do, which is really crucial and you can see the results from working on that, as opposed to on the symptom. It had to be invisible because it was driven by the requirements of funding. (Brenda)

Brenda resolved the tension between working within her agency's directives and meeting survivors' care needs by keeping her abuse-focused work a secret. She mentioned that this secret work was very crucial for survivors' recovery and she saw good results coming from her work. Holtgrewe (2001) stated that service workers' formation of professional identity is closely linked to the recognition they receive for the quality of their work and their value as a health professional from their agency and their colleagues. Brenda's covert resistance of her agency's policy deprived her from that recognition, because her most important and effective work took place in secrecy and was not available for appraisal by her agency.

Brenda experienced tension between her professional integrity that motivated her to provide best possible care for survivors and the requirement to follow

organisational policy and guidelines of her agency. A recent Canadian study (Austin, Rankel, Kagan, Bergum, & Lerner, 2005) explored these conflicts. They stated that moral choices are “complex, messy, multifaceted things...when lived in practice. The practice environment is invested with political, social, and personal issues in which manipulation, conflicts, and power struggles flourish” (p.210). They suggest that only an appreciation of the complexity of moral dilemmas can bring about improved understanding and create the opportunities for genuine dialogue and an environment where difficult ethical decisions can be explored amongst colleagues. Brenda, however, avoided addressing her moral dilemma with her agency. Yet, by circumnavigating her agency’s restrictions on her autonomy and self-agency as a therapist Brenda partakes in reproducing mechanisms of misrecognition “This is how conformism is re-produced through subjective involvements and investments in the way things are” (Holtgrewe, 2001, p. 3).

The public mental health system is quite punitive with regards to clients. If they complain or disagree with what health professionals consider the right treatment they are immediately labelled ‘non-compliant’. “The professionals know better”. (Ester)

Ester described the public mental health system as punitive and unwilling to collaborate with survivors about important treatment decisions. She alludes to the marginalisation that is deeply entrenched in the way the mental health system perceives, respects, and treats survivors and thereby reinforces survivors’ subordinate position in the survivor/service provider hierarchy. Frazer (2003) considers misrecognition as “institutionalised patterns of cultural value in ways that prevent one from participating as a peer in social life...that constitute some categories of social actors as normative and others as deficient or inferior” (pp. 29-30).

Most clients that struggle with the treatment they receive are unable to access consumer advocates. They are too afraid and can’t deal with the stress on top of the PTSD symptoms. They don’t even go there. (Brenda)

Brenda explained that most survivors struggle to assert their rights or get their care needs met. This struggle has also been discussed in Chapter Ten (pages 181-202) which showed that survivors need to develop self-confidence, self-respect, and self-esteem before they can challenge authorities. A finding of this study is that survivors are unable to assert their rights and challenge authority unless their positive self-relations of self-confidence, self-respect, and self-esteem are strengthened. Survivors in public mental health services may not be able to utilize patient advocacy and complaint procedures until these positive self-relations are developed.

Conclusion

This chapter has shown that service providers' definition of recovery from sexual abuse closely mirrors the understanding of participating survivors. The importance of the therapeutic relationship has been confirmed as the most important tool for recovery to proceed. It came as a surprise that ACC did not perceive that they had an important role in the shaping of survivors' recovery from sexual abuse. However, caution needs to be taken with this finding given that only one person, a senior manager, had been interviewed. Her view might not be representative of how ACC as a whole perceives their role in the recovery from sexual abuse.

Survivors have expressed (Chapters Eight) how significant the impact of ACC is on their recovery and service providers, who work with survivors of sexual abuse, have had a similar experience. However, service providers did not only struggle with ACC and the strains ACC puts on the therapeutic relationship, they also commented on how hard it is to be exposed to the post traumatic symptoms displayed by survivors of sexual abuse. The break-down of mutual recognition between ACC and providers of ACC funded therapy for the recovery from sexual abuse has been compared to the experiences of survivors. Whilst therapists felt undervalued and disrespected by ACC and ACC case managers, they responded to this with disrespecting ACC in return. It has been suggested that this breakdown not only threatened therapists' self-respect and self-esteem, it also threatened the therapeutic relationship and the recovery of survivors.

Service providers' difficulties to provide appropriate abuse-focused therapy in the public mental health system was discussed and the conclusion has been drawn that service providers' compliance with institutional policies that require the treatment of symptoms while sexual abuse remained invisible contributed to the reproduction of misrecognition and maintained the status quo.

The difficulty to engage in a meaningful dialogue and to work towards resolving conflicts between service providers in private settings and service providers who work in larger system settings, has stood out in this chapter. Without opportunities to find ways for inter-professional co-operation, the breakdown of mutual recognition appears to be almost inevitable.

The following chapter will provide an in-depth discussion of the findings that led to the formulation of a dynamic model of recovery.

CHAPTER TWELVE

BALANCING RECOGNITION AND DISRESPECT

This study has explored the research question “How is the recovery of victims of sexual abuse shaped by the services available”? Participating survivors of sexual abuse and service providers have shared their stories and views of recovery with me. I have learnt from them that the journey of recovery is a journey filled with hope and despair, with times when progress is experienced, and times when set-backs are harsh reminders of the struggle called recovery. The following table 17 gives an overview of this chapter.

Table 15 Chapter Overview: Balancing Recognition and Disrespect

Balancing Recognition and Disrespect
Shaping Through Mutual Recognition
Shaping Through Disrespect Public Mental Health Services ACC Lack of Understanding Whose Needs are Being Served?
Shaping Through Balancing
Reflections on Using Honneth’s Recognition Theory Limitations of Recognition Theory The Study’s Contribution to Recognition Theory
Recommendations for Theory and Practice Service Provision Removing Disrespect Consumer Advocate Asking About Abuse Treatment Policies
Limitations
Further Research Understanding Sexual Abuse Policy Development Theory Development Professional Development
Conclusion

Participants' stories and views and my interpretation of their recovery experiences, have led to understand the recovery of victims of sexual abuse as being 'Balancing Recognition and Disrespect', which is integral to the model outlined in figure 13 (page 222). Its main parts, the cycle of recognition and the cycle of disrespect have already been discussed separately in the findings chapters Seven, Eight, Nine, and Ten. I will present here the model in its whole and discuss its implications for practice, education, and research and then elaborate on the limitations of this study and further research.

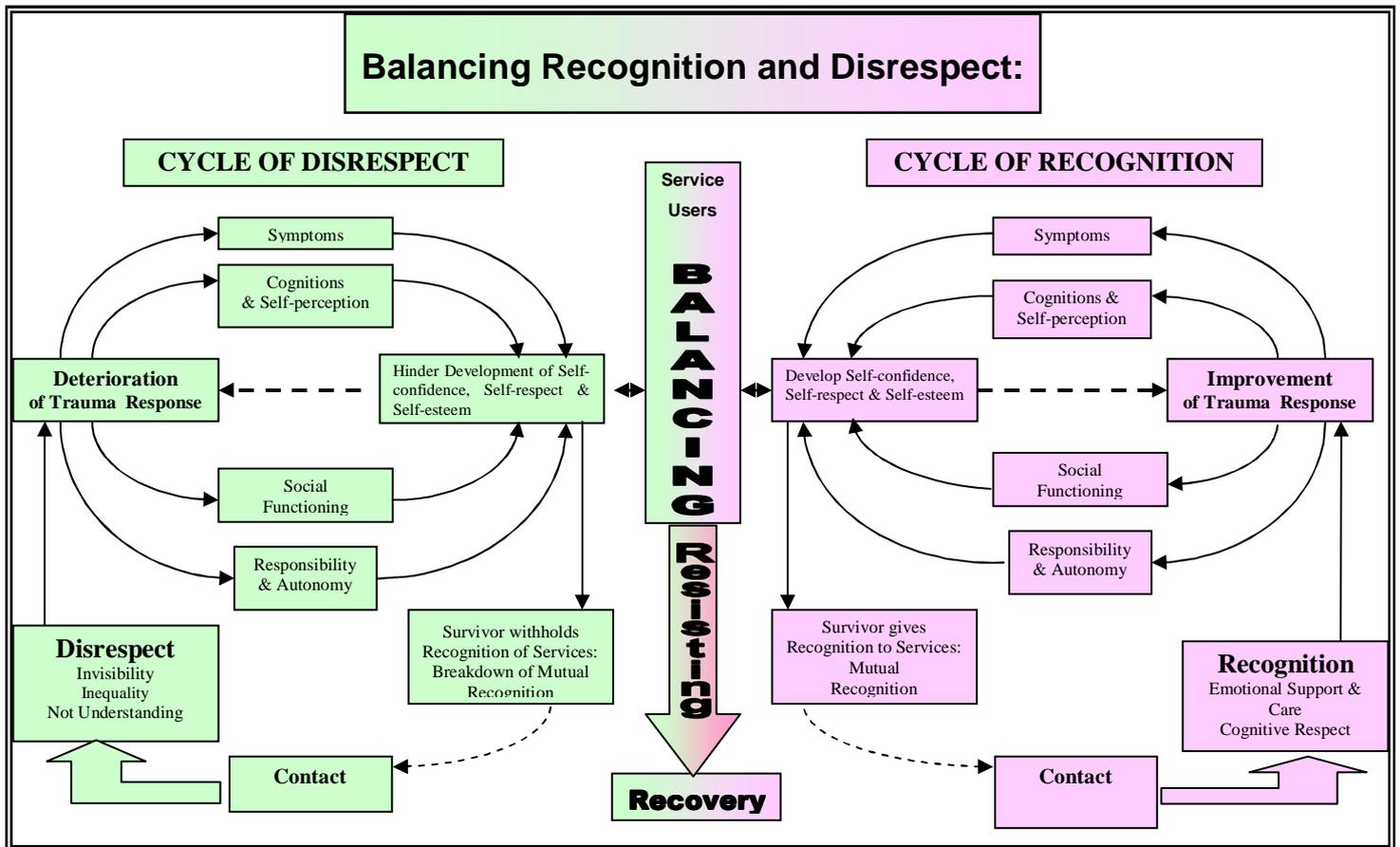
Services shape the recovery of victims of sexual abuse through providing experiences of recognition and disrespect that directly affect the development of survivors' self-relations and identity. In pursuit of recovery participants had to internalise experiences of recognition and balance them with experiences of disrespect. This balancing was not linear and not always conscious. It took place through a backwards and forwards dynamic that reflected the varied experiences survivors had had with a wide range of service providers. Experiences of recognition led to the development of self-confidence, self-respect, self-esteem, and the formation of a positive identity.

Although disrespect was perceived by participants as hindering recovery, the findings of this study propose that experiences of disrespect had the important function of facilitating the development of participants' resilience and distress tolerance which assisted the recovery process. It is a conclusion of this study that only through engaging in the struggle for recognition and resisting acts of disrespect have participants been able to realise that recovery had progressed and that they no longer needed professional assistance.

Balancing recognition and disrespect has been likened to the loss of innocence whereby the longing for the good and benign caregiver had to be surrendered for the realisation that therapists, health professionals and agencies, all have the capacity to be 'good' and provide nurturing and care and to be 'bad' by not being able or willing to meet participants' requests for care or services.

It was a struggle to represent the complexity and depth of the interpersonal dynamics as well as the intra-personal dynamics that shape recovery in a two-dimensionally model. The model therefore can only be a 'roadmap' that offers some guidance through a landscape marked by a web of multiple relationships between survivors and service providers with the influences of perceptions, interpretations, beliefs, and deep psychological processes.

Figure 13 Balancing Recognition and Disrespect



Shaping Through Mutual Recognition

Mutual recognition can be found in the cycle of recognition (figure 13, page 222) at the beginning just after contact between participating survivors/service provider, and at the last point of interaction. Honneth (1995b) explains that a person's development of positive self-relations is dependant on mutual recognition, or reciprocal recognition. Mutual recognition describes the quality of the relationship between persons, who are mutually willing and able to treat each other with consideration, support, care, respect, and appreciation. Thus the term mutual recognition describes what is known in therapy as the therapeutic alliance.

Mutual recognition is placed in the positions in figure 13 because they follow logically in the linear representation of the model. However, the processes described are not at all linear. Survivors may not notice that they have received recognition from service provider(s). Perceptions may have been distorted or acts of recognition may even have been interpreted as experiences of disrespect. If participants did not perceive the treatment they received as helpful, it was ineffective and unhelpful for them, independent of whether the treatment was appropriate and good or not. This highlights how important it is for the delivery of effective services that service providers are aware of survivors' interpretations of the treatment they receive.

Charon (1998) explains that human beings are unable to comprehend reality because all experiences are subject to an interpretative process that is influenced by perceptual filters, for example, our history, values, and beliefs. Subsequent emotional and behavioural responses will be based on that person's filtered perceptions. Thus providing recognition by itself does not lead to mutual recognition and does not lead to recovery unless survivors accurately perceive that recognition has been given and a cycle of recognition, supported and driven by mutual recognition, has been established. This highlights the importance of service providers tracing survivors' perceptions of therapy in a collaborative spirit of inquiry, equality, and recognition. Only then can the collaborative project of recovery be nurtured through mutual recognition towards a successful outcome.

It is also conceivable that mutual recognition may be experienced at several stages of the cycle of recognition, or that s have a delayed response to receiving recognition and need time to develop trust before they extend recognition to the health professional. Most important is to keep in mind that survivors have an important part in the establishment of the therapeutic relationship and therefore of mutual recognition. Thus the research question "How do services shape the recovery" must always be

answered with the additional comment that survivors are always a significant partner in the shaping of recovery, which emerged in this study as a reciprocal process.

Participants, who came from an impoverished social environment in which care and support was scarce, were very grateful for the care and support they received from service providers. This gratitude was expressed through recognition participants extended to service providers in the form of trusting the service provider, acknowledging the important role the service provider had in keeping them alive, and appreciating his or her professionalism (Chapter Ten, pages 181-202). A self-reinforcing, perpetuating cycle consisting of mutual recognition, care, improvement in symptoms, and improvement in self-relations was established and participants took large strides towards recovery.

The findings of this study confirm the many studies (Draucker, 1999; Glaister & Abel, 2001; Hyman, Gold, & Cott, 2003; Palmer, Brown, Rae-Grant, & Loughlin, 2001; Starzynski, Ullman, Filipas, & Townsend, 2005) that named the therapeutic relationship consisting of validation, support, kindness, and empowerment between service provider and s as the main determinant of positive therapy outcomes. However, beyond confirming the above-mentioned studies, it was possible to demonstrate within this study that recognition in the form of emotional support and care, cognitive respect, and social esteem are most helpful because they directly touch the core of human self-understanding and identity formation, which is critical in the process of recovery. Recognition and mutual recognition derive their importance for recovery from sexual abuse in that they facilitate the development of a positive sense of self which has tried so hard to emerge from a self that had been contaminated by experiences of abuse.

Therefore, under the condition of mutual recognition services shape the recovery of victims of sexual abuse through providing experiences of recognition that impact on the development of positive self-relations and the formation of a positive identity (figure 13, page 222). The cycle of recognition represents the social space that has been discussed as an enriched environment in which people treat each other with respect, care, and an appreciation of what the other has to offer (page 55). The cycle of recognition represents a space in which connections are made, help is offered, and the other person's well-being is considered. It represents the 'nursery' of human development in which growth occurs.

The findings of this study suggest that, independent from the different therapeutic settings in which survivors may pursue their recovery, the conditions of the 'nursery' need to be present. How therapists and ACC met these needs and facilitated

the recovery from sexual abuse by providing recognition through love by believing, creating hope, being there, and understanding and through the granting of rights by funding abuse-focused therapy has been illustrated in Chapter Ten (pages 181-202).

The recovery process began when participants engaged in abuse-focused therapy with a therapist with whom they were able to establish mutual recognition. Participants started to internalise the supportive presence of the validating, knowledgeable, and understanding therapist. Participants self-structures developed and strengthened through the therapist giving undivided attention, offering new insights, and encouraging the practice of new behaviours while challenging unhelpful ones.

Again, similar to the establishment of mutual recognition, the progress of recovery did not just come about through the provision of recognition needs by the therapist, but depended largely on participants' important task of internalising the recognition given by the therapist. Identity formation is a process whereby persons come to form their sense of identity through the way 'others' interact with them and by how they interpret that interaction. It demonstrates in its most simplified form that if a person is treated with support and care s/he will come to see him or herself as somebody that might be worth caring about. Over time abuse-based identity statements such as 'I am worthless' will be replaced with a more positive sense of identity of 'I am worthy of care' (see Chapter Two, pages 15-19).

This became evident when participants talked about their blossoming self (Chapter Ten, pages 181-202). They started to feel like human beings when they noticed an improvement in their trauma responses. Symptoms either ceased completely or became manageable. Cognitions were decontaminated and participants' self-perceptions improved. These were the most significant trauma responses which, when improved, enabled participants to function better in social, occupational, as well as recreational contexts. It gave them a sense of control over their lives along with a sense of self-responsibility and autonomy.

This internalising process set up a self re-enforcing loop of improvement between trauma response and self-relations (figure 13, page 222), indicated by the dotted line. This could be explained with Cozolino's (2002) premise that new neuro-pathways are built when people are exposed to challenges whilst having access to care and support. New ways of behaving, thinking, and understanding oneself became possible for participating survivors. It is this identity forming quality of intersubjective processes that make interactions with service providers so vital for the recovery from sexual abuse.

Just as providing recognition affects survivors by developing positive self-relations of self-confidence, self-respect, and self-esteem, therapists and other service providers will also be affected by the recognition they receive from s. The impact of such recognition is most likely less profound for therapists than it is for survivors, because therapists usually don't have such a huge deficit in positive self-relations as survivors have. Nonetheless, they can not avoid being affected. This is the case both for recognition given as well as for disrespect given.

The achievement of self-confidence, self-respect, and self-esteem can not be treated as a by-product. Treatments and interventions, no matter of what theoretical orientation, will be effective when provided under conditions of emotional support which promote self-confidence, cognitive respect which promote self-respect, and social esteem which promote self-esteem. Achieving the establishment of these positive self-relations and a positive identity constitutes recovery insofar that therapy is no longer required.

Besides shaping recovery through recognition, services also shaped the recovery of victims of sexual abuse through providing experiences of disrespect that directly impacted negatively on participants' self-relations and inhibited the development of a positive sense of identity. Rowe (1987, p. 11) gives a moving description of the devastation caused by threats to the self "We fear death, but far worse than death is the annihilation of our self. In this our body might survive but that which was our self has vanished into chaos and nothingness". The following discusses how the findings reflect the threats to participants' selves.

Shaping Through Disrespect

The cycle of disrespect represents the social space in which people became hurt because their basic right for recognition was compromised, ignored, or even violated (figure 13, page 222). It is the social space in which power relations of domination, exploitation, injustice, discrimination, favouritism, and marginalisation implicit in the experiences of sexual abuse, are reproduced by services that maintain the invisibility of sexual abuse and re-enforce the inequality between service providers and survivors. The asymmetrical distribution of power marked in this study as invisibility of sexual abuse, inequality, and lack of understanding was synonymous with not giving recognition and became a threat to participants' physical and mental health.

Public Mental Health Services

The findings of this study suggest that the recovery of victims of sexual abuse is hampered in public mental health settings because sexual abuse as a causal factor of psychiatric disturbances is in most instances ignored and abuse-focused therapy is rarely, if at all, provided (Chapter Four, pages 64-67). Participants may have received care and treatment for their symptoms, but not emotional support and care that considered their whole being within the contexts of their histories of abuse, neglect, or other forms of interpersonal violence. It is suggested that the invisibility of sexual abuse has been the main cause of participants' continuing, and at times escalating, struggle with psychiatric disturbances. Disturbances, which started to recede as soon as participants engaged in abuse-focused therapy with the 'right' therapist.

Instead of providing therapy that has proven to assist in the recovery from sexual abuse (Briere, 2002; Herman, 1992), public mental health services have relied largely on medication and became convenient dispensaries for drug companies. The findings discussed in Chapter Seven (pages 126-140) showed that participants' experiences within the public mental health system were disastrous for them. Years were wasted coping without appropriate treatment and without significant improvement of psychiatric disturbances. Yet, participants were so vulnerable and under-resourced through the lack of emotional support and care; they were unable to complain or to make their voices heard. By having the monopoly of being the only provider for free mental health services and by serving a consumer group that struggles to find its voice, public mental health services escape the regulatory market dynamics of supply and demand and can continue providing services to a large number of service users that are ineffective.

New Zealand studies (Lothian & Read, 2002; J. Read, Young, Barker-Collo, & Harrison, 2001) have reported that 64% of the users of public mental health services have a history of sexual or physical abuse. Given the findings of this study it may be therefore concluded that treatment for over half the number of service users in the public mental health system may be ineffective because sexual abuse remains invisible and therapy is not offered that could provide recognition through emotional support and care, cognitive respect, and social esteem. Expenditures for public mental health services have risen between 1995/96 and 2004/05 by 88% (after considering inflation) to a staggering \$866.6 million for 2004/05 (MHC, 2007, p. 14). This rise in expenditures is not surprising when it is allowed for that over half the number of service users is unlikely to respond positively to the treatment given because the treatment does

not include addressing therapeutically histories of (sexual) abuse. Instead service users barely manage, or, as shown in Chapter Seven (pages 126-140) deteriorate to a concerning level in their functioning.

The disrespect is not only reflected in not receiving appropriate treatment, participants' consumer rights to informed consent, participation, and unnecessary prolonging of suffering have been violated. Information was not given about the impact of sexual abuse, available sexual abuse treatment, and ACC compensations, preventing participants from accessing resources and compensations they are entitled to by law. As a consequence, participants have unnecessarily suffered for many years with disabling symptoms and compromised functioning.

Keeping sexual abuse invisible is not only costly to society and survivors it is a waste of funds and a waste of years in which participants could have enjoyed a better quality of life. Invisibility is indeed a lack of recognition. Participants' suffering has been reduced to identifiable symptoms of depression, anxiety, or other disorders for which medication has been prescribed. In response, public mental health service providers were perceived by participants as unhelpful, incompetent, or neglectful.

The individual stories of participants show that they were unaware that their psychiatric disturbances could be associated with their experiences of sexual abuse in their childhood (Chapter Seven, pages 126-140). Not knowing about the connection and the shame and fear associated with the abuse made it impossible for participants to take initiative and disclose their sexual abuse history to health professionals without being asked. If it had been possible for participants to connect with a health professional regularly and establish a therapeutic relationship based on recognition principles, participants might have had a more positive experiences with public mental health services.

However, public mental health services can not be held responsible for all incidents in which sexual abuse remained invisible. Clients do not disclose for a raft of reasons. Defence mechanisms of avoidance, suppression, repression, and dissociation that are frequently observed in survivors of sexual abuse, might inhibit the disclosure of sexual abuse. Some survivors of sexual abuse may not believe in therapy as a useful treatment for their problems. They might be very willing to have drugs prescribed in the hope to medicate their problems away without having to go through what they might perceive as the unpleasant, time consuming, and painful exercise of therapy.

This study emphasises the need for public mental health services to inquire about (sexual) abuse histories in patients which has already been mentioned by Read

and colleagues (2001). This has been the single most important issue for participants in this study in their experiences with public mental health services.

ACC

In contrast to public mental health settings where disrespect had been devastating for participants, their experiences of perceived disrespect in their dealings with ACC have been less destructive to their self-relations and identity. Although they struggled with perceived disrespect from ACC, they were able to balance the distressing experiences with ACC with the care and support they received from their therapists. This balancing continuously fuelled the growth and development of participants' self-relations, understanding, and resilience.

Before engaging with ACC, participants had held the unspoken expectation that ACC would be a caring agency that would make the best effort to assist in their recovery and would more noticeably reflect social responsibility. Participants were surprised and disappointed when they realised that ACC did not seem to care about the individual claimant but followed strictly the policies and procedures outlined by the law. Getting used to the procedures of an insurance company and having to deal with case managers that were perceived to have no understanding of sexual abuse or the therapeutic process was difficult for participants. Participants felt they had to submit to procedures that caused extensive distress because they were reminiscent of the dependency and powerlessness of their childhood circumstances in which they were abused, used, and betrayed. This led to a deterioration of their trauma response described in Chapter Eight (pages 140-160) and their psychiatric disturbances increased.

Participants had no choice but to submit to what they saw as ACC's demands, because there were no alternative services for them to approach. Public mental health services do not offer abuse-focused therapy and participants could not afford to pay for their therapy privately. The development of autonomy, one's ability of "...thinking, feeling, and making moral decisions that are truly your own, rather than following along with what others believe" (Steinberg, 1999, p. 276), was hampered through these experiences that enforced dependency. A mainstay of recovery, survivors' need for autonomy, was given up for the bureaucratic and administrative interests of ACC.

Even though Garry Wilson (Chief Executive of ACC in 2003) expressed in a letter sent to the NZAC (Dallaway, 2003) that "The purpose of these (reviews and assessments) is to ensure appropriate referrals to other treatment providers are considered, and to 'check' on the progress of counselling", participants and participating service providers

believed that ACC's motivation is to discourage claimants from applying for further funding. This impression has been re-enforced by media reports of claimants feeling harassed by the constant requests for assessments and giving up applying for funding (Crampton, 2003; Howard, 2002a) and of ACC's intentions to get 'stock' (claimants) off their scheme (Crampton, 2002). Reports of rigorous 'tail management' through using claimants' exit rates as key performance indicators for staff, which are "constantly being reinforced at all levels in the organisation by senior management" (Char, 2002, p. 2) had added to suspicions about ACC's intentions.

Participants' sense of injustice was evoked by implicit and explicit demands of submission, lack of equality, and lack of control over the course of their treatment causing anger, fear, and distress. ACC had knowingly or unknowingly set up a system of disempowerment that functioned through participants being exposed and observed and through bureaucratic layers that were difficult to penetrate. Participants perceived that basic principles of empowerment, avoiding retraumatisation, safety, and support were non-existent in their relationships with ACC. Mutual recognition broke down and recovery was hindered.

Sexual abuse therapy funded through ACC involves three parties which are ACC, the therapist, and the participant. This triad was powerfully pulled into the dynamics of the drama triangle whereby participants, ACC, and therapists were taking turns in embodying the victim, perpetrator, or rescuer position. All but one participant had the impression that ACC is an abusive service provider whereas all participants made admiring comments about their therapist, thus splitting both service providers into good and bad. Although this dynamic was particularly noticeable in participants' interactions with ACC, splitting into good and bad service providers and the re-enactment of the drama triangle occur frequently when participants had been subjected to traumatic victimisation in the past. It is the victims inability to tolerate a frustration of his or her needs that has been mentioned by Herman (1992) and Chefnetz (1997), that drives this dynamic and interferes with the recovery process. The findings chapters Eight (pages 141-160) and Eleven (pages 211-217) have given many examples of how these unhelpful dynamics have emerged amongst participants and service providers. This splitting, explained by Klein (1991, p. 181) as "one of the earliest ego mechanisms and defences against (frustration and) anxiety", is a powerful distortion of reality. It allows the child to 'split' the mother into the 'good' mother/breast that is gratifying the child's needs and the 'bad' mother/breast that is withholding gratification. By splitting, the child avoids reconciling that mother can be bad and good. This reconciliation is only

possible much later when through maturation and good enough mothering the child is able to tolerate that not all its needs are instantly gratified.

Although ACC seems to give enough evidence for its ‘badness’ through their overly bureaucratic, inflexible, policy driven, and money oriented structure, there is a lot of good coming from ACC that is ignored through the ‘splitting’. The financial help and assistance in rehabilitation that ACC offers for many people, including survivors of sexual abuse, is in other countries either not available at all or only through costly private health insurance schemes.

Therapists easily occupy the ‘good’ side of the split simply through the nature of their work that requires that they focus for an entire hour each week fully on the needs, thoughts, dreams, pains, and hopes of the survivor. Participants in this study were very grateful for having such an opportunity and were able to develop strong bonds with their therapists. However, having assigned the ‘bad’ in the splitting dynamic to ACC, participants were able to avoid acknowledging the ‘bad’ in their therapists who will at times have slipped by being not understanding, hurtful, neglectful, and not available for support.

Most of all, splitting allowed participants not to deal with their internal good-bad split that reflected their struggle with abuse, shame, self-blame, love, and rage and instead released their feelings of fear and anger in their relationship with ACC. This avoidant aspect made splitting a significant obstacle in the progress of recovery from sexual abuse. Instead of working therapeutically survivors vented their strong feelings of hate and love towards service providers who intended to help, even if this help was delivered clumsily or unhelpfully.

If ACC and therapists would unite and offer their strong partnership for progress in recovery, survivors would not be able to project out their internal ‘good’ and ‘bad’ split and would have to deal with their internal conflicts and their traumatic past. It is this counter therapeutic nature of splitting and the detrimental impact on the self-relations of survivors and health professionals, that makes the call for inter-professional co-operation most urgent. Treating such co-operation as a non-urgent item of luxury on the agenda of professional development could be a costly mistake. It costs participants years of struggle rather than enjoying mental health as represented in the cycle of disrespect (figure 13, page 222), and it costs society large amounts of money that could be spent for other urgent social projects.

Even if such collaboration is not quickly forthcoming therapists are well advised to use make full use of their skills and supervision to avoid being the infallible therapist.

Although it might be seductive to aim for the title of infallibility, survivors are only recovering when they have to cope with their needs and desires being frustrated. Thus the infallible therapist might in itself be an obstacle to recovery.

Lack of Understanding

Participants' experiences with a wide range of service providers by whom they felt mistreated have been interpreted in this study as health professionals' lack of understanding sexual abuse, basic sexual abuse treatment principles, and the needs of survivors of sexual abuse. Chapter Nine (pages 161-179) described experiences that can be related to the invisibility of sexual abuse in the public mental health system, whereby treatment has been provided without taking the specific needs of survivors of sexual abuse into account. Other experiences in Chapter Nine revealed the power differential between participants and service providers, whereby participants have not been consulted, not been treated as equal, or their needs have been openly disrespected.

Read and Fraser (1998) researched the staff responses to histories of sexual abuse in psychiatric patients. They found that many did not see the need for specific training and believed that their training in general mental health care prepared them adequately for dealing with service users with a history of sexual abuse. This attitude is not just noticeable in public mental health settings. Training institutions in New Zealand give only the smallest attention to the treatment of sexual abuse, if any at all, even though survivors of sexual abuse and other forms of interpersonal violence make up more than half of the people who engage with mental health professionals (Lothian & Read, 2002). Thus sexual abuse is not only kept invisible in public mental health settings but also in training institutions that prepare therapists and other health professionals for a wide range of agencies and treatment settings.

If therapists want to further their education about the specific needs of survivors of sexual abuse, they have to rely on literature and occasional workshops. As a result, provider for sexual abuse services might be poorly prepared for the challenges survivors of sexual abuse present for them. The model 'balancing recognition and disrespect' (figure 13, page 222) demonstrates with the cycle of disrespect how this lack of understanding translates into escalating trauma responses and hinders recovery.

Incidences of interpersonal disrespect link also to the asymmetrical distribution of power described by Armstrong (2005) as social distancing. He explains the disrespect as due to tendencies that are inherent in human nature and predispose individuals to

inflict pain on weaker and devalued people. This takes place through deceived and distorted perceptions that exaggerate the differences between service users and service providers. It gives service providers an identity that is distinct to those they are to serve and widens the distance between them and service users. Social distance is created by de-individualising service users who become a "...homogenous group of individuals, indistinguishable from each other, functioning as replaceable cogs without independent thought and action and who require extensive policies to prevent the individual from making decisions" (Armstrong, 2005, p. 4).

Health professionals and other staff within health care systems may support attitudes, values, beliefs, stereotypes, and ideologies that increase the degree of inequality between service users and service providers and enforce hierarchical social structures both inside and outside of treatment settings. Beliefs that support that taking histories of sexual abuse is not necessary in the treatment of psychiatric disturbances keep sexual abuse invisible. They give service providers the moral and intellectual justification for social practices of disrespect and the withholding of recognition (Sidanius & Pratto, 1999). Survivors of sexual abuse are unable to participate actively and self-direct their recovery. Instead they are 'being done to', as many incidences discussed in Chapter Nine (pages 162-180) show. It is this unequal power distribution between participants and health professionals that led participants to perceive the treatment they received as mistreatment resulting in the breakdown of mutual recognition and maintaining the cycle of disrespect (figure 13, page 222)..

This confirms Herman's (1992) notion that no intervention that takes power away from survivors is helpful. Yet the call for empowerment and participation promoted by Herman and the recovery model (Chapter Four, pages 57-59) is not easy to translate into clinical practice. Participants' lack of understanding about the origin of their symptoms, their lack of self-confidence, the passivity implicit in victim hood, and the disabling legacies of sexual abuse described in this study as the trauma response (figure 13, page 222) prevented them from fully participating. Service providers are faced with the difficult task to find a balance between providing experiences of recognition without acting patronising and encouraging undue dependency.

Whose Needs are Being Served?

A common question asked in studies that use the broad framework of critical theory is 'whose needs are being served?' This study has shown that services providers not

always served the needs of participants. Therapy outcome studies (Botella, 1999; Lambert, 1992; S. Miller, Duncan, Johnson, & Hubble, 2000; Wampold, 2001) and social support studies (Campbell, 2005; Draucker, 1999; Hyman, Gold, & Cott, 2003; van Loon, Koch, & Kralik, 2004) conducted over the last two decades emphasise the importance of a therapeutic relationship based on care, understanding, support, respect, equality, and education. Yet this vast body of research appears to be often ignored or overlooked by service providers and policy makers. Services are provided according to what service providers have to offer, not according to what survivors need.

This is especially noticeable in public mental health settings, where the lack of providing therapy is justified with limited financial resources and a strong attachment to a bureaucratic model that emphasises a hierarchical process that is led by doctors and has an emphasis on drug treatment. Limited financial resources and emphasis on drug treatment have over the years forged an influential, mutually re-enforcing liaison because the costs of one person's drug treatment for a month is significantly less than providing therapy for the same time. Those survivors, who prefer drug treatment with its promise of quick and painless solutions to their problems rather than engaging in potentially painful and time consuming therapy, add strength to the liaison between limited financial resources and attachment to the bureaucratic model mentioned above. The knowledge service providers, policy makers, and voss base their decisions on when choosing treatment pathways is strongly influenced by drug companies who, given the lack of public funding for independent research, provide funding and/or financial assistance for most research, conferences, and professional journals (Read, 2006).

There is an influential multi-billion dollar industry invested in selling drugs, techniques, and training courses catering to service providers, institutions, and agencies who look for the 'special ingredient' that makes therapy effective and most of all cost effective. Driven by these financial concerns, service providers and policy makers pay little or no attention to the views of survivors who talk about the healing effect of the therapeutic relationship. Care, support, and respect are not items that can be marketed easily. This makes it hard for treatments that emphasise the relational aspects to compete with drugs or techniques that can be measured or come in a blister pack.

Rather than serving service users, treatment provided often serves the financial and ideological interest of service providers, drug companies, and training institutions (Botella, 1999; J. Read, 2006). The wealth of income that is generated by selling the 'special ingredient' can not even remotely be achieved by the limited selling power of

‘being a helpful therapist who gives emotional support and care’. Thus the treatment provided is not based on what survivors have for many years identified as helpful but instead is based on the financial interests of an industry that protects its vast income source by promoting themselves and their ‘special ingredient’. While the recovery of survivors of sexual abuse relies on relational skills and care, many service providers hinder recovery by following their own agenda (Chapter Seven, Eight, and Nine).

Shaping Through Balancing

Participants’ views of how services have shaped their recovery from sexual abuse have been represented with the cycles of recognition and disrespect and recovery has been interpreted as the process of identity formation. This process involved the balancing of recognition and disrespect. Participants described their experience of recovery as the improvement of their psychiatric disturbances, their cognitions, and their social functioning, and included the development of positive self-perceptions, self-responsibility, and autonomy. It has been suggested that these improvements have occurred as a result of the development of neural networks that are connected to a person’s construction of the self and positive identity (Chapter Three, pages 44-45). While sexual abuse had disrupted and/or harmed positive identity formation, balancing recognition and disrespect, experienced from services involved in their recovery journey, facilitated the development of a positive sense of identity.

The more participants had internalised experiences of recognition, the more they were able to cope with experiences of disrespect. Participants had an awareness of recovery when they were able to resist disrespect and fight for their rights. Resisting and fighting could take the form of actively engaging in conflict or in removing one-self from an environment in which disrespect occurred. Only through resisting disrespect and fighting for one’s rights did participants gain a full sense of recovery. This leads to the conclusion that both recognition and disrespect are facilitative of recovery.

A core finding of this research is that recovery from sexual abuse is only possible through engaging in the struggle for recognition and resisting acts of disrespect. By being able to overcome or resist acts of disrespect that have been described in the findings chapters, participants discovered new aspects of their identity, realised that recovery had progressed, and they became aware that they no longer needed professional assistance. Rather than continuing to respond from their ‘abuse-based identity’ of helplessness, dependency and submitting to disrespectful treatment,

participants trusted their newly developed self-confidence, self-respect, and self-esteem and asserted themselves challenging service providers or any other persons they came in contact with.

Participants had been aware of injustice and feelings of hurt long before they were able to voice their claims for recognition. In the early phase of their recovery process participants were often entangled in dynamics of learnt helplessness, attachment to the perpetrator dynamics, and self-destructive behaviours. The experiences of sexual abuse had harmed the development of participants' self structures and prevented them from being able to notice or articulate to others that their rights had been violated. They became distressed, angry, hurt, or acted out in self-destructive ways. In the later phase of their recovery, when participants had started to improve their self-relations, they were able to use the emotional support and care they received to cope with hurtful interactions. This gave them the opportunity to develop regulation skills and positive self relations that helped them to respond more resourcefully to incidences of perceived injustice.

For participants to know that they were no longer victims of the past they had to rise to the challenges and engage in behaviours that were unthought-of prior to their recovery, for example confronting a spouse, an employer, a case-manager, their therapist, or ACC. Just as disrespect came in many forms ranging from minor infringements to grave acts of abuse (page 178), resisting disrespect was displayed in different levels of assertiveness. Resisting disrespect became the catalyst for participants' identity formation. It had the double function of being vital in the development of positive self-relations and of providing feed back to survivors that recovery is progressing.

Only by having to respond to conflict or obstacles to their planned action (resisting disrespect) did participants become aware that they had increased their self-confidence, self-respect, and self-esteem. This signalled to them that recovery had progressed and new ways of thinking, believing, and functioning were possible. Therapy and its emphasis on emotional support and care assisted in developing readiness and strength for resisting disrespect. Incidences of disrespect provided opportunities for testing the strength of participants' self-confidence, self-respect, and self-esteem and engaging in the struggle for recognition.

The cycles of recognition and disrespect reflect the polarised position of 'good' (recognition) and 'bad' (disrespect). This splitting into good and bad, or black and white, is a common characteristic observed in survivors of sexual abuse, which is due to

not having received good enough recognition through love to develop self-structures capable of buffering abusive or neglectful caregivers. Klein (1991, p. 197), one of the honoured ancestors of psychoanalytic psychotherapy, describes the mechanism of splitting as “...part of normal development” that infants acquire in the first six months of their lives with the aim to protect themselves from frustration, and fear of persecution.

Klein (1991) explains that unable to cope with the tension of wanting the ‘good breast’ and having their desire frustrated by the ‘bad breast’, the infant projects out onto others its own destructive impulses as well as its good parts of the self. The early defence mechanism of splitting has been especially noticeable in participants’ glowing descriptions of their therapists as good and of their complete indignation with ACC as bad. This dynamic reflects participants deep longing for the benign and good ‘other’ who can do no harm and will give unconditional love. It is the remnant of the longing of the undifferentiated infant who has not realised that mother is a separate person with her own needs and desires.

Rather than having to project out to others both their good and bad parts of the self, participants had to enter the depressive position which is described as the growing ability to hold the good and the bad and tolerate the associated depressive feelings of suffering, conflict, remorse, and guilt, and overall a more accurate perception of external reality (Klein, 1935). She elaborates that the more persons are able to establish a good relationship with their caregivers, the more they will progress and overcome the depressive position. Translated into recognition theory, participants can work through the depressive position by increasingly internalising acts of recognition, developing their positive self-relations, and moving along on their recovery journey.

Cole (2003) claims that life would be impossible without resistance. She explains that resistance is not an impediment but the driving force for any progress and forward movement. Without resistance people cannot blow-dry their hair, cars don’t move, and people would slide off chairs. When participants experienced disrespect or obstacles (resistance) from service providers or other persons in their environment, they were at times able to move ahead in their recovery by overcoming these obstacles, and at other times experienced a setback when they were unable to do so. This backward and forward movement is represented in the balancing of recognition and disrespect. Participants were no longer victims of their past but could understand themselves as equal and autonomous members of society when they were able to resist disrespect.

Putting aside the dynamic complexity of human existence, recovery from sexual abuse might mean to be able to respond to subsequent incidences of disrespect in ways that allows survivors to maintain their positive identity. Rather than coming from a position in which the world is seen as either ‘good’ or ‘bad’, whereby the ‘bad’ is intolerable and the ‘good’ desperately longed for, recovery from sexual abuse means facing the good, the bad, and all the other shades of experiences on the good-bad continuum instead of becoming a health or mental health patient.

Reflections on Using Honneth’s Recognition Theory

Recognition theory (Honneth, 1995b) has provided this study with the framework for understanding how services shape the recovery of victims of sexual abuse. It offered a conceptual framework for analysing how experiences of support, care, respect, and appreciation on one hand and experiences of disempowerment, injustice, disrespect, and discrimination on the other hand affected participants’ self-relations and identity formation (figure 13, p. 222).

I had a strong sense of ‘home coming’ when I realised that recognition theory spoke a language that I was very familiar with through my work as psychotherapist. After all, psychotherapy aims to develop the aspects of the self that have been negatively affected through harmful experiences in life. It appears to me that recognition theory provides a framework that explains the processes of how aspects of the self are harmed and how the shaping of a more positive sense of self is facilitated.

I am especially pleased that the language and the concepts of recognition theory are close to normal, every day experiences. My main aim for undertaking this study was to inform service providers, who may not have a clinical background, about the impact their actions and behaviours have on survivors of sexual abuse. By drawing on recognition theory it was possible for me to restrict the use of the specialised language of psychodynamic or psychoanalytic theories. This would hopefully make the findings of this study accessible to service providers and survivors who may not be familiar with these models.

One person I talked to about recognition theory said “This Honneth is a bit of an idealist wanting everyone to be recognised through love, rights, and solidarity”. After feeling initially defensive and protective of ‘my theory’, I spent some time reflecting on this statement. Rather than discarding recognition theory as an idealistic construct that

prescribes the ideal social order, I understand recognition theory as a useful framework that locates areas of social injustice and indicates pathways towards social inclusion.

Recognition theory provides me with a lens that has expanded my capacity for empathy with people. Rather than understanding people as being a nuisance, demanding, or unreasonable, I consider their requests as an attempt to meet their basic human need for recognition. Even though I might not be able to meet their particular request, for example for an extra session, I have a wide range of other responses available that convey to survivors that I give emotional support and care.

The notion of equality as a pre-condition for the development of self-respect had the biggest impact on me and my clinical practice. I became aware of the various ways in which my actions as therapist could easily slip into controlling, patronising, or disempowering by assuming that I know better than the client about what is good for her or him. Although that might be true in some instances, recognition theory emphasised for me that I have to stay in constant dialogue with my clients about their needs and about my ability and/or willingness to meet those needs. I envisage that other therapists and health professionals may experience similar benefits when they explore this study and familiarise themselves with recognition theory.

I believe that survivors of sexual abuse also benefited from participating in this study. Most of them expressed gratitude for being given the opportunity to share their struggles with me. Their hope was that publication of these findings will inform a wider forum of the difficulties survivors of sexual abuse experience when they engage with services. Being invited to participate was also an act of recognition through solidarity, because their participation in this study symbolises an appreciation and valuing of the contribution they were able to make to my research and to the wider public. All participants will be provided with the opportunity to discuss the findings and the usefulness of recognition theory in the recovery process. This could inform them about aspects of their recovery struggle they may not have been aware of. Such new awareness might lead to conclusions and/or actions that could impact on their life-long recovery process.

I propose that the model 'balancing recognition and disrespect' (figure 13, page 222) can be used to complement clinical diagnostic tools because it indicates survivors' recognition needs at any point of their recovery journey. The two critical positions in the model for indicating treatment needs are the trauma responses and self-relations. Deficits in clients' positive self-relations or in exaggerated trauma responses indicate that recognition in the form of emotional support and care, cognitive respect, or social

esteem is needed. Survivors' specific circumstances and needs can then be collaboratively explored and steps towards meeting these needs can be taken to further the recovery process.

This study has shown that it is possible to discuss pathways of recovery from sexual abuse and therapeutic treatment without attachment to theoretical models that have, as discussed in the literature review (Chapter Four, pages 79-85), in the past been a barrier to inter-professional co-operation. Thus recognition theory could be used as a meta-framework from which programs, treatments, processes, and interventions can be evaluated and discussed amongst a range of different professional disciplines using the principles of love, rights, and solidarity.

Limitations of Recognition Theory

A limitation of using recognition theory for this study has been the lack of theoretical constructs that allow distinguishing between justified and unjustified claims for recognition. This study has indicated that participants may have mis-perceived some service providers' actions, yet they suffer greatly. Honneth (2007) speaks of providing the opportunity for democratic deliberation of individuals' sense of injustice. How exactly could survivors of sexual abuse do that? There has been no guidance from Honneth how to handle these situations.

Whereas survivors are encouraged to express their disappointments in the therapy setting, agencies, health providers, and support services may need to develop formal and informal processes to assure that survivors feel safe to express their discontent with service delivery. Fraser (2003) suggests that the legitimacy of recognition claims needs to be discussed in a public forum. However, only under conditions of safety and equality will survivors be able to dialogue with service providers about whether their recognition claims are justified or not.

Honneth also does not clarify how the categories love, rights, and solidarity interact and how to proceed when they overlap. This shortcoming has already been briefly mentioned in the method's chapter (table 9, page 101). How do the categories interact, what are the processes and rationalisations that explain the flow from love to rights to solidarity and vice versa? Which form has priority in any given situation? Honneth does not provide guidance for answering these questions. Recognition theory has conceptual potency when applied to larger groups in which individuals' needs are subsumed by the groups' claim for recognition. When applied to individual

circumstances of survivors of sexual abuse, for example, the categories are less clear and a claim for recognition might be made in the categories of love, rights, and solidarity. Even though the individual claim may be representative of claims made by all survivors, the complexity of human co-existence does not allow reducing recognition claims to one category. The model 'Balancing Recognition and Disrespect' could indicate a path to solving this impasse. First of all, peoples' emotional expressions of suffering require a response of recognition through love. Once they have developed or strengthened their self-relations they will be able to present their claims for equality and appreciation. Services, agencies, and institutions that operate in the widest sense in the area of helping people need to be aware that survivors expect them to provide recognition through love and through the granting of rights.

Recognition theory, while it provides a framework for understanding the struggle of larger groups, it does not explain how the struggle of individual survivors of sexual abuse could transform into the struggle of survivors of sexual abuse as a group. How can the individual struggle become a political struggle when feelings of shame, self-blame, and fear impose a restriction on survivors' ability to publicly voice their claims for recognition? Social support services such as rape crisis, women's centres and sexual abuse help centres have a long tradition of speaking for survivors of sexual abuse. These services are usually led by professionals that may or may not have personally experienced sexual abuse and only operate on a small local scale. These support services are, however, well positioned to organise activities on a national scale, become more visible politically, and enable survivors of sexual abuse to become actively involved either through subscription or some form of membership.

Honneth (1995b) states clearly that recognition theory describes the social development of groups or larger sections of society and, at no point, aims to describe individual's psychological development. Nevertheless, it was possible to some extent to describe the intersubjective development of the self. Because the focus of this study was on the intersubjective relationships between service providers and survivors, and a language was wanted that could be understood across a range of professional disciplines, recognition theory provided me with a satisfying framework. I had to reach for concepts of psychoanalysis, psychotherapy, psychology, neuro-biology, and trauma therapy to interpret more complex intra-psychic processes in the analysis of this study.

The Study's Contribution to Recognition Theory

To my knowledge this is the first time that recognition theory has been used as the main underpinning framework in the field of mental health and psychotherapy/counselling (therapy). By having used recognition theory, this study contributes to its development and its applicability in professional practice through demonstrating its usefulness in the field of mental health care.

The focus of recognition theory on intersubjective processes allows the exploration of empowerment and disempowerment, social responsibility and self-responsibility, education, participation, provision of care, and discrimination, all issues that have been discussed in the literature review as the guiding principles for mental health service delivery in New Zealand (Chapter Four, pages 54-85). This study contributes to the development of recognition theory by showing that recognition theory is well positioned to provide a framework to explore salient issues of New Zealand's mental health sector.

A further contribution pertains to the controversial discussion whether feelings of hurt are strong enough to be the motivational force for actors to engage in the struggle for recognition (see Chapter Two, pages 27-28). It is demonstrated in this study that, in the context of mental health recovery, survivors' ability to resist disrespect is a process of growth and self-development. This process involves creating readiness through the engagement with service providers who are able to consistently meet survivors' recognition needs. The capability to resist disrespect does not just emerge from feelings of hurt but from 'balancing recognition and disrespect' (figure 13, page 222) through which participants were able to form a positive sense of identity and positive self-relations for resistance.

Recommendations

The findings of this study as 'Balancing Recognition and Disrespect: Recovery as the Process of Identity Formation' lead to recommendations for the provision of services, policy making, and theory development.

Service Provision

Understanding recovery from sexual abuse as the formation of identity through the development of self-confidence, self-respect, and self-esteem requires services to provide treatment and interact with survivors of sexual abuse in ways that facilitate the

development of positive self-relations. Service providers' actions and behaviours are significant because they directly affect survivors' recovery. Actions and behaviours that express support, care, respect, understanding, valuing, and empowerment shape recovery by having a positive affect on survivors' identity formation, whereas actions and behaviours that are perceived by survivors as disempowering, judging, punishing, exposing, or abusive have a negative affect on survivor's identity formation.

It has been confirmed in this study that not techniques and models are the important aspects of treatment but the quality of the relationship between health professional and survivor. For that reason, it is not what interventions have been made but how the interventions have been made that impacted on the recovery of participants. The recommendation for public mental health services is to develop protocols for effective (sexual) abuse screening. Upon positive identification of sexual abuse in-depth information about treatment options and available service providers should be given to enable the survivor to make an informed decision about their treatment of choice. As long as abuse focused treatment is not available in public mental health services, referrals to services that do provide should be made. For clients with severe psychiatric disturbances or co-morbid substance abuse a co-operative treatment regime between survivor, public mental health services, and abuse-focused service providers should be aimed for.

Being vulnerable, in distress, and in need of help puts survivors into a position of unequal power distribution in relation to (mental) health professionals. This position requires of service providers to be mindful of giving survivors the opportunity to share the power. Because empowerment will positively impact on survivors' self-respect and self-confidence, service providers should continuously encourage survivors to participate in decision making about their treatment. That can be in the form of asking "How do you want to use your session today", by continuously asking for feedback "How are we doing, is this helpful for you?", and by engaging survivors actively in exploring their treatment needs and treatment termination.

A conclusion of this study is that the difference between procedures that are cruel and exceed survivors' coping skills and those that are undertaken even if they are unpleasant could lie in preparing survivors empathically (Chapter Nine, pages 162-180). By doing so service providers demonstrate respect for survivors as capable adults who can engage in contractual arrangements and make meaningful decisions. When a clear therapeutic alliance is established that prepares survivors for the processes ahead of them and that informs them about the limits of service providers' ability to be available,

survivors might be better able to regulate their distress. To feel more in control will positively affect survivors' self-respect and self-confidence.

The point has been made that interventions are effective only when survivors perceive them as effective (Chapter Twelve, pages 223-234). This requires health professionals to continuously monitor survivors perceptions of the effectiveness of the treatment they receive. That way any misperceptions can be immediately detected and worked through therapeutically. Monitoring can take place through informal inquiry at regular intervals, or formally through asking survivors to fill out a feedback sheet at the end of a session or treatment. It is certainly necessary to inquire whether a session or treatment has been helpful when service providers have the impression the survivor is not satisfied, misses sessions, or deteriorates in his/her overall functioning.

Whilst techniques and models are useful and may be necessary for the flow of the session, the main focus needs to be on how the relationship between health professional and survivor develops. Persons with a history of sexual abuse have been badly injured at the core of their self-hood and require caring, respectful, and understanding health professionals who are willing to provide an enriched environment of emotional support, care, and appropriate challenges, that assist in the reconstruction of their selves.

The need for such an enriched environment might be known by therapists who have a psycho-dynamic understanding and regular contact with survivors. Service providers such as ACC, WINZ, the police and other social support services without a sound clinical background, need to be aware that their actions could aggravate the trauma response and throw patients into the chaos of psychiatric disturbance. Because every contact with formal social support services has an impact and may make the difference between coping or being in crisis and continuing with treatment or giving up, service providers without clinical background should familiarize themselves at least with some of the literature by Herman or Briere cited in this study or attend workshops about abuse dynamics and survivors' basic treatment needs. Appropriate, helpful responses to survivors not only aids their recovery but may also translate into substantial savings in health and mental health expenditures.

One of the core findings of this study is that recovery involves the process of identity formation through the development of self-confidence, self-respect, and self-esteem that takes place as survivors balance recognition and disrespect (figure 13, page 222). This might explain the insignificant impact drug treatment had in the recovery of participants (see Chapter Nine, page 173/Anna). However, while drugs are not able to

provide experiences that foster the development of the self and facilitate the formation of identity, they may be helpful in assisting survivors in regulating and/or decreasing psychiatric disturbances and enabling them to engage more fully in their recovery work. It is advised, however, that additional to prescribing drugs, information about sexual abuse and available abuse-focused treatment is given or a referral is made to health professionals who are able to provide the information and the treatment.

Removing Disrespect

Another core finding of this study is that disrespect, which did not overwhelm participants coping skills, turned out to strengthen participants' sense of self (Chapter Ten, page 196/Jacob and page 197/Johanna). Recovery has been fully experienced only when participants were able to test their newly developed positive self-relations by resisting disrespect. It would therefore be counter therapeutic to aim for changing all those procedures that were perceived as disrespect and only provide experiences of recognition. Instead, if services want to facilitate recovery through their interactions with survivors, processes and procedures need be timed so that survivors' level of established self-relations is able to deal with the challenges and use them to move forward in their recovery. If the challenges out-balance survivors' self-relations and capacity to cope, crises will occur and recovery will be impeded. Adopting a collaborative approach and involving survivors more fully in treatment planning, treatment decisions, and treatment terminations might enable them to view certain procedures as unpleasant yet necessary instead of perceiving them as acts of disrespect. Deciding on the right timing of challenging interventions might be difficult for some service providers. Inter-professional co-operation between service providers and survivors could close that information gap and may result in collaboratively working together for the best therapeutic outcome.

The most significant recommendation for improving the treatment of survivors of sexual abuse is to improve the inter-professional co-operation between therapists, other service providers, and ACC. The possibility of splitting into 'good' and 'bad' service providers is very high in the treatment of trauma survivors and the detrimental impact for survivor and service provider has been discussed earlier in this chapter (page 235-238). Improving inter-professional co-operation and increasing transparency would minimize splitting and the counter-therapeutic dynamics of the drama triangle. By increasing the collaboration between service providers, survivors have less opportunity to divide them into 'good' and 'bad' providers. Instead, they will have to own their

projection or transference and deal with them therapeutically. Like parents, ACC and therapists have to provide a united front that offers survivors the safe environment in which they can undertake their therapeutic work as best as possible.

The comments of service providers who participated in this study indicate that therapists and ACC work on a parallel course rather than a collaborative one. More work has to be done to establish understanding, trust, and respect between these important providers and to find ways of effectively working together.

It has been shown in Chapter Eight (page 147-151) that participants experienced fear and distress due to a lack of transparency of ACC processes and a lack of participation in decision making. This lack created a vacuum that was filled with participants' perceptions and distortions that may not have accurately reflected ACC's intentions but became detrimental to the recovery process. For ACC to re-think and review their procedures for the authorisation and re-authorisation of treatment and adapt them to survivors' ability to cope would be a positive move forward. Making processes more transparent and enabling survivors' collaboration in decisions about their rehabilitation to a larger degree than currently practiced could positively impact on survivors' recovery.

In-depth reports at the beginning of abuse-focused treatment always aggravate the trauma response when survivors are not comfortable yet to discuss the sexual abuse. The increased distress is unnecessary and counter therapeutic, given that at that early stage of therapy the therapeutic relationship and self-relations for effective coping strategies are rarely available to survivors. Cover determination for ACC funding requires no more than an acknowledgement that according to the crimes act a sexual abuse incident has occurred. A treatment plan and impact report can follow later when the therapeutic relationship has been established.

Consumer Advocate

This study has given many examples of participants' inability to assert their rights and confront service providers openly. In its place they resigned and lost hope. It has also been indicated that survivors struggle to access consumer advocates in public mental health settings (page 219/Brenda). It would be important for the empowerment of survivors if service providers could collaboratively investigate what processes could be useful to set up an effective consumer advocate service for survivors of sexual abuse. Rather than perceiving consumer advocates as the first instance of a complaint procedure, it could be more effective to have consumer advocates filling the position of

a support person who speaks for the survivor who may not have a voice yet. While consumer advocates in public health settings are linked to the health commissioner, survivors engaged with privately practicing therapist might benefit from having for example access to staff from Rape Crisis Centres for support and advocacy needs.

Asking About Abuse

This study has shown the devastating impact of keeping sexual abuse invisible. Although health professionals may be uncomfortable asking about abuse, not asking about it has shown to have a crippling impact (Chapter Seven, pages 126-140). It is not only against the guidelines of the Blueprint for Mental Health Services and a violation of consumer rights, it also is a concerning impediment of recovery. Asking about abuse is respectful because it acknowledges the whole person in the context of their lives. Asking about abuse could facilitate recovery by dispelling survivors' ill conceived ideas about being crazy or other causal theories they may have about their psychiatric disturbances.

Treatment Policies

This study suggests that services shape recovery from sexual abuse by impacting on survivors' self-relations and identity formation. The findings imply that services will facilitate the recovery from sexual abuse by reviewing their policies and procedures so that full advantage can be taken of the healing impact of recognition through love, rights, and solidarity. Recovery and the development of self-confidence will be facilitated if services provide emotional support and care by being helpful, compassionate, and friendly. Treating survivors with respect and inviting their active participation in the planning of their treatment will give the message that they are seen as being equal to the health professional and will develop self-respect. Taking into account survivors' viewpoint and treating them as persons of value who, despite their struggle, do the best they can, will facilitate recovery and develop self-esteem. It is my assumption that treatment costs will be reduced and/or treatment will be shortened by applying the principles of recognition and the recovery model and treating survivors of sexual abuse as respected collaborators in the mutual project of recovery.

Limitations of this Study

The main limitation of this study has been in the context of selecting participants. All participants were self-selected and may have had followed a personal interest or need when they decided to participate. For that reason this study might reflect the experiences and perceptions of survivors who had strong views about the services they received. Part of their motivation might have been to air their grievances about service providers and to protect 'others' from going through similar 'harrowing' experiences. Survivors who may have been satisfied with service providers might have views that differed from the findings of this study. This would be an important area for further research.

Another limitation has been the use of self-reports and not other forms of data collection to triangulate the data. This meant that the data gathered is based on perceptions, beliefs, and attribution of cause and effect for which in most cases no corroboration is sought. Then again, whether participants' reports were an accurate reflection of reality was less important than understanding and highlighting how their perceptions and beliefs caused reactivity and distress that impacted detrimentally on their recovery. Still, the data gathered from service provider interviews substantiated the perceptions of survivors to a significant degree.

It is also a limitation of this study that only therapists and one ACC case manager were interviewed. An exploration of how services shape recovery that involved a wider range of service providers might have resulted in a deeper understanding of services role in the recovery from sexual abuse. However, the limitations of the PhD course did not allow for a widening of the investigation.

A limitation of this study is also that all participants had used ACC funded counselling provided by privately practicing therapists. Survivors of sexual abuse who have only used public mental health services, who funded their treatment themselves without using either ACC or public mental health services, and those who recovered without any help from health or mental health professionals, have not been interviewed. Their experiences may differ significantly from those described by participants. This would be a valuable area for further research. However, in dissemination of the findings transferability may become clearer as the stories told here ring true for other readers, service providers, and survivors.

Furthermore, participants in this study struggled with moderate to severe psychiatric disturbances and had been for many years involved with mental health professionals. Survivors who only experienced mild psychiatric disturbances and who

use mental health services only for a short period of time may not have experienced the difficulties and disrespect participants in this study described.

Another limitation of this study has been the researcher. It was very difficult for me to leave the 'psychotherapist hat' behind and slip fully into the role of the researcher. Upon reflection I noticed that during the interview process I moved at times into empathy rather than staying in the inquiry mode and missed asking for clarification because I assumed to understand what participants talked about. However, there was the opportunity to seek clarification in the second interviews and where possible clarification was undertaken.

Further Research

Conducting this study has created new understanding about the recovery from sexual abuse and about how services shape this recovery. By doing so it has opened areas that are not well understood yet, where exploration and research could provide valuable information for understanding sexual abuse, policy development, theory development, and professional development. These areas are now briefly addressed.

Understanding Sexual Abuse

This study has given insight into the processes of recovery from sexual abuse involving privately practicing therapists, ACC, and a few public mental health services. To arrive at a clearer picture of service providers' understanding of how they shape the recovery from sexual abuse, further research would be needed that included general practitioners, police, victims support services, women's refuge, community alcohol and drug services, eating disorder services, child and youth services, and pastoral services.

It has also been indicated that service providers struggle to demonstrate the effectiveness of treatments offered for survivors of sexual abuse. A study that develops a process for assessing treatment effectiveness by providing reliable data of base-line functioning at the beginning of therapy and the level of improvement at certain stages of the recovery process and at the end of treatment would close that gap. Service providers, survivors, funding agencies, and policy makers could then be presented with more accurate indications of effective therapeutic pathways that lead to recovery.

It has been mentioned in the literature review (page 51) that only 7% of survivors of sexual abuse seek professional help. A study that focuses on the experiences of the other 93% to understand how they have coped without using services

available could provide important data for the design of services, for improving treatment, and for preventative programs.

Policy Development

The constraints of this PhD study required to limit the focus to the interactions between survivors and service providers. However, it has briefly been mentioned that the recovery from sexual abuse is affected by a complex web of services, self, and community (Chapter Five, figure 6, page 106). To understand the interplay between policies, community, and service delivery a study would be needed that explored how policies are developed that regulate services for survivors of sexual abuse, where policy makers seek advise to create policies, how these policies are translated into practice, how they meet the principles of participation, equality, and care outlined by Honneth (1995b), by the Mental Health Commission (MOH, 2005), and by the Ministry of Health (ACC, 2006b), and how they meet the needs of survivors of sexual abuse. Such study could provide important information and direction to what policies and processes are needed to treat those who have experienced sexual abuse in the most effective way.

After having completed this study I have been left with the question whether ACC as an insurance agency should oversee the treatment of sexual abuse or whether public mental health services as a specific treatment provider should develop 'trauma units' for survivors with an abuse history? Research that explores the ramifications of a policy change could investigate whether survivors of sexual abuse are not better served within the mental health system without having to battle with the processes and procedures of an insurance company and its non-clinical staff.

I also wonder whether there is sufficient justification for treating sexual abuse differently to physical violence or neglect. Treating survivors like accident victims, as ACC does, and granting them weekly compensation and lump-sum payments may be a discrimination of victims of physical violence or neglect. It might be timely to examine whether policy decisions that led to treating survivors of sexual abuse like accident victims, are now, thirty years later, still relevant and appropriate.

Theory Development

Following on from the discussion in this chapter (pages 240) of the suitability of recognition theory as a philosophical underpinning of mental health research, research valuable for theory development could explore how the categories of love, rights, and solidarity interact with each other, especially when services simultaneously occupy the

position of primary care giver (recognition through love) and legal institution (recognition through the granting of rights) and community (solidarity). Also, it has been entirely unclear in this study how recognition theory would deal with distinguishing legitimate claims of recognition from non-legitimate claims. Recognition theory would be strengthened if further research would explore the issue of legitimacy, what it means, and how would stakeholders arrive at a judgement of what constitutes legitimacy.

Professional Development

Barriers to inter-professional co-operation have been discussed in the literature review (Chapter Four, pages 79-84). A valuable research interest could focus on the inter-professional relationships between providers in New Zealand who are involved with survivors of sexual abuse. How is the quality of inter-professional relationships shaped and maintained, how do they impact on the work with survivors, and what form of structure would be needed to enable the exchange of knowledge that spans across a range of professions such as psychiatry, psychology, psychotherapy/counselling, social work, nursing, occupational therapists, and general practitioners.

The data from participating service providers (Chapter Eleven, pages 231-232) suggests that dealing with survivors of sexual abuse exposes therapists to stress and vicarious traumatisation that may have a detrimental impact on their work and the shaping of recovery. It would be important for the quality of service delivery to understand the impact of vicarious traumatisation, supervision or the lack thereof, overall workload, and the recognition or disrespect service providers receive from colleagues and the wider community on service providers' ability to function well and work effectively.

Conclusion

Services shape recovery from sexual abuse, defined in this study as the process of identity formation, through experiences of recognition and disrespect. Experiences of recognition that came in the form of emotional support and care, cognitive respect, and social esteem needed to be balanced with experiences of disrespect that came in the form of struggling with the invisibility of sexual abuse, struggling with inequality, and struggling with not understanding. The recovery process has been described as the loss of innocence and involved a balancing of recognition and disrespect, whereby participants needed to reconcile the 'good' and the 'bad' within themselves and within service providers.

Participants experienced recovery when they were able to resist disrespect and either engaged in fighting for their rights or removed themselves from situations in which their rights could be violated. The ability to assert their claims for recognition and resist acts of disrespect was essential to the experience of recovery. Only by having a practical experience of being able to protect their physical and psychological integrity did participants become aware that they had recovered from the legacies of sexual abuse to the extent that they could proceed with their lives without professional assistance.

For the participants in this study services had an important role in shaping their recovery – without them recovery would not have been possible. However, some services are not utilising the power of recognition through love, rights, and solidarity as much as they could and therefore hindered speedy recovery by not being transparent, participatory, and caring. Recovery was not facilitated by a particular treatment model but by service providers who were willing to establish relationships with participating survivors of sexual abuse that were based on principles of recognition.

The outcome of this research has been a powerful affirmation of the importance of the human need to receive recognition through love, rights, and solidarity. This basic human need continuously fuelled participants' struggle for recognition. With recognition theory Honneth continues the line of philosophers who have emphasised for centuries that human beings rely on recognition for the development of a self that is self-actualised, autonomous, and able to enjoy a good quality of life (Honneth, 1995b). Without recognition self-confidence, self-respect, and self-esteem are not possible and neither is recovery.

APPENDIXES

Appendix A: Health and Disability Ethics Committees' Approval

Appendix B: Letter to therapist recruiting service users

Appendix C: Information Sheet Participants: Service Users

Appendix D: Consent Form Service User

Appendix E: Approval Focus Group

Appendix F: Participant Information Sheet: Service Provider

Appendix G: Letter Recruiting Service Providers: Counsellors

Appendix H: Letter Recruiting Service Providers: Services

Appendix I: Consent Form Service Provider

Appendix J: ACC 290 – Sensitive Claims Cover Determination

Appendix K: Client Interview Schedule

Appendix L: Meeting the Provisions of the Treaty of Waitangi

Appendix M: Provider Interview Schedule

Appendix N: Participants Details

Appendix O: Provider Details

REFERENCES

- Aaron, & Anderson, G. (1998). *Relational Perspective on the Body*. London: The Analytic Press.
- ACC. (2002). *Treatment Provider Handbook 2002/03: A comprehensive guide to working with ACC*. Wellington: ACC.
- ACC. (2003, 1.2.2003). Code of ACC Claimant's Rights. 2003, from <http://www.acc.co.nz/claimscare/resolve-issues/make-a-complaint/index.html>
- ACC. (2006a). ACC Injury Statistics 2005 (First Edition): Section 13.1 Sensitive Claims. Retrieved 15.8.2006, from http://www.acc.co.nz/wcm001/idcplg?IdcService=SS_GET_PAGE&ssDocName=SS_WCM_115954&ssSourceNodeId=8070
- ACC. (2006b). What Am I Entitled To? *ACC: Claims and Care: Entitlements* Retrieved 15.8.06, 2006, from http://www.acc.co.nz/wcm001/idcplg?IdcService=SS_GET_PAGE&nodeId=3883&dhtml=claims&ref=2
- Acocella, J. (1999). *Creating Hysteria: Women and Multiple Personality Disorder*: Jossey-Bass Pub.
- Agger, B. (1991). Critical Theory, Poststructuralism, Postmodernism: Their Sociological Relevance. *Annu.Rev.Sociol.*, 17, 105-131.
- Ahles, D. (2002, Sep 22, 2002). Psychotherapy at the Price of Volunteering. *The New York Times*, p. 14CN.17.
- Ainsworth, M. D. S. (1969). Object Relations, Dependency, and Attachment: A Theoretical Review of the Infant-Mother Relationship. *Child Development*, 40, 969-1025.
- Anderson, J., Martin, J., Mullen, P., Romans, S., & Herbison, P. (1993). Prevalence of childhood sexual abuse experiences in a community sample of women. *J American Academy Child & Adolescent Psychiatry*, 32(5), 911-919.
- Andrews, B., Brewin, C. R., & Rose, S. (2003). Gender, social support, and PTSD in victims of violent crime *J Trauma Stress*, 16(4), 421-427.
- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal*, 16(4), 11/23.
- Anthony, W. A. (2000). A Recovery Oriented Service System: Setting Some System Level Standards. *Psychiatric Rehabilitation Journal*, 24(2), 159-168.
- Anthony, W. A. (2003). The Decade of the Person and the Walls that Divide Us. *Behavioral Healthcare Tomorrow*(April 2003).
- APA. (2001). Understanding Child Sexual Abuse. Retrieved 15.7.2006, from www.apa.org/releases/sexabuse/
- Armstrong, J. (2005, 10-12th August 2005). *Lessons from Genocide*. Paper presented at the Many Faces of Abuse Conference, Auckland, New Zealand.
- Arnow, B. A. (2004). Relationships Between Childhood Maltreatment, Adult Health and Psychiatric Outcomes, and Medical Utilization. *J Clin Psychiatry*, 65(suppl 12), 10-15.
- Arnow, B. A., Hart, S., Scott, C., Dea, R., O'Connell, L., & Taylor, C. B. (1999). Childhood sexual abuse, psychological distress, and medical use among women. *Psychosom Med*, 61, 762-770.

- Atlas, J., & Wolfson, M. (1996). Depression and dissociation as features of borderline personality disorder in hospitalized adolescents. *Psychol Rep*, 78(2), 624-626.
- Audard, C., & Grosz, S. (2000). Recognition. *Institute of Psychoanalysis: News & Events, Spring & Summer 2000*.
- Austin, W., Rankel, M., Kagan, L., Bergum, V., & Lernermeier, G. (2005). To Stay or To Go, To Speak or Stay Silent, To Act or Not To Act: Moral Distress as Experiences by Psychologists. *Ethics & Behavior*, 15(3), 197-212.
- AWC. (2006). Louise Nicholas on Trial, *Gossip - Newsletter* (pp. 4). Auckland: Auckland Women's Centre.
- Baker, C., Wuest, J., & Stern, P. N. (1992). Method slurring: the grounded theory/phenomenology example. *Journal of Advances Nursing*, 17, 1355-1360.
- Barnett, H., & Lapsley, H. (2006). *Journeys of Despair, Journeys of Hope: Young Adults Talk About Severe Mental Distress, Mental Health Services and Recovery*. Wellington: Mental Health Commission.
- Beitman, B. D. (1998). *The psychotherapist's guide to cost containment - how to survive and thrive in an age of managed care*. London: Sage.
- Blum, S. R. (1992). Ethical issues in managed mental health. In S. Feldman (Ed.), *Managed mental health services* (pp. 245-266). Springfield, IL: Charles C. Thomas.
- Blunden, A. (2006). George Herbert Mead 1901: The Social Self. Retrieved 13.03.2006, 2006, from <http://www.marxists.org/reference/subject/philosophy/works/us/mead3.htm>
- Boscarino, J. A. (2004). Post traumatic stress disorder and physical illness: results from clinical and epidemiologic studies. *Ann N Y Acad Sci*(1032), 141-153.
- Boston, J. (1999). New Zealand's Welfare State in Transition. In J. Boston, P. Dalziel & S. St. John (Eds.), *Redesigning the Welfare State in New Zealand: Problems, Policies, Prospects*. Auckland: Oxford University Press.
- Boston, J., Dalziel, P., & St. John, S. (1999). Rebuilding an Effective Welfare State. In J. Boston, P. Dalziel & S. St. John (Eds.), *Redesigning the Welfare State in New Zealand: Problems, Policies, Prospects* (pp. 301-317). Auckland: Oxford University Press.
- Botella, L. (1999). *Personal Construct Psychology, Constructivism, and Psychotherapy Research*. Paper presented at the XIIIth International Congress on Personal Construct Psychology, Berlin, Germany.
- Bowie, R., & Shirley, I. (1994). Political and Economic Perspectives on Recent Health Policy. In J. Spicer, A. Trlin & J. A. Walton (Eds.), *Social Dimensions of Health and Disease: New Zealand Perspectives* (pp. 298-322). Palmerston North: Dunmore Press.
- Bowlby, J. (1988). *A secure base: parent-child attachment and healthy human development*. NY: Basic Books.
- Bremner, J., Shobe, K., & Kihlstrom, J. (2000). False memories in women with self-reported childhood sexual abuse: an empirical study. *Psychol Sci*, 11(4), 333-337.
- Briere, J. (1994). A self-trauma model for treating adult survivors of severe child abuse. In APSAC (Ed.), *Handbook on child maltreatment*. Newbury Park, CA: Sage.
- Briere, J. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, T. Reid & C. Jenny (Eds.), *The APSAC handbook on child maltreatment* (2nd ed.). Newbury Park: Sage.
- Briere, J., & Elliott, D. M. (1994). Immediate and Long-Term Impacts of Child Sexual Abuse. *The Future of Children: Sexual Abuse of Children*, 4(2), 54-69.

- Brodsky, B., Cloitre, M., & Dulit, R. (1995). Relationship of dissociation to self-mutilation and childhood abuse in borderline personality disorder. *Am J Psychiatry*, 152(12), 1788-1792.
- Calhoun, C. (1995a). *Critical Social Theory: Culture, History and the Challenge of Difference*. Oxford: Blackwell.
- Calhoun, C. (1995b). The Politics of Identity and Recognition. In *Critical Social Theory: Culture, History, and the Challenge of Difference* (pp. 193-230). Massachusetts, USA: Blackwell.
- Campbell, R. (2005). What really happened? A validation study of rape survivors' help-seeking experiences with the legal and medical systems. *Violence Vict*, 20(1), 55-68.
- Campbell, R., Ahrens, C. E., Sefl, T., Wasco, S. M., & Barnes, H. E. (2001). Social reactions to rape victims: healing and hurtful effects on psychological and physical health outcomes. *Violence Vict*, 16(3), 287-302.
- Carroll, M. A. (1997). The Multifaceted Ethical Dimension of Treating the Mentally Ill. In J. Lonsdale (Ed.), *The Hatherleigh Guide to Ethics in Therapy* (pp. 161-179). New York, N.Y: Hatherleigh Press.
- Carspecken, P. F. (1996). What is Critical Qualitative Research? In *Critical Ethnography in Educational Research: A Theoretical and Practical Guide*. New York, NY: Routledge.
- Cary, G. L. (2001). The Traumatic Bond Between the Psychotherapist and Managed Care. *American Journal of Psychotherapy*, 55(1), 150.
- Char, P. (2002, 10.11.2002). ACC staff paid bonuses for high 'exit' rate. *Sunday Star Times*.
- Charon, J. M. (1998). *Symbolic interactionism: An introduction, an interpretation, and integration* (6 ed.). Upper Saddle River, NJ: Prentice Hall.
- Chefet, R. A. (1997). Special Case Transferences and Countertransferences in the Treatment of Dissociative Disorders. *Dissociation*, 10(4), 255-265.
- Chodoff, P. (1996). Ethical dimensions of psychotherapy: A personal perspective. *American Journal of Psychotherapy*, 50(3), 298-310.
- Cloitre, M., Cohen, L. R., & Koenen, K. C. (2006). *Treating survivors of childhood abuse: psychotherapy for the interrupted life*. New York: Guilford Press.
- Cloitre, M., Tardiff, K., Marzuk, P., Leon, A., & Portera, L. (1996). Childhood abuse and subsequent sexual assault among female inpatients. *J Trauma Stress*, 9(3), 473-482.
- Cohen, J., & Mannarino, A. (2000). Predictors of treatment outcome in sexually abused children. *Child Abuse Negl*, 24(7), 983-994.
- Cole, K. C. (2003). Resistance. In *Mind over Matter: Conversations with the Cosmos* (pp. 338). Orlando/Fl: Harvest.
- Coney, S. (1997). Open Letter to the Uninformed: Managed Care Means Damaged Ethics. *Health Care Analysis*, 5(3), 252-258.
- Courtois, C. A. (1999). *Recollections of Sexual Abuse: Treatment Principles and Guidelines*. NY: Norton.
- Cozolino, L. J. (2002). *The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain*. New York: Norton.
- Crain, W. C. (1985). *Theories of development: Concepts and applications* (2nd Ed.). New York: Prentice Hall.
- Crampton, D. (2002). Docking The ACC Herd. Retrieved 23.10.2002, 2003, from <http://www.scoop.co.nz/mason/stories/HL0210/S00160.htm>
- Crampton, D. (2003). ACC case manager and assessor collude prior to assessment to save money. Retrieved 18.2.2003, 2003, from <http://www.scoop.co.nz/archive/scoop/stories/df/75/200302180838.a99a52e3.html>

- Criab, I. (1984). *Modern Social Theory*. Hertfordshire: Harvester Wheatsheaf.
- Cusack, K. J., Frueh, B. C., & Brady, K. T. (2004). Trauma History Screening in a Community mental health Center. *Psychiatric Services, 55*(2), 157-162.
- CYF. (2003a). *About us*. Wellington: Child Youth and Family Services.
- CYF. (2003b). *Reporting Child Abuse and Neglect*. Wellington: Child Youth and Family Services.
- Dalenberg, C. J. (2000). *Countertransference and the treatment of trauma*. Washington, DC: American Psychological Association.
- Dallaway, J. (2003). Report for NZAP council re ACC issues. In E. O'Keefe (Ed.) (pp. electronic mail). Taupo.
- Davies, E., & Masson, J. (2003, 11.8.2003). Ellis Book Research Questioned. *The New Zealand Herald*.
- Davies, J. j., & Frawley, M. (1994). *Treating the Adult Survivor of Childhood Sexual Abuse*. New York: Basic Books.
- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11-19.
- DeMause, L. (1991). The Universality of Incest. *The Journal of Psychohistory, 19*(2).
- DeMause, L. (1998). The History of Child Abuse. *Journal of Psychohistory, 25*(3).
- DeMause, L. (2002). *The Emotional Life of Nations*. New York: Karnac.
- Deranty, J. P. (2004). Injustice, Violence and Social Struggle. The Critical Potential of Axel Honneth's Theory of Recognition. *Critical Horizons, 5*(1), 297-322.
- deVries, M. W. (1996). Trauma in Cultural Perspective. In v. d. B. A. Kolk, A. C. McFarlane & L. Weisaeth (Eds.), *Traumatic Stress* (pp. 398-417). NY: Guilford
- DOL. (2000). Accident Insurance. 2003, from <http://www.tocover.govt.nz/Html/assident.htm>
- Donato, R., & Shanahan, M. (2001). The economics of child sex-offender rehabilitation programs: beyond Prentky & Burgess. *Am J Orthopsychiatry, 71*(1), 131-139; discussion 140-131.
- Draucker, C. B. (1999). The psychotherapeutic needs of women who have been sexually assaulted. *Perspect Psychiatr Care, 35*(1), 18-28.
- Dufour, M., Nadeau, L., & Bertrand, K. (2000). Resilience factors in the victims of sexual abuse: state of affairs. *Child Abuse Negl, 24*(6), 781-797.
- Edward, J. (1999). Is managed mental health treatment psychotherapy? *Clinical Social Work Journal, 27*(1), 87-103.
- Elliott, D. M., & Briere, J. (1995). Posttraumatic stress associated with delayed recall of sexual abuse: A general population study. *Journal of Traumatic Stress, 8*(4), 629-647.
- Engster, D. (2004). Care Ethics and Natural Law Theory: Toward an Institutional Political Theory of Caring. *The Journal of Politics, 66*(1), 113/135.
- Erikson, E. H. (1977). *Childhood and society*. Frogmore, St. Albans: Triad/Paladin.
- Everett, B., & Gallop, R. (2001). *The Link Between Childhood Trauma and Mental Illness: Effective Interventions for Mental Health Professionals*. London: Sage.
- Fergusson, D. M., Horwood, L. J., & Lynskey, M. T. (1996). Childhood sexual abuse and psychiatric disorders in young adulthood: part I: The prevalence of sexual abuse and the factors associated with sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1355-1364.
- Finkelhor, D. (1994). Current Information on the Scope and Nature of Child Sexual Abuse. *The Future of Children: Sexual Abuse of Children, 4*(2), 31-53.
- Finkelhor, D., Hotaling, G., Lewis, I., & Smith, C. (1990). Sexual abuse in a national study of adult men and women: Prevalence, characteristics and risk factors. *Child Abuse and Neglect, 14*, 19-28.
- Forbes, S. (2002, 6.4.2002). Doctors fear fraudulent claims. *Western Leader*.

- Foucault, M. (1980). *Power/Knowledge: Selected interviews and other writings*. Brighton: Harvester.
- Foucault, M. (2003). *Madness and Civilization* (R. Howard, Trans.). London: Routledge.
- Fraser, N. (2003). Social Justice in the Age of Identity Politics: Redistribution, Recognition, and Participation (J. Golb, J. Ingram & C. Wilke, Trans.). In *Redistribution or Recognition? A Political-Philosophical Exchange* (pp. 7-107). London: Verso.
- Freyd, J. J. (1998). *Betrayal Trauma: The Logic of Forgetting Childhood Abuse*. Cambridge: Harvard University Press.
- Gershuny, B., & Thayer, J. (1999). Relations among psychological trauma, dissociative phenomena, and trauma-related distress: a review and integration. *Clin Psychol Rev*, 19(5), 631-657.
- Geuss, R. (1999). *The Idea of a Critical Theory: Habermas & the Frankfurt School*. New York: Cambridge University Press.
- Glaister, J. A., & Abel, E. (2001). Experiences of women healing from childhood sexual abuse. *Arch Psychiatr Nurs*, 15(4), 188-164.
- Glaser, B. G. (1968). The constant comparative method. In B. G. Glaser (Ed.), *More grounded theory methodology: A reader*. Mill Valley: Sociology Press.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: strategies for qualitative research*. Hawthorne, NY: Aldine.
- Goldsack, S., Reet, M., Lapsley, H., & Gingell, M. (2005). *Experiencing a Recovery-Oriented Acute Mental Health Service: Home Based Treatment for the Perspectives of Service Users, their Families and Mental Health Professionals*. Wellington: Mental Health Commission.
- Goodyear-Smith, F., Lobb, B., & Mansell, J. (2005). Sexual abuse counselling: Treatment rates provided by psychiatrists, psychologists and counsellors under ACC funding. *NZFP*, 32(6), 389-393.
- Gorey, K. M., & Leslie, D. R. (1997). The prevalence of child sexual abuse: integrative review adjustment of potential response and measurement bias. *Child Abuse and Neglect*, 21(4), 391-398.
- Graham, D. L. R., Rawlings, E. I., & Rigsby, R. K. (1994). *Loving to Survive: Sexual Terror, men's Violence and Women's Lives*. New York: University Press.
- Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Newbury Park, Calif: Sage
- Habermas, J. (1984). *The Theory of Communicative Action* (T. McCarthy, Trans. Vol. I). Boston: Beacon.
- Harding, C. M. (1994). An examination of the complexities in the measurement of recovery in severe psychiatric disorders. In R. J. Ancill, S. Holliday & G. W. MacEwan (Eds.), *Schizophrenia: Exploring the spectrum of psychosis* (pp. 153-169). Chichester: Wiley & Sons.
- Harlow, H. F. (1986). *From Learning to Love: The Selected Papers of H.F. Harlow*. Westport: Praeger.
- Hay, L. L. (1999). *You can Heal your Life*. Carlsbad: Hay House Inc.
- HDC. (2006). *Meeting Consumer Needs in a Managed Care Environment*. Retrieved from <http://www.hdc.org.nz/publications/presentations?Meeting%20Consumer%20Needs%20in%20a%20Managed%20Care%20Environment#header>.
- Heard, V. (2004). Psychosomatic Illness. *Alternative Therapies* Retrieved 6.5.2006, 2006, from http://www.ps-magazine.com/artman/publish/printer_132.shtml
- Hegel, G. W. F. (1979). *System of Ethical Life (1802/03) and First Philosophy of Spirit (Part III of the System of Speculative Philosophy 1803/04)* (H. S. Harris & T. M. Knox, Trans.). Albany, NY: Suny Press.

- Heginbotham, C., & Elson, T. (1999). Public Policy via Law: Practitioner's Sword and Politician's Shield. In N. Eastman & J. Percy (Eds.), *Law Without Enforcement: Integrating Mental Health and Justice*. Oxford: Hart Publishing.
- Held, D. (1980). *Introduction to Critical Theory: Horkheimer to Habermas*. Berkeley: University of California.
- Heller, S. S., Larrieu, J. A., D'Imperio, R., & Boris, N. W. (1999). Research on resilience to child maltreatment: Empirical considerations. *Child Abuse and Neglect*, 23(4), 321-338.
- Herman, J. (1992). *Trauma and recovery: From domestic abuse to political terror*. London: Harper Collins.
- Herman, J., Russell, D., & Trocki, K. (1986). Long-term effects of incestuous abuse in childhood. *Am J Psychiatry*, 143(10), 1293-1296.
- Hinton, D. E., Chhean, D., Pich, V., Safren, S. A., Hofmann, S. G., & Pollack, M. H. (2005). A Randomised Controlled Trial of Cognitive-Behavior Therapy for Cambodian Refugees With Treatment-Resistant PTSD and Panic Attacks: A Cross-Over Design. *Journal of Traumatic Stress*, 18(6), 617-629.
- Holtgrewe, U. (2001). Recognition, Intersubjectivity and Service Work: Labour Conflicts in Call Centres. *German Journal of Industrial Relations*, 8(1), 37-54.
- Honneth, A. (1995a). Foucault and Adorno: Two Forms of the Critique of Modernity. In *The Fragmented World of the Social: Essays in Social and Political Philosophy*. Albany, N.Y.: SUNY.
- Honneth, A. (1995b). *The Struggle for Recognition: The Moral Grammar of Social Conflicts* (J. Anderson, Trans.). Cambridge, Mass.: MIT Press.
- Honneth, A. (1997). *The Critique of Power: Reflective Stages in a Critical Social Theory* (K. Baynes, Trans. 3rd Ed.). London: MIT Press.
- Honneth, A. (2001). Invisibility: On the Epistemology of 'Recognition'. *The Aristotelian Society, supplementary vol. LXXV*, 111-126.
- Honneth, A. (2003). Redistribution as Recognition: A Response to Nancy Fraser. In *Redistribution or Recognition? A political-philosophical exchange*. London: Verso.
- Honneth, A. (2007). Is Universalism a Moral Trap? The Presuppositions and Limits of a Politics of Human Rights (J. Farrel, Trans.). In *Disrespect: The Normative Foundations of Critical Theory* (pp. 197-218). Cambridge, UK: Polity Press.
- Hood, L. (2001). *A City Possessed: The Christchurch Crèche Case*. Dunedin: Longacre.
- Horen, S. A., Lechner, P. P., & Lawson, J. S. (1995). Prevalence of dissociative symptoms and disorders in an adult psychiatric inpatient population in Canada. *Canadian Journal of Psychiatry*, 40(4), 185-191.
- Howard, M. (2002a). ACC's Conscious Disregard for Claimants Health. Retrieved 6.11.2002, 2002, from <http://www.scoop.co.nz/mason/stories/HL0211/S00029.htm>
- Howard, M. (2002b). ACC Victimisation. Retrieved 9.9.2002, 2002, from <http://www.scoop.co.nz/mason/stories/HL0209/S00036.htm>
- Howard, M. (2002c). ACC: Three Stooges and the Mad Hatter's Tea Party. Retrieved 12.12.2002, 2002, from <http://www.scoop.co.nz/mason/stories/HL0212/S00075.htm>
- Howard, M. (2003). ACC Shambles Ruining People's Lives. Retrieved 15.1.2003, 2003, from <http://www.scoop.co.nz/mason/stories/HL0301/S00044.htm>
- Hyman, S. M., Gold, S. N., & Cott, M. A. (2003). Form of Social Support That Moderate PTSD in Childhood Sexual Abuse Survivors. *Journal of Family Violence*, 18(5), 295-300.
- Ikaheimo, H. (2007). Analysing Social Inclusion in Terms of Recognitive Attitudes. Retrieved 27 May, 2007, from <http://www.fehe.org/index.php?id=334>

- Jamieson, M., Walker, M., Daicar, A., & Reid, R. (1998). False allegations of pregnancy resulting from incestuous rape and physician misconduct: proof positive. *J Pediatr Adolesc Gynecol*, *11*(4), 181-184.
- Jennings, A. (1994). On being invisible in the mental health system. *J Ment Health Adm.*, *21*(4), 374-387.
- Johnstone, J. (2002). *Voice, identity and coercion: the consumer/survivor movement in acute public psychiatric services*. University of Melbourne, Melbourne.
- Julich, S. (2001). *Breaking the Silence: Restorative Justice and Child Sexual Abuse*. Unpublished PhD Thesis, Massey University, Auckland.
- Jurist, E. L. (1994). Review of Axel Honneth: Kampf um Anerkennung. *Constellations*, April 1994, 176.
- Kaplan, R., & Manicavasagar, V. (2001). Is there a false memory syndrome? A review of three cases. *Compr Psychiatry*, Volume 42(Number 4).
- Karon, B. P. (1995). Provision of psychotherapy under managed health care: A growing crisis and national nightmare. *Professional Psychology: Research and Practice*, *26*(1), 5-9.
- Karpman, S., & Fleener, P. E. (2005). The Drama Triangle. Retrieved 2005, 2005, from <http://www.mental-health-today.com/articles/drama.htm>
- Kearney-Cooke, A., & Ackard, D. (2000). The effects of sexual abuse on body image, self-image, and sexual activity of women. *J Gend Specif Med*, *3*(6), 54-60.
- Kessler, D. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, *52*, 1048-1060.
- Kincheloe, J., & McLaren, P. (1994). Rethinking critical thinking and qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research*. Thousand Oaks, CA: Sage Publications.
- King-Keenan, E. (2001). Using Foucault's "Disciplinary Power" and "Resistance" in Cross-Cultural Psychotherapy. *Clinical Social Work Journal*, *29*(3), 211-227.
- Klein, M. (1935). A Contribution to the Psychogenesis of Manic-Depressive States. *The International Journal of Psychoanalysis*, *16*, 145-174.
- Klein, M. (1991). *The selected Melanie Klein*. London: Penguin Books.
- Kluft, R. P. (1993). The initial stages of psychotherapy in the treatment of multiple personality disorder patients. *Dissociation*, *VI*(2/3), 145-161.
- Kluft, R. P. (1999). An overview of the psychotherapy of dissociative identity disorder. *Am J Psychiatry*, *53*(3), 289-319.
- Kolk, v. d. B. A. (1989). The compulsion to repeat the trauma: Re-enactment, revictimisation, and masochism. *Psychiatric Clinics of North America*, *12*(2), 389-411.
- Kolk, v. d. B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of post-traumatic stress. *Harvard Rev Psychiatry*, *1*, 253-265.
- Kolk, v. d. B. A. (1996). Trauma and memory. In v. d. B. A. Kolk, A. C. McFarlane & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. NY: Guilford.
- Kolk, v. d. B. A., & McFarlane, A. C. (1996). Trauma and its Challenge to Society. In v. d. B. A. Kolk, A. C. McFarlane & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. (pp. 24-46). New York: Guilford.
- Kolk, v. d. B. A., McFarlane, A. C., & Hart, v. d. O. (1996). A general approach to treatment of Post Traumatic Stress Disorder. In v. d. B. A. Kolk, A. C. McFarlane & L. Weisaeth (Eds.), *Traumatic Stress* (pp. 417- 440). New York: Gildford Press.

- Kolk, v. d. B. A., Pelcovitz, D., Roth, S., Mandel, F. S., McFarlane, A., & Herman, J. L. (1996). Dissociation, somatization, and affect dysregulation: the complexity of adaptation of trauma. *Am J Psychiatry*, *153*(7 Suppl), 83-93.
- Kompridis, N. (2004). From Reason to Self-Realisation? Axel Honneth and the 'Ethical Turn' in Critical Theory. *Critical Horizons*, *5*(1), 323-360.
- Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy*, *45*, 214-222.
- Krueger, R. A. (1988). *Focus groups: a practical guide for applied research*. London: Sage.
- Labour, N. Z. (2003). Our History. Retrieved 19.9.2003, 2003, from <http://www.labour.org.nz/history/index.html>
- Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94-129). NY: Basic Books.
- Leete, E. (1989). How I perceive and manage my illness. *Schizophrenia Bulletin*, *15*, 197-200.
- Lewis, T., Amini, F., & Lannon, R. (2001). *A General Theory of Love*. New York: Vintage Books.
- Liebkind, K., & Eranen, L. (2001). Attitudes of future human service professionals: the effects of victim and helper qualities. *J Soc Psychol*, *141*(4), 457-475.
- Linehan. (1993). *Treatment Manual For Borderline Personality Disorder*.
- Lipschitz, D., Kaplan, M., Sorkenn, J., Faedda, G., Chorney, P., & Asnis, G. (1996). Prevalence and characteristics of physical and sexual abuse among psychiatric outpatients. *Psychiatr Serv*, *47*(2), 189-191.
- Lister, R. (2005). Recognition and voice: the challenge for social justice, *ESRC seminar 1: Social justice and public policy* (pp. 7): Scottish Centre for Research on Social Justice.
- Loewenstein, R. J. (1994). Diagnosis, epidemiology, clinical course, treatment, and cost effectiveness of treatment for dissociative disorders and MPD: report submitted to the Clinton administration task force on health care financing reform. *Dissociation*, *VII*(1), 3-11.
- Lothian, J., & Read, J. (2002). Asking About Abuse During Mental Health Assessments: Clients' Views and Experiences. *New Zealand Journal of Psychology*, *31*(2), 98-103.
- MacDonald, G. (2001). *Effective Interventions for Child Abuse and Neglect: An evidence-based Approach to Planning and Evaluating Interventions*. Chichester: Wiley & Sons.
- MacKinnon, L. (1993). Systems in Settings: The Therapist as Power Broker. *A.N.Z.J. Fam. Ther.*, *14*(3), 117-122.
- Malhotra, S., & Biswas, P. (2005). Child Sexual Abuse in Clinical Practice: Identification and Management. *JACAM*, *1*(6), Article 6.
- Maslow, A. H. (1943). A Theory of Human Motivation. *Psychological Review*, *50*, 370-396.
- Maykut, P., & Morehouse, R. (1994). *Beginning qualitative research: A philosophic and practical guide*. London: The Falmer Press.
- McFarlane, A. C., & Kolk v.d., B. A. (1996). Trauma and its challenge to society. In B. A. Kolk v.d., A. C. McFarlane & L. Weisaeth (Eds.), *Traumatic Stress* (pp. 24-46). New York: Guilford Press.
- McFarlane, A. C., & Yehuda, R. (1996). Resilience, Vulnerability, and the Course of Posttraumatic Reactions. In B. A. v.d.Kolk, A. C. McFarlane & L. Weisaeth (Eds.), *Traumatic Stress* (pp. 155-181). New York: Guilford.

- Mead, G. H. (1934). *Mind, Self, and Society: from the Standpoint of a Social Behaviorist*. Chicago: University of Chicago.
- MHC. (1998). *Blueprint for Mental Health Services in New Zealand: How things need to be*. Wellington: Mental Health Commission.
- MHC. (2007). *Te haererenga mo te Whakaoranga 1996-2006: The Journey of Recovery for the New Zealand Mental Health Sector*. Wellington.
- Miller, A. (1983). *For Your Own Good: Hidden Cruelty in Child-rearing and the Roots of Violence*. New York: Farrar, Straus and Giroux.
- Miller, S., Duncan, B., Johnson, L., & Hubble, M. A. j. (2000). Toward an outcome-informed therapeutic practice. *Psychotherapy in Australia*, 6(2), 30-36.
- Miller, S., Duncan, B. L., & Hubble, M. A. j. (2004). Beyond Integration: The Triumph of Outcome Over Process in Clinical Practice. *Psychotherapy in Australia*, 10(2).
- Mitchell, K. (2003, July 2003). Counsellors turn down ACC work. *New Zealand Health Review*, p. 16.
- Modestin, J., Ebner, G., Junghan, M., & Erni, T. (1996). Dissociative experiences and dissociative disorders in acute psychiatric inpatients. *Compr Psychiatry*, 37(5), 355-361.
- MOH. (1998a). *Child Health Strategy*. Wellington: Ministry of Health.
- MOH. (1998b). *Our Children's Health: Key findings on the Health of New Zealand Children*. Wellington: Ministry of Health.
- MOH. (1998c). *Progress on Health Outcome Targets 1998*. Wellington: Ministry of Health.
- MOH. (2005). *Te Tahuhu: Improving Mental Health 2005-2015*. Wellington: Ministry of Health.
- MOH. (2006). *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington.
- MOJ. (1999). Accident Compensation Corporation: Relevant Acts. 2003, from http://www.justice.govt.nz/justicepubs/reports/1999/dire_of_info/list_A/acc.htm
- Moncrieff, J., Drummond, D., Candy, B., Checinski, K., & Farmer, R. (1996). Sexual abuse in people with alcohol problems. A study of the prevalence of sexual abuse and its relationship to drinking behaviour. *Br J Psychiatry*, 169(3), 355-360.
- Morgan, D. L. (1988). *Focus groups as qualitative research*. London: Sage.
- Morgan, D. L., & Krueger, R. A. (1993). When to use focus groups and why. In D. L. Morgan (Ed.), *Successful Focus Groups*. London: Sage.
- Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd Ed.). Thousand Oaks, C.: Sage.
- Mullen, P. E., Martin, J. L., & Anderson, J. C. (1996). The long-term impact of the physical, emotional, and sexual abuse of children: a community study. *Child Abuse and Neglect*, 20(1), 7-21.
- Munhall, P. L., & Oiler Boyd, C. (1993). *Nursing Research: A Qualitative Perspective*. NY: National League for Nursing Press.
- Myhrvold, T. (2006). The different other - towards an including ethics of care. *Nursing Philosophy*, 7, 125-136.
- Navarro, V. (1986). *Crisis, Health and Medicine*. New York: Tavistock.
- Newman, M. (2006). Welfare Reform - more perception than reality. Retrieved 6 February, 2007, from www.murielnewman.co.nz/weekly55.htm
- Noddings, N. (1984). *Caring: A Feminine Approach to Ethics and Moral Education*. Berkeley: University of California Press.
- NZ-Herald. (2004, 21.4.2004). Union says it warned Dyson about bullying managers. *New Zealand Herald Online - Newspaper*.

- NZAC. (2006). Code of Ethics. Retrieved September, 2006, from <http://www.nzac.org.nz/ethics/2.html>
- NZAP. (1986). *Code of Ethics*. Wellington: New Zealand Association of Psychotherapists.
- NZAP. (2003). *Minutes of the AGM March 2003* (Vol. April 2003). Wellington: New Zealand Association of Psychotherapists.
- Onken, S. J., Dumont, J. M., Ridgway, P., Dornan, D. H., & Ralph, R. O. (2002). Phase One Research Report: A National Study of Consumer Perspectives on What Helps and Hinders Recovery. *Mental Health Recovery: What Helps and What Hinders? - A National Research Project For The Development Of Recovery Facilitating System Performance Indicators* Retrieved 21 October, 2005, from <http://www.namisscc.org/Recovery/2002/MentalHealthRecovery.htm>
- Palmer, S. E., Brown, R. A., Rae-Grant, N. I., & Loughlin, M. J. (2001). Survivors of childhood abuse: their reported experiences with professional help. *46*, 2(136-45).
- Paterson, R. (2004, 11 May 2004). *The External Crystal Ball*. Paper presented at the RANZC Psychiatrists Policy Forum, Christchurch.
- Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. NY: Norton.
- Perry, Pollard, Blakely, Baker, & Vigilante. (1995). Childhood Trauma, the neurobiology of adaptation and use-dependent development of the brain. How states become traits. *Infant Mental Health Journal*, *16*, 271-291.
- Polit, d. F., & Hungler, B. P. (1991). *Nursing research: Principles and methods* (4th Ed.). Philadelphia: Lippincott.
- Pope, K. (2001). Sex Between Therapists and Clients. In J. Worell (Ed.), *Encyclopedia of Women and Gender: Sex Similarities and Differences and the Impact of Society on Gender* (pp. 955-962): Academic Press.
- Putnam, F. W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: Guilford.
- Rahm, D., Otte, H., Bosse, S., & Ruhe-Hollenbach, H. (1993). *Einfuehrung in die integrative Therapie: Grundlagen und Praxis*. Paderborn: Jungfermannsche Verlagsbuchhandlung.
- Read, J. (1998). Child Abuse and Severity of Disturbance Among Adult Psychiatric Inpatients. *Child Abuse and Neglect*, *22*(5), 359-368.
- Read, J. (2006). Diagnosis Disorder. Retrieved 13.8.2006, 2006, from <http://www.stuff.co.nz/stuff/print/0,1478,3753678a12935,00.html>
- Read, J., & Fraser, A. (1998). Staff responses to Abuse Histories of Psychiatric Inpatients. *Australian and New Zealand Journal of Psychiatry*, *32*(2), 206-213.
- Read, J., Young, M., Barker-Collo, S., & Harrison, R. (2001). Evaluating and Overcoming Barriers to Taking Abuse Histories. *Professional Psychology: Research and Practice*, *32*(4), 407-414.
- Reserve Bank. (2006). Consumer Price Index Inflation Calculator. Retrieved 18 August, 2006, from <http://www.rbnz.govt.nz/statistics/0135595.html>
- Romans, S. E., Martin, J., & Mullen, P. (1996). Women's self-esteem: a community study of women who report and do not report childhood sexual abuse. *Br J Psychiatry*, *196*(6), 696-704.
- Ross, C. A. (1995). *Satanic Ritual Abuse: Principles of Treatment*. Toronto: University of Toronto Press.
- Ross, C. A. (2000). *The Trauma Model: A Solution to the Problem of Comorbidity in Psychiatry*. Richardson: Manitou Communications.

- Rothschild, G. (2000). *The Body remembers: The Psychophysiology of Trauma and Trauma Treatment*. New York: Norton.
- Rowe, D. (1987). *Beyond Fear*. London: Fontana Paperbacks.
- Rundell, J., Petherbridge, D., Bryant, J., Hewitt, J., & Smith, J. (2004). Issues and Debates in Contemporary Critical and Social Philosophy. *Critical Horizons*, 5(1), 1/25.
- Runtz, M. G., & Schallow, J. R. (1997). Social Support and Coping Strategies as Mediators of Adult Adjustment Following Childhood Maltreatment. *Child Abuse and Neglect*, 21(2), 211-226.
- Rush, F. (1980). *The Best Kept Secret: The Sexual Abuse of Children*. NY: McGraw-Hill.
- Russel, D. (1984). *The Secret Trauma: Incest in the lives of girls and women*. New York: Basic Books.
- Saakvitne, K. W., & Abrahamson, D. J. (1994). The impact of managed care on the therapeutic relationship. *Psychoanalysis and Psychotherapy*, 11, 181-197.
- Schon, D. A. (1991). *The Reflective Practitioner: How Professionals Think in Action* (2nd Ed.). Aldershot: Ashgate.
- Schon, D. A. (1992). The crisis of professional knowledge and the pursuit of an epistemology of practice. *Journal of Interprofessional Care*, 6(1), 49-63.
- Schore, A. N. (2003a). *Affect Dysregulation & Disorders of the Self*. NY: Norton.
- Schore, A. N. (2003b). *Affect Regulation and the Repair of the Self*. New York, NY: Norton.
- Schwartz, J., & Weiner, M. B. (2003). Finding Meaning in Medical Necessity. *Social Work*, 48(3), 392-400.
- Sidanius, J., & Pratto, F. (1999). *Social Dominance: An Intergroup Theory of Social Hierarchy and Oppression*. Cambridge: University Press.
- Siegel, D. J. (1999). *The Developing Mind: How relationships and the brain interact to shape who we are*. New York, NY: Guilford.
- Sinnerbrink, R. (2004). Recognitive Freedom: Hegeland the Problem of Recognition. *Critical Horizons*, 5(1), 271/295.
- Spaccarelli, S., & Kim, S. (1995). Resilience Criteria and Factors Associated with Resilience in Sexually Abused Girls. *Child Abuse and Neglect*, 19(9), 1171-1182.
- Sperling, M. B., & Sack, A. (2002). Psychodynamics and Managed Care. *American Journal of Psychotherapy*, 56(3), 362-377.
- Sperry, L. (1998). Contemporary ethical dilemmas in psychotherapy: Cosmetic psychopharmacology and managed care. *American Journal of Psychotherapy*, 52(1), 54-63.
- Starzynski, L. L., Ullman, S. E., Filipas, H. H., & Townsend, S. M. (2005). Correlates of women's sexual assault disclosure to informal and formal support sources. *Violence Vict*, 20(4), 417-432.
- Steinberg, L. (1999). *Adolescence* (5th Ed.). Boston: McGraw-Hill.
- Stern, D. (1977). *The First Relationship: Infant and Mother*. Cambridge MA: Harvard University Press.
- Stern, P. N. (1994). Grounded theory methodology: Its uses and processes. In B. G. Glaser (Ed.), *More grounded theory methodology: A reader* (pp. 116-126). Mill Valley, CA: Sociology Press.
- Tallman, K., & Bohart, A. C. (1999). The client as a common factor: Clients as self-healers. In M. A. j. Hubble, B. L. Duncan & S. Miller (Eds.), *The heart & soul of change: What works in therapy* (pp. 91-131). Washington DC: American Psychological Association.

- Taylor, C. (1992). The politics of Recognition. In A. Gutmann (Ed.), *Multiculturalism and the Politics of Recognition* (pp. 25-73). Princeton, NJ: Princeton University press.
- Thompson, S. (2005, 5-7 April 2005). *The Emotional Dynamics of Political Resistance*. Paper presented at the Political Studies Association Conference, Leeds, UK.
- Tremblay, C., Hebert, M., & Piche, C. (1999). Coping Strategies and Social Support as Mediators of Consequences in Child Sexual Abuse Victims. *Child Abuse and Neglect*, 23(9), 929-945.
- Tyler, F. (2003a, 10.5.2003). Abuse victims denied help over ACC diagnosis demands. *Dominion Post*.
- Tyler, F. (2003b, 28.4.2003). Claims for sex abuse soaring. *Dominion Post*.
- Ullman, S. E. (1996). Do social reactions to sexual assault victims vary by support provider? *Violence Vict*, 11(2), 143-157.
- Ullman, S. E., & Filipas, H. H. (2005). Gender differences in social reactions to abuse disclosures, post-abuse coping, and PTSD of child sexual abuse survivors. *Child Abuse Negl.*, 29(7), 767-782.
- Ullman, S. E., & Siegel, J. M. (1995). Sexual assault, social reactions, and physical health. *Womens Health*, 1(4), 289-308.
- Unzicker, R. (1989). On my own: A personal journey through madness and re emergence. *Psychosocial Rehabilitation Journal*, 13(1), 71-77.
- van Loon, A. M., Koch, T., & Kralik, D. (2004). Care for female survivors of child sexual abuse in emergency departments. *Accid Emerg Nurs*, 12(4), 208-214.
- Vaughn, R. (Writer) (2006). Picking up the pieces. In TV3 (Producer), *60 Minutes*. New Zealand.
- Wacker, A. (2003). *Doing and Being: How psychotherapists balance the impact of trauma*. Unpublished Masters of Health Science, Auckland University of Technology, Auckland.
- Walker, E. A., Unutzer, J., Rutter, C., Gelfand, A., Saunders, K., VonKorff, M., et al. (1999). Costs of health care use by women HMO members with a history of childhood abuse and neglect. *Arch Gen Psychiatry*, 56(7), 609-613.
- Wampold, B. E. (2001). *The Great Psychotherapy Debate: Models, Methods, and Findings*. Hillsdale, NJ: Erlbaum.
- Weisgerber, K. (1999). *The Traumatic Bond Between the Psychotherapist and Managed Care*. Northvale, NJ: Jason Aronson Inc.
- Wells, D. (2004). Disturbing the Sound of silence. *Mental Health Commission: Occasional paper*(6), 9.
- Wheelock, I. (2000). The value of a psychodynamic approach in the managed care setting. *American Journal of Psychotherapy*, 54(2), 204-215.
- Wiggershaus, R. (1995). *The Frankfurt School*. Cambridge: Polity Press.
- Wilkinson, R. G. (2002). Income inequality, social cohesion, and health: Clarifying the theory - a reply to Muntaner and Lynch. In V. Navarro (Ed.), *The Political Economy of Social Inequalities: Consequences for health and Quality of Life* (pp. 347-365). Amityville, N.Y.: Baywood.
- Wineburgh, M. (1998). Ethics, managed care, and outpatient psychotherapy. *Clinical Social Work Journal*, 26(4), 433-443.
- Winnicott, D. W. (1971). The Use of an Object. In *Playing and Reality*. London: Penguin Books.
- Zanarini, M., Ruser, T., Frankenburg, F., Hennen, J., & Gunderson, J. (2000). Risk factors associated with the dissociative experiences of borderline patients. *J Nerv Ment Dis*, 188(1), 26-30.