How do Adult Survivors of Child Sexual Abuse Navigate the Early Stages of Psychotherapy?

A Hermeneutic Literature Review

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ABSTRACT

This dissertation explores how adult survivors of child sexual abuse experience the early stages of psychotherapy. A hermeneutic methodology is used to illuminate therapy processes and outcomes, including attrition, from a survivor's perspective. First-person accounts found in the research literature assist in illuminating an understanding of what these clients may encounter in this crucial first phase of the therapeutic process. This research proposes that survivors' voices are essential to understanding the diverse experiences of sexual abuse survivors. However, the paucity of first-person accounts of the survivor's initial therapy phase in the academic literature presented a difficulty for this study and points to a gap in existing research. Given the prevalence of child sexual abuse in the Western world, this hermeneutic literature review seeks to contribute toward a better understanding of the therapeutic needs of this growing client group, particularly at the beginning of their journey. This study's findings have implications for the training and clinical practice of frontline health and education workers, including beginning and experienced counsellors and psychotherapists in Aotearoa New Zealand.

TABLE OF CONTENTS

ABSTRACT ... i
TABLE OF CONTENTS ... ii
TABLE OF FIGURES ... iv
ATTESTATION OF AUTHORSHIP ... v
ACKNOWLEDGEMENTS ... vi
CHAPTER ONE: INTRODUCTION ... 1
Overview ... 1
Origin of the Study ... 1
How this Research Topic was Chosen ... 1
Looking Through Survivors' Eyes ... 2
My Family Background ... 2
Structure of the Study ... 3
Definition of Terms ... 3
What is Child Sexual Abuse? ... 3
Who are Adult Survivors of Child Sexual Abuse? ... 4
Symptoms Associated with Child Sexual Abuse ... 4
Prevalence of Child Sexual Abuse ... 5
Thoughts on the Beginning Phase of Therapy ... 5
Rationale for this Research – Why is it Important? ... 6
Summary ... 7
CHAPTER TWO: METHODOLOGY AND METHOD ... 8
Methodology Overview ... 8
Philosophical Underpinnings for this Research ... 8
Interpretivism ... 8
Methodology ... 9
A Conversation Between Reader and Writer ... 9
Unconscious Dynamics ... 10
Care of the Self ... 10
'Lingering and Loitering' (Alchemical Hermeneutics) ... 11
'Fore-understandings' ... 12
Method ... 13
A Hermeneutic Literature Review ... 13
Searching, Sorting, and Selecting ... 14
Snowballing and Citation Tracking ... 16
Surprises Along the Way ... 16
Acquiring and Reading ... 17
The Researcher's Subjectivity ... 17

Moving Through the Circles 18
The Weaving of Data 18
Inclusion and Exclusion 20
When and How to Leave the Hermeneutic Spiral 21
Summary 21
CHAPTER THREE: FINDINGS 22
The Historical Context of this Study 22
Being Believed 23
The Recovered Memory Debate 24
The Beginning Phase of Therapy 25
The Therapeutic Relationship – A Delicate Balance 26
Hiding Behind a Mask 28
The Therapeutic Stance 29
Affective Responses 30
Secrecy – Don't Tell or I Will Kill You! 31
The Centre of My Soul 32
Feeling in Charge 33
Imprints on Minds and Bodies 34
Lost Stories – Attrition 35
Summary 35
CHAPTER FOUR: DISCUSSION AND IMPLICATIONS 37
Child Sexual Abuse – A Public Health Issue 37
Bias Against Survivors 38
Implications 38
Trauma-informed Therapy in the Context of Generic Psychotherapies 38
Disclosure 39
Psychotherapy Training and Practice 40
Strengths and Limitations 40
A Hermeneutic Approach is Subjective – A Story Emerges 40
Attrition and Further Research 42
Ethical Considerations 42
Summary 43
CONCLUDING THOUGHTS 44
REFERENCES 46

TABLE OF FIGURES

Figure 1 A hermeneutic framework for the literature review process consisting of two major hermeneutic circles (Boell & Cecez-Kecmanovic, 2014). 14
Figure 2 A selection of first-person accounts found in the literature 20

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.

Signature:

Isolde Grunwald

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CHAPTER ONE: INTRODUCTION

Overview

In this dissertation, I explore the question: "How do adult survivors of child sexual abuse navigate the beginning stages of formally delivered psychotherapy?" This study aims to contribute to understanding how clients with a sexual abuse history experience the initial psychotherapy phase by investigating first-person accounts in the literature. In this chapter, I outline the background and circumstances of this study's inception and the key points it addresses. Next, I briefly define the main terms related to the research question and current clinical practice in Aotearoa New Zealand.

Origin of the Study

How this Research Topic was Chosen

After completing my clinical psychotherapy training, I started seeing clients who came to therapy because they had been sexually abused as children. Initially, I had felt well prepared to work with adult survivors of child sexual abuse (ASCSA). During training I had a placement in private practice throughout which I worked with a variety of presentations. However, when a couple of clients who had suffered sexual abuse as children prematurely concluded their therapy with me, I started to wonder if I had missed something or done something wrong.

Reflecting on my counter-transference at the time these clients quit, I realised I felt abandoned and rejected, doubting I was a good enough therapist to serve this client group. This sparked my interest in finding out more about the diverse experiences survivors of child sexual abuse may have during the pivotal first phase of therapy. I wanted to see the world through their eyes, and surmised that emotionally nuanced survivor accounts might assist me in getting closer to these clients' early therapy experiences.

ASCSA have a reputation for being difficult and demanding clients (Herman, 1997; Nehls & Sallman, 2005). Indeed, Herman (1992) proposed that therapists can experience counter-transferential struggle in their work with the trauma survivor. I was intrigued by these notions and wondered if this client group was stigmatised and marginalised. I also wondered what might underlie these prejudices and how they might affect the therapy experience of these clients. Lastly, I was interested in the issue of ASCSA ending psychotherapy prematurely.

Looking Through Survivors' Eyes

In my initial literature search, I was surprised at the difficulties finding material in psychodynamic and psychoanalytic theory books, and my search confirmed the paucity of both clients' and therapists' child sexual abuse therapy in the academic literature, despite a plethora of research on child abuse and psychotherapy (Dale, 1999; Parry & Simpson, 2016). At this point, I started my hermeneutic journey by turning to self-help books in my search for first-person accounts (Bass & Davies, 1988; McGregor, 1994), hoping to find out how this key client group had navigated the beginning stage of psychotherapy.

My Family Background

I was born in Germany, the fourth daughter in a family with five girls. Growing up, sexual violence and abuse were not discussed in our household, even though my parents were seemingly liberal and apparently open to debating various social and political issues.

As a child, I did not grasp the meaning of the terms sexual abuse and stranger danger. Later, as a teenager, I learned not to ask questions about these things because it made my parents and other adults uncomfortable. By the time I was a young adult, I had absorbed the lessons from my upbringing that sexual abuse of children was not to be discussed or referred to; that violence against children was acceptable if they were disobedient or answered back; and that sexual violence would go largely unpunished and be kept secret. To put this in context, I had a materially comfortable, middle-class upbringing and these attitudes and behaviours were pervasive as Miller (1990) contends; my family was not unusual in its response to these issues.

After leaving home, crossing the world, raising my own family in Aotearoa New Zealand, and completing my psychotherapy training, I am coming full circle and searching for the voices of ASCSA with renewed curiosity. Sexual violence perpetrated against marginalised groups is ubiquitous in Western countries and many cultures and societies around the world (Nehls & Sellman, 2005). Yet, talking about this contentious issue makes many people uneasy (Armstrong, 1996). For instance, since the beginning of my research, I have noticed some people's reactions when I mentioned my dissertation topic of how ASCSA navigate the beginning stages of psychotherapy. People would step back and stop talking, seemingly shocked and carefully considering their response. Moreover, conversations with peers and colleagues indicate that the history surrounding attitudes towards child sexual abuse and the beginnings of psychotherapeutic work in this area over the last 130 years are not well known or discussed among frontline health workers.

Structure of the Study

This hermeneutic study will review psychodynamic theory, research, and clinical practice as it pertains to my research question; however, my primary focus remains the survivor's experience of therapy, particularly through first-person accounts as they appear in the literature. In addition, reading and reflecting on poetry and prose fiction around the area of my research topic was valuable to help me access the unconscious dimensions involved in the topic.

These unconscious dimensions are described in Chapter Two where I delineate the methodological approach and discuss epistemology, theoretical perspective, and research methods used in the study, and explore how the hermeneutic model (Boell & Cecez-Kecmanovic, 2014; Smythe & Spence, 2012) creates knowledge for the researcher and the reader alike; thus, contributing to clinical understanding in working with this client group. Inclusion and exclusion criteria are also addressed.

In Chapter Three, I outline the historical background of this study and survivors' experiences of being believed, secrecy and disclosure of child sexual abuse. My findings also highlight the therapeutic relationship, therapeutic neutrality and therapists' affective responses and cover current therapeutic approaches, possible reasons for attrition in psychotherapy and ethical issues.

Chapter Four discusses child sexual abuse as a public health issue, bias against survivors, trauma-informed therapy approaches and the topic of disclosure. I evaluate the limits and strengths of my research and discuss its implication for psychotherapy training and practice. I discuss attrition, a gap in the research, particular needs of Māori survivors and consider ethical issues.

I conclude by sharing thoughts on my personal experiences and clinical learning that this study has provided; and the hope that this study might contribute to a better understanding and health provision for ASCSA.

Definition of Terms

What is Child Sexual Abuse?

In this thesis, the term 'child sexual abuse' is based on the definition offered by the World Health Organization (WHO, 2006) as follows:

> The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society. Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility, trust or power over the victim. (p. 10)

Child Matters (2022) specifies further:

> It includes any touching for sexual purpose, fondling of breasts, buttocks, genitals, oral sex, sexual intercourse, an adult exposing themselves to the child or young person, or seeking to have a child touch them for a sexual purpose. It also includes voyeurism, photographing children or young people inappropriately, involving the child or young person in pornographic activities or prostitution or using the internet and phone to initiate sexual conversations with children or young people.

Who are Adult Survivors of Child Sexual Abuse?

People who have experienced sexual abuse as children increasingly prefer the term 'adult survivor' and reject being labelled as victims (Bass & Davies, 1988; McGregor, 1994). Surviving child sexual abuse carries a particular meaning that is different from surviving severe physical illness, for instance, where a person may be cured after a course of treatment. The healing process for survivors of child sexual abuse is often lifelong as survivors mitigate their traumatic childhood experiences (Parry & Simpson, 2016). The following is a direct quote from a survivor's experience of therapy:

> I always thought that going to a counsellor would be similar to going to a medical doctor. 'These are my symptoms. What do you prescribe?' But the process is different. It comes from me. And I think that was my first experience in realising I was going to heal myself; that he wasn't going to do it, that he had no magic answers. It was like I was in charge of the session. (Koen, 2007, p. 49)

For the purpose of this dissertation, I will use the term ASCSA to represent any person 16 years and over who has experienced any sexual violation in line with the WHO's (2006) definition of child sexual abuse as described earlier. Furthermore, the terms ASCSA and 'survivor' or 'survivors' or 'sexual abuse survivors' will be used interchangeably in this study; as are the terms counsellor/therapist and counselling/psychotherapy.

Symptoms Associated with Child Sexual Abuse

ASCSA can experience a broad spectrum of symptoms which are often complex, long-lasting, and severe. These include depression; anxiety; post-traumatic stress symptoms; difficulties in interpersonal relationships; dissociation; eating disorders; substance abuse; somatic disturbances; a tendency toward re-victimization; feelings of isolation and stigma; low self-esteem; intense feelings of guilt; difficulty trusting others; social isolation; sexual maladjustment; environmental neurosis; and developmental fixations and arrest (Briere & Scott, 2013; Chu, 1998; Maniglio, 2009; Nehls & Sallman, 2005; Parry & Simpson, 2016; Polusny & Follette, 1995).

These symptoms can also be understood as the general outcome of trauma, especially complex or developmental trauma (Briere & Scott, 2013). Their presence can alert a therapist to a possible child sexual abuse history. This survivor reflects on the ongoing and deepening struggle:

> I just got worse and worse – I'd say, 'I can't take the trains anymore. Now I'm taking buses.' And then a year later, it was 'Dr Horowitz, I can't get on the bus anymore. I'm too frightened. What's happening?' (Bass & Davies, 1988, p. 532)

In Aotearoa New Zealand, some of the symptoms indicating trauma may be seen as associated with intergenerational historical trauma (Pihama et al., 2014), particularly if the survivors are Māori.

Prevalence of Child Sexual Abuse

The harrowing statistics on child sexual abuse are well known. Moreover, they are unlikely to reveal the true extent of the problem as only an estimated one in 10 sexual abuse crimes is reported (Gonzales, 2017). The national child protection agency – Child Matters (2022) – approximates the number of children who suffer sexual abuse in Aotearoa New Zealand, as one in five. Other local research indicates that one in three girls and one in seven boys may be sexually abused before they reach adulthood (Help, n. d.). Perpetrators abusing girls are mostly family members; boys are more likely to be abused outside the family (Courtois, 1988a; Fanslow et al., 2007). Māori are overrepresented in trauma statistics (Fanslow et al., 2007; Pihama et al., 2014), appearing as a higher percentage of sexual abuse survivors than their incidence in the general population would indicate (Fanslow et al., 2007). The following poem, written by a survivor, references the prevalence of child sexual abuse:

> *One In Four*
> *It has happened to a quarter of us*
> *(us? Is that a community?)*
> *twenty-five out of every one hundred*
> *hung, hearts, spleen and lungs*
> *drawn and everything is quartered,*
> *memory split, hemisphere*
> *like a dangerous rebel carcassed*
> *and dispatched to the corners of the realm,*
> *the Elisabethian, Cromwellian, Rome-subjugated*
> *territory, so that no one will ever forget.* (McLoghlin, 2020, p. 101)

Thoughts on the Beginning Phase of Therapy

Ideas differ on what counts as the beginning of therapy. For example, in some approaches, a thorough assessment over a certain number of therapy hours may define the initial treatment phase of the therapeutic process (Newman et al., 1996). However, Rothschild (2000) maintained that

work with traumatised clients requires a more skill-based view of the first therapeutic phase rather than a certain number of therapy sessions completed. As such, trauma-informed talk therapies may begin the therapeutic process by resourcing the client with fundamental skills for stabilisation and self-regulation (Briere & Scott, 2013; Rothschild, 2000, 2017; van der Kolk et al., 1996). Furthermore, Briere and Scott (2013) posited that assessment and treatment intertwine and become indistinguishable in trauma-focused therapy. There is no easy and generally applicable definition of this phase and how to approach it.

Regardless, it is generally accepted that establishing a therapeutic alliance is essential in the first stage of therapy, independent of the modality applied. According to Baldwin et al. (2007), a strong bond between client and therapist predicts both treatment outcomes and attrition.

As I read first-person accounts in the literature, I wondered about the diverse ways in which survivors perceive the beginning of therapy, including factors determining the strength of the therapeutic alliance between client and therapist, and whether their experiences seem to mirror what is written in psychotherapy literature about the early client/therapist relationship.

Rationale for this Research – Why is it Important?

It is well known that a considerable proportion of new clients end psychotherapy within the first three sessions (Baldwin et al., 2007; Hiler, 1958; Rogers, 1951; Roseborough et al., 2016). These rates have not significantly changed over the last 70 years (Barrett et al., 2008; Rogers, 1951; Roseborough et al., 2016) and may represent early drop-outs.

However, for various reasons, client experiences of the beginning stages of therapy are hard to obtain. Using a hermeneutic approach to uncover the voices of survivors in the literature, I hope to glean what ASCSA may experience when they enter therapy and how it impacts whether or not they continue. Ideally, future research would be undertaken with bigger sample sizes of interviewees and focusing solely on how ASCSA navigate the beginning stages of treatment.

More research is also needed to discern the factors involved in client attrition in the early therapy stages (Barrett et al., 2008). In particular, more understanding is needed to determine to what degree child sexual abuse plays a role in survivors ending therapy early. This is challenging because once a survivor has quit therapy, relevant information contributing to the cessation of treatment is usually inaccessible. However, examining ASCSA's reasons for premature discontinuation will inform clinical practice and assist in serving this client group. The growing interest in talk therapies that puts pressure on mental health providers will likely continue to do so (McGregor, 2003). Thus, a better understanding of ASCSA's therapeutic needs is of utmost

importance, especially if survivors are Māori, given the prevalence of child sexual abuse in Aotearoa New Zealand (Fanslow et al., 2007; Fergusson et al., 1996, 2001, 2013).

This research is also important because child sexual abuse has lifelong impacts. Barriers to therapy can prevent survivors from accessing support that may enable them to live different lives. I believe such research would be highly relevant for the clinical practice of beginning and experienced mental health care practitioners in Aotearoa New Zealand.

Summary

In this chapter, I introduced my research question about how ASCSA navigate the beginning stages of psychotherapy and described what sparked my interest in the research topic, followed by my background. Next, I outlined the dissertation structure, defined relevant terms, and considered symptoms associated with child sexual abuse and its prevalence in Western culture and societies. I then contemplated the beginning phase of therapy as reflected in the literature. Lastly, I presented the rationale for this research project and how its findings might contribute to improved clinical outcomes for ASCSA and practice-focused psychotherapy training in Aotearoa New Zealand.

CHAPTER TWO: METHODOLOGY AND METHOD

My research is about exploring the experiences of ASCSA in the early stages of psychotherapy. In this chapter, I discuss the methodology and method most appropriate to get close to the subject under investigation; and to gain a more nuanced understanding through reading and interpreting academic literature, statistics, self-help literature, and first-person survivor accounts.

Methodology Overview

I have chosen a hermeneutic literature review because it is well suited to capture the fine nuances of survivors' perceptions, attitudes, and feelings about psychotherapy as they appear in the literature. As such, the methodology is analogous to the psychotherapy process, which is the object under investigation as experienced by ASCSA. I will describe later, in this chapter, how the hermeneutic approach resembles the psychotherapeutic process itself.

Philosophical Underpinnings for this Research

This research is based on a constructivist, interpretivist epistemology. Epistemology is a way of understanding and explaining how we know what we know (Crotty, 1998). A constructivist epistemology, in particular, asserts that we gain understanding by interpreting the world in which we live. Thus, there is no single 'objective' reality; rather, knowledge is created through different perspectives, and objectivity is neither possible nor desired (Schwandt, 1998). Similarly, in my clinical work, I find that every therapeutic relationship is unique, as is the knowledge I gain from and with my individual clients. As I embarked on my research, I wondered if this might be reflected in the literature review I was undertaking.

Interpretivism

Interpretivism is the basis of a constructivist approach. It is derived from existential philosophies and includes the German intellectual tradition of hermeneutics or 'Verstehen'[1] (Schwandt, 1998). The interpretive paradigm states that reality is constructed through interactions between a researcher and the research subject. In contrast to a positivist approach, interpretivism seeks to understand the human experience and the different meanings people draw from their life events; thus, it provides the theoretical perspective for much qualitative research, including hermeneutics (Grant & Giddings, 2002).

[1] 'Verstehen' is the German word for understanding.

The interpretivist researcher takes the “first and smallest step of abstraction” (Grant & Giddings, 2002, p. 104), aiming to reveal the participants’ self-understanding contained in the research data. I experienced this process as stepping away enough to allow meaning-making to emerge after reading a text. This slight step back provided further information relevant to the research question (Cocks, 1998). Given this focus on participants’ own understanding, an interpretivist perspective is suitable to investigate how ASCSA navigate the beginning stages of psychotherapy through first-person accounts found in the literature.

Methodology

A Conversation Between Reader and Writer

Hermeneutics is named after Hermes, the messenger of the gods in Greek mythology, who moved between the worlds of the gods and the humans. In the Christian tradition, hermeneutics is the science of biblical text interpretation (Orange, 2011). Friedrich Schleiermacher is widely seen as the founder of modern and more general hermeneutics that would go on to elucidate all human understanding (Crotty, 1998).

For Schleiermacher, hermeneutic interpretation is psychological, as the reader seeks to illuminate the author’s intentions and assumptions through their own interpretation and understanding. In this sense, reading a text is like a conversation between the writer and the reader; the reader becomes a listener using “a kind of empathy” (Crotty, 1998, p. 93) as words, phrases, sentences, and grammar are ‘taken in’ to understand what is expressed by the author.

Martin Heidegger and, later, his student Hans-Georg Gadamer, understood hermeneutics to be a reflective inquiry that challenges our understanding of the world around us. (Crotty, 1998). Accordingly, the hermeneutic perspective views phenomena as context-specific and ‘Verstehen’ develops through the ‘back and forth’ between the researcher and their focus (Smythe & Spence, 2012). One way of navigating this ‘back and forth’ in conducting hermeneutic research is through the hermeneutic circle. The researcher gains a sense of the whole by expanding “the unity of the understood meaning centrifugally” (Gadamer, 1989, p. 291) which, in turn, illuminates every part of the area under investigation.

Through such a dialogical encounter between the parts and the whole, both positions co-produce and revise one another. As this process of understanding is deepened and widened, and the researcher stays open to nuanced interpretations, the hermeneutic circle is said to contribute to the enriching and broadening of the researcher’s horizon and to produce unique research outcomes (Boell & Cecez-Kecmanovic, 2014). Consequently, using the ever-widening

hermeneutic circle (Gadamer, 1982) to guide this research aims to model evolving thinking and learning rather than present a single reality.

"Life is thistly", Heidegger is supposed to have said (Harman, 2007, as cited in Smythe et al., 2008). As I delved into the thorny process of discovering how ASCSA navigate the beginning stages of psychotherapy, I found myself remembering these words as I encountered feelings of uncertainty, confusion, and, sometimes, overwhelm, as I sought a path through the thick undergrowth of the literature.

Unconscious Dynamics

In contrast with empirical research, the hermeneutic paradigm presents an argument generatively and in an open-ended way rather than seeking to present 'the absolute truth' (Smythe & Spence, 2012). Gadamer (2007) proposed that there are "conscious and unconscious interests at play" (p. 241) in hermeneutic research. These can show up as foregrounding and/or concealing of materials and literature, and in our own unconscious prejudices and preconceived ideas.

This process can be seen in the hermeneutic spiral which extends and deepens the hermeneutic circle to take these unconscious dynamics into account. As such, the notion of the hermeneutic spiral (Romanyshyn, 2020) as a research methodology tasks psychological research "to make the unconscious dynamics in our sciences and philosophies more conscious" (Romanyshyn, 2020, p. 222).

As I embarked on this study, and started to engage in a mindful dialogue with survivors' accounts by uncovering and interpreting hidden meaning, I became aware of the hermeneutic spiral at play as my inevitable prioritising and discarding of information became evident. This process might be likened to the conscious and unconscious dynamics which a therapist may experience with a client. In this way, it appears that I was only the slightest step removed from becoming the 'as if' therapist as I investigated how survivors navigate the beginning stages of psychotherapy. Consequently, I found that my subjective response (or counter-transference) to the material in the literature was, at times, intense. It follows that the hermeneutic approach is an appropriate methodology in guiding this research on adult survivors' psychotherapy experience because it activates and mirrors the unconscious processes inherent in psychotherapy research.

Care of the Self

As I worked with the hermeneutic spiral and immersed myself in this research, I soon drew further parallels with my clinical work. I found that reading literature on ASCSA, including first-person accounts, required considerable emotional capacity; and thus, I felt the need to monitor my levels

of self-care. In speaking about Sandor Ferenczi's work[2], Orange (2011) said that "each devastated patient would require a level of involvement and willingness [on the therapist's part] to change that we could not imagine in advance" (p. 109). This quote speaks of the openness, humility, and resilience I found necessary in order to remain steady on the hermeneutic path as I investigated adult survivors' experience of psychotherapy.

As part of this self-care I contemplated Heidegger's (1995) suggestion that thinking is a bodily 'being-in-the-world experience'. I surmised that a study like this might benefit from the researcher's body being in good working order to help sustain the steadiness required. As such, I frequently used grounding techniques and conscious breathing to prevent getting overwhelmed by counter-transferential numbness as I read through the harrowing accounts. Furthermore, regular yoga practice assisted in metabolising and assimilating the information at hand. Bike rides during my breaks from reading and writing provided particular inspiration as I was often reminded of Gadamer's analogy between hermeneutics and the wheel of a bicycle (Smythe et al., 2008). The analogy suggests that, just like the wheel of a bicycle, a hermeneutic enquiry needs the right amount of play between structure and freedom to run smoothly (Smythe et al., 2008).

Likewise, the hermeneutic approach required that I carefully listen to my thoughts and subjective responses as I delved deeper into the research process. Smythe et al. (2008) proposed for the researcher "to be always open to questions, and to following a felt sense of what needs to happen next" (p. 1389).

'Lingering and Loitering' (Alchemical Hermeneutics)

Romanyshyn (2020) further developed the hermeneutic approach by articulating the notion of alchemical hermeneutics, suggesting that "the researcher who uses the Alchemical Hermeneutic method is content to dream with the text, to linger in reverie in the moment of being questioned, as one might, for example, linger for a while in the mood of a dream" (p. 223). Romanyshyn's (2020) lyrical description spoke to me as it likened the alchemical hermeneutic process to being in a state of reverie. In the context of psychodynamic psychotherapy and psychoanalysis, reverie is defined as 'evenly hovering attention' (Freud, 1912) or listening without memory or desire (Bion, 1967). Similarly, I felt Romanyshyn's notion of the alchemical hermeneutic approach invited me to dwell with the material and gain an intuitive understanding of the questions under investigation (Romanyshyn, 2020)

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[2] Sándor Ferenczi was a Hungarian psychiatrist, psychoanalyst, and associate of Sigmund Freud. He was known for his work with the most disturbed patients. Unlike Freud, Ferenzci believed that his patients' corroborated accounts of child sexual abuse were real and truthful (Ferenzci & Dupont, 1988).

Smythe and Spence (2012) recommended that a hermeneutic literature review use material from different eras, disciplines and genres, including philosophical texts, to develop a historical consciousness. An awareness of our historicity, in turn, helps us to understand our prejudices and that we are likely to interpret research findings in the light of these prejudices (Hekman, 1986).

Indeed, Gadamer (2006) noted that "what we expect depends on how much insight we have into the context" (p. 14). As such, I realised that an exploration of my personal historical horizon and its possible effects on this research project was of growing significance. Talking about child sexual abuse, or any sexual abuse, was taboo when I was growing up; hence, I became curious to know what might have been written about survivors' experience in those 'hidden' days.

In contrast to systematic literature reviews, which follow strict scientific methods and are commonly used to inform evidence-based practice, hermeneutic literature reviews uncover information that interests the individual researcher and generates new thinking. Therefore, a hermeneutic literature review is an appropriate method to get close to the experience of ASCSA entering psychotherapy.

'Fore-understandings'

In a hermeneutic literature review, the pre-existing knowledge and beliefs a researcher holds about the topic under study are important to the research process. For example, my initial research question and curiosity arose out of clinical experience; then, once I began to research the question, I discovered that first-person accounts of ASCSA on the beginning stages, or any stages, of therapy were rare in academic literature.

Dale (1999) and McGregor (2003) confirmed this in their work; while Herman (1992) and Hoult (1998) went as far as to say that the direct voice of the sexual abuse survivor is often unwelcome within professional and academic publications. Finally, Johnstone (2001) hypothesised that the reluctance to include survivors' accounts in such literature may be due to the stigma attached to clients with mental health issues.

As a beginning psychotherapist working with ASCSA, I found this a troubling possibility. I was reminded of Dupont (1988) commenting on Sándor Ferenczi's apparent madness in later life, saying that "those who get too close to the insane are always looked upon with suspicion" (p. 258).

Method

A Hermeneutic Literature Review

As outlined previously, my initial curiosity in this research was sparked by the premature termination of several clients who had experienced sexual abuse as children, and my desire to know if this abuse was a factor in the decisions of those clients to discontinue their psychotherapeutic treatment. I became curious about the particular needs of this client group, especially in the beginning phase of therapy. In this section, I delineate the steps involved in a hermeneutic literature review and the way I implemented each step.

At the outset of this project, I had considered thematic analysis as my research method. Thematic analysis evaluates data across a data set to find commonalities (Braun & Clarke, 2012). However, the paucity of first-person accounts in the literature prompted me to re-think this plan.

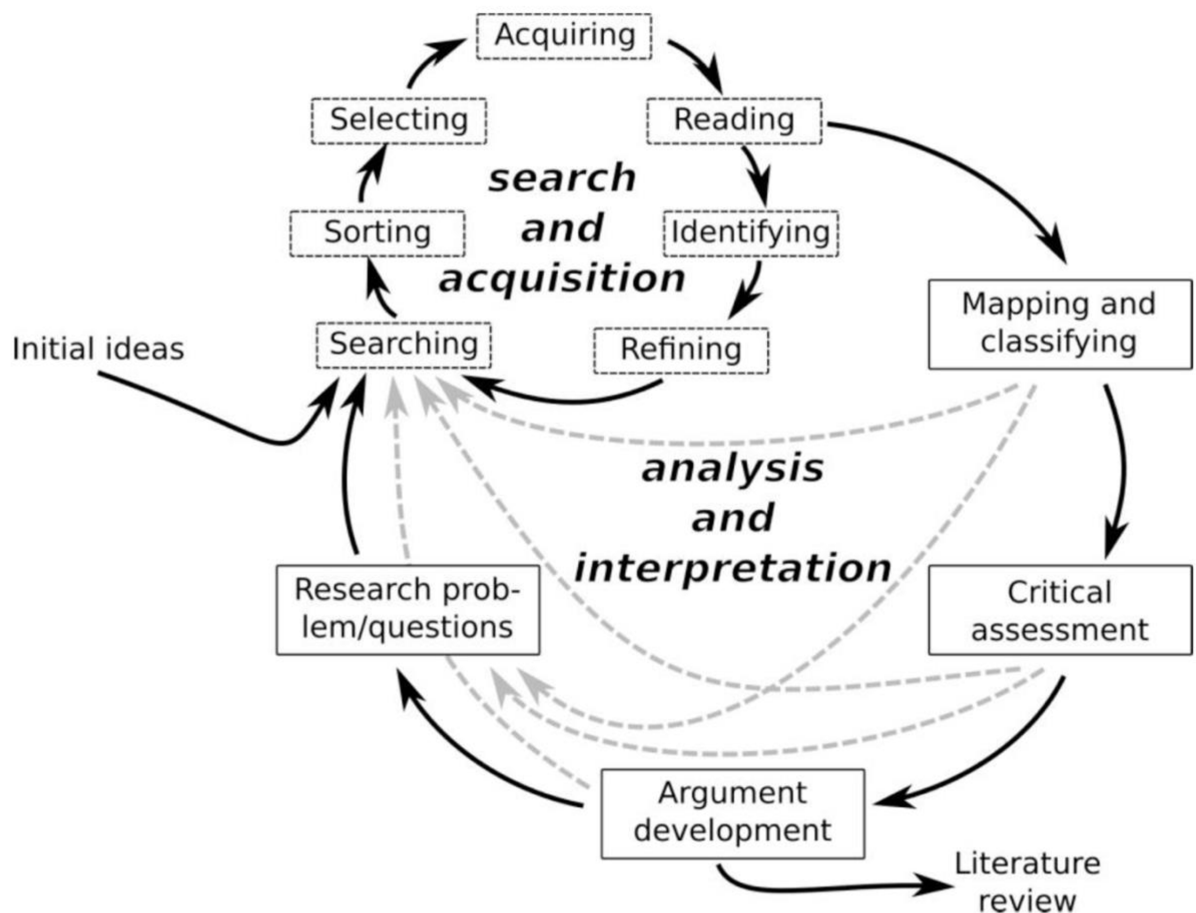
Furthermore, only very few first-person accounts seemed directly related to my research question of adult survivors' experience of the beginning phase of psychotherapy. I started to become interested in the underlying reasons why survivors did not appear to talk about this particular period of their recovery, and in the reasons why some had chosen not to seek psychotherapy at all.

I decided to follow the steps of a hermeneutic framework offered by Boell and Cecez-Kecmanovic (2014). This model (see Figure 1) includes 11 steps that are organised around two key processes: the first seven stages consist of searching databases, sorting and selecting articles and books, acquiring additional material, continuing reading, identifying literature of interest, and refining searches; while the next four stages are described in a separate circle as mapping and classifying, critical assessment, argument development, and research problems/questions.

In addition, I incorporated elements of an alchemical process inherent in the hermeneutic approach as discussed by Romanyshyn (2020). For example, the 'lingering with a text' added a more three-dimensional aspect to the process of the literature review because it allowed me to go back and forth and up and down between ideas, revising and reviewing as I went. Thus, I started to experience the hermeneutic approach as the spiral described by Romanyshyn rather than a circle—not an 'enclosed' process; rather, an open-ended process that led me onward to further reflection and discoveries.

Figure 1

A hermeneutic framework for the literature review process consisting of two major hermeneutic circles (Boell & Cecez-Kecmanovic, 2014, p. 264).



Searching, Sorting, and Selecting

The key task of these initial steps is to determine which publications are relevant to the research topic. Boell and Cecez-Kecmanovic (2014) stated that identifying a smaller selection of highly relevant literature is fundamental to the hermeneutic approach. Next, relevance rankings, publication release dates, or citations may be employed to sort the material at hand. As the third step, the researcher determines which publications are appropriate for acquisition and reading.

When I started to investigate how ASCSA navigate psychotherapy, I was surprised to find that there were few first-person survivor accounts in psychodynamic and psychoanalytic theory books. I wanted to persist because Bindar et al. (2016) proposed that first-person accounts are key to grasping nuanced intrapersonal and interpersonal processes; it follows that first-person accounts can sensitise readers to the emotional complexity experienced by survivors (Bindar et

al., 2016). At this point, I turned to self-help books, hoping to find survivors sharing their psychotherapy experiences and to start my hermeneutic journey.

The Courage to Heal by Bass and Davies (1988) was among the first reference books providing survivors with resources to help them understand their suffering. It contains first person accounts which provided the lived experience and emotional authenticity I had been seeking. Similarly, McGregor (1994) included direct accounts of the experience of many adult survivors and their recovery and healing in Aotearoa New Zealand.

As I started to expand my knowledge, I realised that the decades between 1960 and 1980 were pivotal in the historical discourse of child sexual abuse in many parts of the Western world (Russell, 1986). As such, my area of research seemed to become more complex as I developed a more integrated understanding. At this point, I came to realise the extent to which historical, social and political contexts made a significant difference to the visibility of this issue, and whether there was acknowledgement that child sexual abuse even existed (Bolen et al., 2000; Rush, 1980)

Boell and Cecez-Kecmanovic (2014) suggested that selecting good quality review articles is an effective way to gain an initial overview of the research field and immerse the researcher in the concepts and vocabulary. To give fair play to positivistic and empirical ontologies, I felt it pertinent to include the Cochrane Database of Systematic Reviews (n.d.) in my search, as this database is said to provide the gold standard of evidence-based information. However, neither their trials nor their reviews yielded any primary qualitative data pertaining to my research question.

I continued my search with AUT Google Scholar and the AUT library using truncated terms like adult* survivor* child* sexual* abus* begin* init* start* psychotherapy* counseling* experience*. I combined these terms in various ways, using Boolean operators (AND, OR) and brackets to achieve greater search accuracy. These searches revealed a considerable number of qualitative studies on the experiences of ASCSA in psychotherapy. As I was scanning the titles and abstracts, however, it became apparent that none of them focused on investigating the beginning stage of therapy—my specific area of interest.

I repeated my search with the same terms on PsychInfo, a database which covers a wide variety of psychodynamic literature and publications on behavioural and social sciences (American Psychological Association, 2010). The result produced a selection of diverse research that was circling closer around my research topic; then a couple of relevant dissertations I discovered during my PsychInfo search led me to traverse the Proquest Dissertations & Theses Global database (n.d.) in search of more obscure material and literature sources.

Snowballing and Citation Tracking

Throughout my literature search, I paid close attention to, and took note of, the reference lists of pertinent studies and interesting articles, a technique known as snowballing or citation tracking (Boell &Cecez-Kecmanovic, 2014). Greenhalgh and Peacock (2005) maintained that only a small portion of identified literature is obtained through systematic searches, even in systematic literature reviews. In fact, snowballing and selecting material through personal contacts or knowledge provide a significant proportion of primary sources for most reviews.

As I scoured through reference lists, it felt as if I was finding the footprints other researchers had left and walking for a while in their shoes. This made the research process more intuitive, unpredictable, and exciting, with the feel of a treasure hunt—I was actively engaged with my research and contributing to the body of knowledge on my chosen topic by finding new pathways through it.

Surprises Along the Way

Smythe and Spence (2012) said that relevant literature may be found in unlikely places. Hence, I decided to look through two boxes of *Psychotherapy Networker*[3] hardcopies issued between 1995 and 2010 that a previous supervisor had given me before she retired.

To conclude the structured part of my search, I visited the local second-hand bookshop and phoned the 'Women's Bookshop' to ask whether they could help me locate recent releases on child sex abuse and psychotherapy. When I mentioned having read *The Courage to Heal* by Bass and Davies (1988), the person on the phone instructed me that *The Courage to Heal* was "old and outdated" because the book supports the view that traumatic memories are suppressed until such time as the survivor feels safe enough to confront their past. This was not the current thinking, she maintained firmly.

As I noticed my counter-transferential response of uncertainty, confusion, and annoyance in response to the shop assistant's comments, I wondered if my feelings were reflective of an over-identification with this particular client group as I asked myself: What if I were a survivor just embarking on psychotherapy? How confused would I be about my symptoms and whether I was right or wrong in the light of that person's remark on the phone? And had things in my past actually happened the way I remembered them, or had they not happened at all?

[3] The Psychotherapy Networker is an American journal on psychotherapy and related topics.

With relief, I reminded myself that the point of this thesis was not to argue which side is right in what has been named the 'recovered memory debate'[4]. Instead, the purpose of my research question and study was to get close to the client's psychotherapy experience as they begin the journey to healing from sexual abuse, and to better understand how psychotherapy and a therapeutic connection can help or hinder survivors in this quest.

Acquiring and Reading

Through my various searches, I gathered a substantial amount of literature containing first-person accounts of adult survivors' general psychotherapy experience. Still, I noticed the gap in the research on this client group's experience of the beginning of their psychotherapy journey as conceptualised by Alvesson and Sandberg (2011).

A hermeneutic approach refers to the research question as 'the whole' and to the literature that is found in trying to answer the research question as 'the parts' (Boell & Cecez-Kecmanovic, 2014). Accordingly, I started to get a sense of the whole—how adult survivors navigate the beginning of psychotherapy; and see how the parts—selected literature on my subject—might fit together and answer my research question.

As I moved back and forth between the literature and my research question, I noticed that some of the material gained increasing importance, while other areas of interest faded to the background. I felt inspired by this process of knowledge-creation and the time and care it took, and thought of Romanyshyn's (2020) notion of alchemical hermeneutics being analogous to the firing of a ceramic vessel "which cracks if the process is rushed and the heat is too high" (p. 227).

The Researcher's Subjectivity

Gadamer (as cited in Smythe and Spence, 2012) proposed that "the recognition that all understanding inevitably involves some prejudice gives the hermeneutical problem its real thrust" (p. 16). Smythe and Spence (2012) went on to suggest that "this already-there-understanding is seldom explored in traditional research methodologies" (p. 16).

Strictly speaking, my internal response during the conversation with the assistant at the Women's Bookshop, as described above, may not be part of the hermeneutic process; this was a phone call

[4] "The 'recovered memory debate' has been an ongoing controversy within the mental health and legal professions for the past four decades. Disagreement remains in the field over the veracity of "forgotten memories of childhood sexual abuse that are recalled or recovered during therapy" (Colangelo, 2009, p. 103).

to someone about whom I did not have any further information at all. However, the encounter evoked my 'fore-understanding' around the recovered memory debate which unexpectedly confronted me. I also recognised that my apparent identification with this client group may have directed my curiosity in choosing my research question in the first place.

Moreover, as I continued to immerse myself in clinical and personal perspectives during my work on this thesis, my 'fore-understanding' was revealed further; namely, that survivors' memories unlock if and when they feel safe enough to acknowledge the terror and shame of past abuse. Consequently, I approached the literature and my data sets with renewed energy and fresh eyes because I both recognised my subjectivity as a researcher and realised how this could enhance rather than limit my thinking (Smythe & Spence, 2012).

Moving Through the Circles

I realised that the chance encounter with the shop assistant led me deeper into the hermeneutic research process described by Boell and Cecez-Kecmanovic (2014). To make sense of the assistant's comment, I felt compelled to identify, re-read, and evaluate some of the selected literature relevant to the recovered memory debate, as this controversy appeared to be significant. I started to map and classify the material I had gathered, leading me into the next stages of the bigger 'analysis and interpretation' circle of Boell and Cecez-Kecmanovic's (2014, p. 264) diagram (see Figure 1).

As I noticed and mapped out broader themes relating to my research, I developed an overview which enabled critical assessment and the development of important concepts for the discussion of adult survivors' experience of formally delivered talk therapies.

The Weaving of Data

The hermeneutic approach suggests that the data analysis is closely interwoven with the research process itself, and can occur simultaneously with other stages of the hermeneutic model. Smythe and Spence (2008) proposed that the researcher "let thinking go in whatever direction feels right but to somehow capture the thinking that emerges" (p. 1395).

As I scanned through the selected literature and came across additional books and articles, I kept collecting first-person accounts (see Figure 2). At this point in the hermeneutic spiral, I started to feel a different kind of resonance with the material due to the knowledge I had accumulated through repeatedly moving back and forth between my research question and the gathered literature. I trusted my internal responses which pulled me towards recurring themes in the data set and recorded those themes as they emerged. I felt a strong sense that the process would lead

to a new understanding of how ASCSA navigate the beginning stages of their psychotherapy journey, and illuminate the question I was asking.

Figure 2

A selection of first-person accounts found in the literature

Inclusion and Exclusion

My review includes studies, books and articles which look at the psychotherapy experience from the survivor's perspective. Material that contained first-person accounts particularly drew me into the emotionally complex world of ASCSA. I included literature relating to a range of formally delivered talk therapy, and I was also attracted to autobiographical material and poetry written by survivors that did not focus exclusively on their psychotherapy experience, as this material broadened my understanding of this client group's therapeutic needs and worked to illuminate the context of this study. In line with the hermeneutic approach (Smythe & Spence, 2012), this material was included as long as it was written in the English language.

Statistics show that females are at increased risk of being the victims of sexual violence (Borumandnia et al., 2020; Fanslow et al., 2007) and the majority of literature used for this review relates to female survivors. However, literature on other victimised groups has not been excluded if it seemed relevant to this research.

I have excluded survivors' experiences of healing methods including touch, spiritual rituals, and religious teachings, as inclusion would have exceeded the scope of this review which deals with texts and textual analysis pertaining to formally delivered talk therapy.

When and How to Leave the Hermeneutic Spiral

As I went back and forth through several iterations of the hermeneutic circles, as proposed by Boell and Cecez-Kecmanovic (2014), I gained a comprehensive understanding of the issues and contexts in the literature pertaining to my research question. Although I could see myself continuing to find relevant literature, I was aware of the structure and time-frame of my study, and that it was time to formulate my thinking and invite the reader along to share the journey, as described by Smythe and Spence (2012).

Summary

In this chapter I have outlined the reasons why the hermeneutic framework is a suitable methodology for my research on the beginning stages of psychotherapy as experienced by ASCSA. The dialogue with a wide range of texts and sources has expanded my knowledge as a clinician in unexpected and fruitful ways, and facilitated a rich and rewarding inquiry into the challenges this client group may face on their road to recovery.

CHAPTER THREE: FINDINGS

I begin this chapter by outlining critical concepts that form the study's background. These include the historical context of the study, the issue of being believed when disclosing sexual abuse, and a brief discussion about the recovered memory debate. Then, I outline findings from my research about the beginning stages of psychotherapy from the ASCSA's perspective. A variety of themes arose from the literature on sexualised violence and its effects. I will discuss these themes from first-person accounts of ASCSA, in particular those that discuss their therapy experiences in academic and other literature.

The Historical Context of this Study

As Gadamer (2004) stated, we are influenced by our historical, social and political contexts, or horizons. So, when I began this research I found myself looking back to the inception of psychoanalysis in Europe during the late 19th century when Joseph Brewer[5] and Sigmund Freud[6] had started to treat female patients who were diagnosed with a mental disorder called hysteria[7]. Initially, using hypnosis, they had begun to develop what was later referred to as 'the talking cure'. Pronouncing the successful treatment of hysteric patients in his paper "The Aetiology of Hysteria", Freud outlined the link between child sexual abuse and psychological and somatic symptoms. He stated, "I therefore put forward the thesis that at the bottom of every case of hysteria there are one or more occurrences of premature sexual experiences, occurrences which belong to the earliest years of childhood" (Freud, 1896/1962, p. 203).

Yet, only a couple of years later, Freud retracted his so-called 'seduction theory' (Triplet, 2004) and made a complete turnaround. Backing away from his original connection of female hysteria with child sexual abuse, Freud (1966) claimed instead:

> Almost all my women patients told me that they had been seduced by their fathers. I was driven to recognise in the end that these reports were untrue and so came to understand that the hysterical symptoms are derived from phantasies and not from real occurrences. (p. 584)

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[5] Joseph Breuer, born 1842, was an Austrian physician who made key discoveries in neurophysiology. With his patient, Anna O., he developed what became known as the talking cure and, as such, laid the foundation for psychoanalysis.

[6] Sigmund Freud, born 1856, in Austria, was Joseph Breuer's protégé. He developed psychoanalysis as a clinical method for treating psychopathologies and expanded on Breuer's work by using concepts like transference, free association, and dream interpretation.

[7] In the 19th century, hysteria was a diagnosable illness in women with a plethora of symptoms including shortness of breath, anxiety, insomnia, fainting, amnesia, paralysis, pain, spasms, convulsive fits, vomiting, deafness, bizarre movements, seizures, hallucinations, inability to speak and infertility.

Turning his discovery upside down within a short time, Freud went from believing that his female patients' accounts of their childhood experience were true, and dealt with events that had actually happened and in which the women were offended against, to apparently believing that the events related had not happened; that the women had invented them and, furthermore, had invented them because of their own unconscious desires for sexual congress with adults. This astonishing turnaround has had profound and damaging consequences that have played out now for more than a century, and are still ongoing.

Being Believed

The exact reason for Freud's radical change of mind is not known. However, many psychodynamic theorists and psychiatrists have argued that acknowledging the occurrence of widespread child sexual abuse throughout society was too unpalatable for the powers-that-be (Courtois, 1988a; Herman, 1992; Miller, 1990; van der Kolk et al., 1996); that is to say, the patriarchal power structures of church, state and family who held absolute authority in public and private life.

The implications of this explanation of 'hysteric' symptoms would have been immense for psychiatry and psychopathology, since the patriarchal power elite of Europe at the end of the 19th century would very likely have denied and counterattacked any suggestion of endemic rape, incest, and other forms of child sexual abuse by debunking this controversial new field of study, then in its infancy. Freud's theory was, in all likelihood, simply too scandalous to be admitted as possible, let alone true.

Subsequently, psychiatry and psychoanalysis fell into a kind of amnesia (van der Kolk et al., 1996), which some call 'the age of denial' (Armstrong, 1996). Even though there has been a plethora of scientific research done over the past 100 years to ascertain whether the memory of trauma survivors can or should be trusted, the end of this debate is still not in sight (Shaw & Vredeveldt, 2018).

As I immersed myself in this research, I saw the fundamental dilemma that originates with Freud's reversal mirrored in the first-person accounts of ASCSA who often fear that they will not be believed if they disclose the abuse they suffered (Denov, 2003). One survivor, cited in Bass and Davies (1988) said: "My mother just kept yelling – I don't believe this. It never could have happened" (p. 497).

The controversy about the existence and the consequences of child sexual abuse went underground in the psychoanalytic and psychiatric discourse to such an extent that, as recently as the 1975, a respected psychiatric textbook still maintained that the prevalence of incest was 'one

in a million' (Henderson, 1975). Shockingly, this textbook further suggested that the possible benefits of incest could diminish a subject's susceptibility to psychosis.

In terms of Aotearoa New Zealand's history, it is important to note that a 'therapeutic' commune on the outskirts of Auckland promoted sex between adults and underage children as 'normal and natural' throughout the 1980s and 1990s. The commune leader, and some of his followers, were eventually sentenced to prison terms for sex crimes against children (Harvey, 2012).

However, it was also evident by the early 1980s, as a result of the child protection and women's movements of the 1960s and 1970s, that incest and other forms of child sexual abuse were in fact much more common than previously thought, with horrific consequences (McGregor, 2003). Indeed, the conceptualisation of post-traumatic stress disorder led to the realisation that war veterans and survivors of child sexual abuse suffer basically the same symptoms (Herman, 1991); thus, acknowledging child sexual abuse as traumatic. Finally, child sexual abuse was recognised as playing a significant role in the aetiology of adult psychopathology (Meiselman, 1994).

But the damage had been done. Given society's hostile attitude and the ambivalence of the medical and psychiatric profession towards disclosures of child sexual abuse over the last 130 years, it is not surprising that survivors feel hesitant, to this day, to disclose their experiences. Self-hatred and internalised shame are often a consequence of nondisclosure (Courtois, 2001; Folette et al., 2010; Harwell, 2016) and is vividly characterised in the following survivor's account:

> I had spent many years running away from the issues [...] I reached crisis point [...] the first time I'd made a disclosure [...] I was ashamed and felt guilty and dirty and filthy and all those things that you feel [when you talk about child sexual abuse]. (McGregor, 2003, p. 171)

It follows that being believed and supported following disclosure is likely to be a pivotal experience in any survivor's life (Chouliara et al., 2011; Herman, 1992).

The Recovered Memory Debate

The debate over the validity of child sexual abuse memories re-emerged with vehemence in the 1980s, reaching its acrimonious peak in the mid-1990s (Lindsay & Briere, 1997). This time, the media played a significant role in promoting both sides of the 'recovered memory debate', which also became known as the 'memory war'. Stakeholders were divided over "whether memories can be forgotten and remembered; the mechanisms involved in forgetting abuse; the processes by which memories return, and the accuracy and reliability of returning memories" (McDonald, 2017, p. 5).

Legislators and mental health professionals pushed to have their opposing positions legally or scientifically validated. Lobby groups, like the False Memory Syndrome Foundation (FMS), were founded, with some members publicly sanctioning paedophilia (Geraci, 1993). Once again, abused children and adult survivors were accused of lying, fantasising, and exaggerating. Mental health practitioners found themselves embroiled in legal battles and suspected of instilling illusory memories in their clients' minds. Accordingly, McFarlane and van der Kolk (1996) maintained that "victims are readily suspected of making false accusations, whereas perpetrators are given the benefit of the doubt and may escape appropriate punishment" (p. 36).

As a consequence of the memory war, the psychotherapy profession was viewed with suspicion, and many practitioners grew wary of treating trauma survivors, including ASCSA (Courtois, 2001). Lindsay and Briere (1997) concluded that generalisations had been made on both sides of the polarised debate and appealed in favour of toning down the rhetoric.

Fortunately, much research was conducted in the following decades, and this provided a foundation for developing clinical guidelines to serve adults who suffered sexual abuse as children (Briere, 1992; Briere & Scott, 2013; Chu, 1998; Courtois, 2001; Herman, 1997; McGregor, 2000, 2003; Rothschild, 2000; van der Kolk et al., 2001). These guidelines, for instance, require a therapist's acute awareness of transference and counter-transference issues and an understanding of vicarious traumatisation (Courtois 2001).

However, few studies have investigated the therapy experience from the clients' perspective. Therefore, scant qualitative research could be found on clients' experience of the initial phase of their therapy—the crucial phase I have chosen to explore in my research question.

The Beginning Phase of Therapy

The following survivor's account illustrates that the moment of choosing to enter therapy is often a charged one for the ASCSA:

> I woke up one morning and just couldn't stop crying, I didn't know what was wrong with me. It was like, just, you know, like I'd hit the wall, as they say… um… went to my GP, she said 'You're depressed' and I said 'Great (laughs), what do I do?' and she said 'Well, I can give you medication or, you know, have you considered therapy?' So that was the first time I'd heard the magic word 'therapy'. (Forde & Duvvury, 2020, p. 639)

It takes ASCSA enormous courage to show up in the therapy room (Morrow & Smith, 1995). Given the complex personal histories and symptomologies survivors may present with, including post-traumatic stress disorder, anxiety, depression, relationship difficulties, dissociation, substance abuse and suicidality (Briere, 1992; Briere & Scott, 2013; Herman, 1992), building a

positive therapeutic relationship from the outset is critical (Chu, 1998; Forde & Duvvury, 2020). This is an urgent task because adult survivors' relationships have often been constricted by shame and guilt for many years. In addition, survivors' expectations of interpersonal dynamics are likely to be based on anxiety, threat, and mistrust due to the interpersonal betrayal inherent in their abuse (Chu, 1998; Parry & Simpson, 2016; Rothschild, 2000).

The following account reflects the multiplicity of emotional experiences during the first two years of therapy. The client describes: "I now realise that what I was really doing was doing my best to sit in the same room with you and to cope with the vulnerability and terror of you actually seeing me" (Chu, 1998, p. 121). This client's voice resonates with me for several reasons. It expresses deep reflectiveness, self-capacity (McCann & Perlmann, 1990), and an ability to articulate strong emotions. This nuanced account also reflects the determination, trust and hope required from a client to regularly attend their psychotherapy sessions and cope with what is, at times, unspeakable distress. It hints at the struggle of learning how to bear overwhelming trauma memories, which initially may be triggered by the therapeutic process, interventions and the therapeutic setting.

Over time, positive feelings generated by a solid therapeutic relationship are likely to make the emergence of distressing, traumatic material (Scott & Briere, 2013), inside and outside of the therapy room, easier to bear, because the therapeutic relationship serves as a counter-weight to the trauma and is a vital validation of the survivor's experience. Finally, the above account also highlights the importance of working within the containment and safety of Briere's (1996) 'therapeutic window'[8] during the initial stage.

The Therapeutic Relationship – A Delicate Balance

The therapeutic relationship is of utmost importance in the therapeutic process. It has been described as the "feelings and attitudes the participants hold toward one another and the psychological connection between the therapist and patient, based on these feelings and attitudes" (Gelso & Hayes, 1998, p. 17). A strong therapeutic relationship is essential for healing and recovery from childhood sexual abuse as it offers "a relational world that is positive and growth-producing, enabling patients to learn new skills" (Chu, 1998, p. 125). The trust and safety of such a relationship provides a basis for the survivor to challenge traumatically-based interpersonal assumptions (Chu, 1998; Parry & Simpson, 2016).

[8] "The therapeutic window represents the psychological midpoint between inadequate and overwhelming activation of trauma-related emotion during treatment. It's a hypothetical 'place' where therapeutic interventions are thought to be most helpful" (Briere & Scott, 2013, p. 140).

Herman (1992) proposed that adults who have been sexually abused as children may be particularly sensitised to the power differential in the therapeutic relationship as traumatic experiences of their childhoods resurface. From the outset of the therapy, intense feelings can be present in the room and inevitably transfer on to the therapist (Briere, 1992; Courtois, 1988b; Herman, 1992; McCann & Perlman, 1990; Rothschild, 2000). The broad range of first-person accounts describing clients' perceptions of their therapists found in the literature support this notion.

The following excerpt highlights this kind of transference. On the one hand, this account could be seen as a response to an incompetent therapist; on the other hand, the expression of such strong emotions lead me to wonder about this client's feelings of transferential anger and powerlessness, which can jeopardise the initial process of building trust and safety in the relationship.

> I felt overpowered […]. Like, I've got to do what this parental person says, and he's the professional […]. This was very autocratic, authoritarian. I felt like my power was taken away almost forcefully. I felt really pressured, like, "You just have to do what I want, lady!" And I felt very obliged to agree with him […]. It was abusive. His ego needed me to be little and him to be big, me to be down and him to be up […]. There was a sense that he needed power, at someone's expense. (Koehn, 2007, p. 48)

By contrast, the following survivor quotes depict close and positive therapeutic relationships:

> I was very aware of her […] deep concern and love for me as a therapist and as a person.

> I became very attached to her very quickly, I mean to the point, I guess it's called the process of transference or something and she um […], she became my surrogate mother. (Phelps et al., 2007, p. 325)

According to Horvath (2001), a strong early therapeutic rapport is the best predictor of positive therapeutic outcome, as expressed in the survivor quote below.

> An instant click […] when you meet somebody and you take a liking to them […] in other circumstances I could have had a friendship with her, which was how I felt about (her) [...] she seemed very secure, confident, and together in her own personal life […] I felt safe […]. I had a personal rapport to identify with her and I felt […] that she understood me. (McGregor, 2003, pp. 177-178)

Nonetheless, first-person accounts show a wide range of clients' working alliances with their therapists. These findings highlight the diverse ways in which adult survivors navigate their experiences both during the beginning stages of therapy and as they progress further. Even though interpersonal difficulties are considered integral to adult survivors' symptomology, research has

shown that these clients are capable of forming strong early working alliances with their therapists, thus experiencing positive treatment outcomes (Arias & Johnson, 2013; Polyne, 2018).

Hiding Behind a Mask

The establishment of the therapist/survivor relationship can be made additionally complex by a survivor's coping mechanism of masking 'unacceptable' emotions with 'acceptable' ones. Briere (1998) posited that ASCSA may cope by disconnecting from their internal pain and presenting with a smile, while feeling angry and powerless within themselves. One survivor wondered: "What did I have to do to make my psychiatrist see that underneath the apparent coping I was a mess?" (O'Brian et al., 2014, p. 5).

Briere (1998) further suggested some survivors develop a 'cover story' conveying that everything is fine while trying to control their inner turmoil, thus attempting to pace the therapy and avoid feeling overwhelmed and vulnerable.

> Underneath that false personality was a blankness, and underneath the blankness was a tremendous rage. I was sure that if I ever allowed my behaviour to manifest any sign of the problems I had inside, everything would crumble entirely and I'd end up in an insane asylum or police lockup. (Bass & Davies, 2008, p. 15)

Briere (1998) recommended that therapists accept the 'cover story' without challenge in the initial phase of therapy so that the survivor feels in control; hiding their feelings of shame and terror behind a mask is often a well-developed survival technique. It is a guard they may let down once an initial sense of trust towards the therapist is established.

As I sat with these findings, I wondered what the initial sessions might have been like for a couple of my clients who prematurely terminated their therapy with me. I clearly remembered moments when I was unsure who I needed to be for them, and wondering how they were truly feeling and what they were thinking. In particular, one client came to mind with whom I felt a strong affinity and rapport from the very beginning, so it was a real shock when she did not arrive for her third session. I never heard from her again, and I felt counter-transferential abandonment, confusion, and sadness – feelings she might have unconsciously feared to re-experience in the therapeutic relationship with me.

Of course, there are many possibilities for what might have happened. Chu (1998), for instance, posited that a clinician's relatively intact self-worth and assumptions about others' state of wellness can result in empathic failure. For an inexperienced clinician, this empathic failure can lead to a lack of understanding that a client may enact past abusive relationships by unconsciously

expecting the therapist to be hostile, exploitative, and abandoning. This survivor puts it very clearly: “I see people as vicious” (Tummala-Narra et al., 2012, p. 644).

The abrupt ending of therapy with my client reminded me that developing a therapeutic relationship with ASCSA can be challenging due to the pervasive effects and the complex range of symptoms of abuse (Courtois, 1988a; Simpson & Parry, 2016). Olio and Cornell (1993) also emphasised that survivors can have difficulties forging secure relationships when engaging in therapy, as reflected in the survivor’s quote above.

The Therapeutic Stance

One of the reasons I set out on this research was because I found ‘generic’ psychodynamic theory to be an uncomfortable fit for working with ASCSA, as they have particular therapeutic needs. In particular, my discomfort was based on the notion of the therapist as a blank slate. In my ‘fore-understanding’, this therapeutic stance can be triggering for survivors, who may transfer their traumatic childhood experience with their abuser onto their therapist, rather than staying in the ‘here and now’ as described by Yalom (2002).

This ‘fore-understanding’ is supported in the literature (Briere & Scott, 2013; Dalenberg, 1998; Meiselman, 1994). For instance, Lister (1982) noted that therapists who withhold any expression of their own emotions or use exaggerated objectivity can be experienced by ASCSA as if the therapist is the abuser, who commonly demanded silence. Meiselman (1994) proposed that traditional psychotherapy modalities provide some treatment approaches but are not adequate by themselves to treat ASCSA.

The deeply embedded betrayal trauma often suffered by these clients makes them particularly vulnerable to therapy errors (Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994). Feeling judged, not met, or misunderstood can be symptomatic of a therapeutic error and re-traumatise a survivor who is sensitised to experience betrayal and abandonment (McGregor et al., 2006; Salter, 1995). For example, I remember using single words or the smallest of gestures which potentially may have caused a rupture in the relationship with a new client who suffered sexual abuse as a child. Other times, the pauses between me and a survivor client might have just been too long, and so the therapeutic connection was lost.

Courtois (1999) added that survivors are likely to begin therapy when in crisis, presenting as hypervigilant, tentative and anxious. In their hyper-aroused state, these clients may be scanning the therapist intuitively for an apparent lack of empathy or inability to cope with hearing descriptions of child sexual abuse (van der Kolk, 1996). They are also likely to monitor for safety.

The following first-person account may illustrate the delicate balance that clinicians have to strike in their work with survivors:

> I shared my abuse with two therapists and they just weren't qualified or educated in how to help me and it just wasn't a good match […]. I knew when I was first talking with them that I would get stuck and needed prompting […] I would be so confused and they would wait, you know, for me to talk and that got very frustrating because if I knew how to solve my problems I wouldn't be coming to see them. (Anderson & Hiersteiner, 2008, p. 420)

Interestingly, Herman (1997) proposed that by remaining "disinterested and neutral" (p. 135), a therapist conveys respect for their clients' autonomy. She says that by taking a 'disinterested' stance, a professional power differential in the therapeutic relationship is ensured, and the therapist is kept from gratifying their own personal needs. Herman maintained that a neutral stance is imperative for the client to feel safe and for the therapist not to appear "to take sides in the patient's inner conflicts or to try to direct the patient's life decisions" (p. 135). However, my findings show that just such a neutral therapeutic stance can be challenging for some survivors who are seeking the ally or protector they never had, especially in the initial phase of therapy. As one survivor said of their therapist:

> She was passive, very, very passive […] there was no involvement as such [...]. As the client, you are supposed to find your own solutions and sort your own crap out […] they're just there to listen and facilitate rather than being actively involved in anything […] I think sometimes people need ideas and suggestions […] if they knew the solutions, they might have found them already. (McGregor, 2003, pp. 189-190)

Indeed, the first-person accounts found in the literature point to the importance of Rothschild's (2000, 2010, 2017) integrative approach, which promotes healing and recovery through accessing a client's somatic awareness. These bodily experiences lead the process, carefully monitored by the therapist as described by Forde and Duvvury (2020).

Affective Responses

My findings suggest that the clinician's initial affective response to a client's disclosure of child sexual abuse history can adversely impact the beginning of therapy. Gardener (2008) confirmed this finding. Pearlman and Saakvitne (1995) noted that therapists who are not attuned to the specific needs of clients with child sexual abuse history can negatively affect the initial phase of therapy and likely impede the progress of that therapy. Such an experience can prevent clients from seeking further treatment (Gardener, 2008). The following example illustrates how this experience plays out:

> A female counsellor who is a graduate student greets you during the first session and you disclose sexual abuse by your father from the age of five to 16 years of age. After disclosing this for the first time to anyone, the counsellor responds with a surprised and shocked look, followed by anxiety and visible discomfort. The counsellor then tells you that she is unfamiliar with your problem and needs to talk with her supervisor. She excuses herself and leaves the room. (Gardener, 2008, p. 1)

The same survivor adds:

> After that negative experience with the counselling centre, 10 years passed before I finally sought counselling for my childhood sexual abuse. The primary reason that it took me so long to return to counselling was the rejection and lack of support I felt with my first experience with counselling and a counsellor. (Gardener, 2008, p. 2)

Research shows that the strength of the therapeutic relationship is largely independent of the modality used (Baldwin et al., 2007). However, the amount and quality of the therapist's child sexual abuse training and experience has been shown to positively influence therapists' affective responses, and thus underpin the therapeutic relationship and the therapy progress (Gardener, 2008; McGregor et al., 2006).

Turner et al. (1996) concluded that while the therapy outcomes are "a function of the individual peculiarities of both patient and therapist" (p. 539), it is the therapist's responsibility to ensure that the survivor feels safe and in rapport with the therapist to avoid possible re-traumatisation. The following account seems to reflect such understanding and connection: "So, um, my therapist has been nothing but kind to me and […] validating and supportive so [...] I have felt safe with her. I've felt that she won't hurt me, just about from the very beginning" (Phelps et al., 1997, p. 325).

Secrecy – Don't Tell or I Will Kill You!

The grooming of children in order to abuse them without detection is a pervasive factor in child sex abuse (Maniglio, 2009). Perpetrators are often skilled manipulators who go to great lengths to cover their tracks and evade the consequences of their crimes, in some cases for many years. Grooming has a devastating effect on the survivor, particularly when the abuse happens within families and at an early age (Maniglio, 2009).

Reflecting on my work with ASCSA, I can only begin to imagine how terrifying it might be to consider exposing long-held secrets, like incest, to a therapist. The survivor's very life or the lives of their loved ones may have been threatened should they break the silence and speak about the abuse. This experience is highlighted by Duvvury and Forde (2020) who investigated Rothschild's (2000) integrative approach to addressing child sexual abuse trauma. One client encapsulates the struggle and terror as follows:

> It is not like we are consciously trying to lie, but it is just too terrifying to talk about. I would like to get rid of it, but still inside of our heads there are these death threats […] these catastrophic threats in the back of our brain about saying certain things, or talking about certain things. So it is not like we are trying to lie, but we do withhold. (Anderson & Hiersteiner, 2008, p. 418)

As this survivor's voice resonated with me, I reflected on those of my clients who had never talked about their abuse before coming to therapy. Keeping a secret is an active process which requires individuals to monitor and suppress their thoughts and feelings (Harwell, 2016). I pondered the significant conscious and unconscious effort some survivors muster to control and withhold their inner world.

For many clients, telling their story may be a relief which helps to process the trauma and challenge the distorted self-perception caused by their adverse childhood experiences (Briere, 1992). Other clients may choose never to talk in detail about the abuse they suffered (Forde & Duvvury, 2020). Another survivor says:

> Being able to talk about it here and explore it more has helped me to bring it into to my day-to-day life which sounds horrible but it is kind of normalised […] not normalised, but it is kind of 'I have said stuff out loud that I have never said' and I think just saying that takes some of the anxiety away, which is a positive. (Chouliara et al., 2011, p. 141)

The Centre of My Soul

The survivor's account below illustrates how deeply held the experiences of child sexual abuse can be, and how the revelation should not be forced:

> People should have to ask your permission before they march into the centre of your soul. You have some privacy, some boundaries. Just because someone asks a question doesn't mean they deserve an answer. It's my soul. And I don't have to talk about it if I don't want to. And I never realised it until then. (Phelps et al., 1997, p. 49)

The literature reviewed for this study generally agrees that self-disclosure of sexual abuse is a significant event in a survivor's life (e.g., Herman, 1997; Rothschild, 2000). Gardener (2008) maintained that the non-disclosure of child sexual abuse may be harmful, while emphasising that disclosing the abuse does not mean the effects are alleviated. Instead, talking about childhood abuse experiences potentially bears both positive and negative consequences for the survivor's recovery (Cantón-Cortés & Cantón, 2010; Finkelhor et al., 2009; Friesen et al., 2010). One survivor recalls:

> It [exposure] really made me worse because of the way they directly […] the way they wanted you to talk specifically about the trauma, the details about what happened right back to when I was a little girl, and that just made me worse, it really did. (Chouliara et al., 2011, p. 141)

Health professionals may assume that survivors' self-disclosure is always an indicator of positive therapeutic progress, and helps the survivor. But for some survivors, disclosing child sexual abuse can lead to further trauma and re-victimisation (Cantón-Cortés & Cantón, 2010; Finkelhor et al., 2009; Hébert et al., 2009). Indeed, Hébert, et al. (2009) posited, and my findings concur, that research on the impact of self-disclosure on treatment outcomes is inconsistent. This may be because survivors' negative self-disclosure experiences are poorly understood (Hébert et al., 2009). Essential factors in this challenging issue include why, when, and with whom a survivor may choose to talk about their traumatic childhood experiences.

As such, it can be inferred from the direct quote below that the following client experienced extreme distress while in therapy, and that the therapist concerned likely never realised the terror experienced by the survivor. While this comment may seem to be an extreme example of a client's response, it highlights how powerful survivors' feelings may be as they navigate the beginning phases of therapy. This survivor found the process: "Like being raped […] I'd go there twice a week and be raped […]. I didn't trust her. I didn't want to talk to her about sexual abuse" (McGregor, 2003, p. 206).

Clearly, the importance of clients' self-disclosure can be a predicament for therapists and clients alike. Importantly, Rothschild (2000, 2010, 2017) noted that trauma theory has moved on from the conviction that survivors must talk about their abuse memory in detail before recovery is possible; indeed, van der Hart and Steele (1997) emphasised that memory-oriented trauma treatment can damage some clients. Equally, if clients do not choose to address their traumatic childhood memory directly, they are still likely to benefit from therapy and experience symptom relief, improved functioning, and coping skills (van der Hart & Steele, 1997). Therefore, beginning therapists who work with ASCSA must be sufficiently trained in trauma therapy (Gardener, 2008; McGregor et al., 2006) to navigate these intricacies before they start working in the field.

Feeling in Charge

Van der Kolk (2014) highlighted that survivors tell their stories through the emotions which arise in therapy, even if they choose not to talk about their memories. As I immersed myself in the lived experience of ASCSA through first-person accounts, it stood out how important it is for these clients to feel supported in working at their own pace and have control over their bodies (Forde & Duvvury, 2020; Parry & Simpson, 2016). After all, the experience of sexual abuse as a child is of having one's power taken away. Therefore, it can take time for survivors of child sexual

abuse to trust the therapist, develop sufficient body awareness to make sense of emotions and behaviours, and differentiate past from present (Rothschild, 2000, 2010, 2017).

According to Rothschild (2000), beginning therapy is like learning how to drive a car, in that trauma sufferers need to learn how to gain a sense of control over the process on which they are embarking. Like a responsible driving instructor who teaches a student how to use the vehicle's brake and gears, an attuned therapist will focus on stopping and pacing first, to protect the client from going too fast and getting emotionally overwhelmed. Some clients start to attain this skill in the beginning phase of trauma-focused talk-therapy (Rothschild, 2000). One survivor's conveyed their experience as such:

> I'm totally in charge of where my therapy goes. I've had months where it's been hard for me to try to get to the feelings. Like I said, she's pretty patient with the process. She knows it can't be forced. She gave me complete freedom to set my own direction. (Phelps et al., 1997, p. 236)

Imprints on Minds and Bodies

My research findings highlight that survivors often start therapy with the idea that they will 'get rid' of the 'abused' part of themselves, or that a therapist can 'fix' them. My clinical experience aligns with these findings. But research also shows that trauma leaves somatic and emotional imprints that may not be undone (Shalev, 1996). For instance, a survivor may not be able to attain full sexual function as an adult due to being abused as a child, as this survivor account illustrates:

> When I first came into treatment, I thought okay, I am going to work really hard on this and in a year's time it's going to be wrapped up in a package with a bow on top, and I can go on with life. And when it didn't, I fell into the pits of despair. (Anderson & Hiersteiner, 2008, p. 418)

However, van der Kolk (2015) and Rothschild (2000) maintained that while we cannot undo horrendous events of the past, self-leadership can be re-established. The traumatic imprint on survivors' minds and bodies can be ameliorated through psychotherapy once survivors feel safe with their therapist at a visceral level (Rothschild, 2000; van der Kolk, 2015). This feeling of safety helps form a protective surface or 'scab' over the deep wound that child sexual abuse can cause. In addition, by learning to set and maintain boundaries, survivors may start to develop an increasing sense of safety in their lives (Rothschild, 2000).

Herman (1992) compared the recovery from child sexual abuse to running a marathon; as well as training the body to develop endurance, the marathon runner needs determination and courage to last the distance. This survivor reflects:

> I don't think I will ever actually be healed because it's like part of me. It's part of my history. I would just like to get to the point where I don't feel vulnerable. You think when you start on therapy and trying to get help for this that everything is going to fall together like in a story book, and six months from now I am going to be fixed! So far it's been six years! (Anderson & Hiersteiner, 2008, p. 418)

Lost Stories – Attrition

As mentioned, when I started working with adult survivors I often blamed myself for apparent ruptures in the therapy or the premature departure of a client. This response can be understood as a kind of countertransference, whereby I felt responsible for the client not returning. In fact, it may be that the connection and intimacy of the therapeutic relationship caused heightened anxiety for the client, rather than soothing and support, and that this resulted in the client's premature departure (Chu, 1998). The first-person accounts I found in the literature indicated several reasons for ASCSA discontinuing therapy (McGregor, 2003). These reasons included ambivalence, inability to find the appropriate client/therapist match, accessibility, and funding. This survivor reflects:

> I would pick non-traditional therapies because I didn't want to work on things. One time I picked a past-life counsellor and, you know, that wasn't what I needed to work on! I'd make the initial appointment because I felt desperate – within one or two visits I wouldn't be quite that desperate and so I'd quit. (Bass & Davies, 2008, p. 47)

I have mentioned that there was a paucity of first-person survivor accounts describing the beginning of therapy. The above comment vividly illustrates one of the reasons for this lack. Another reason is the brevity of their attendance and the ethical issues posed by following up with them to discuss their experience. Forde and Duvvury (2020), for instance, noted that their study participants had been in treatment for at least three months or longer, and that there was no ethical or reasonable way of accessing clients who had left therapy after one or only a few sessions. The researchers identified the inaccessibility of those clients' stories as a limitation for their studies and a gap requiring further research. My research endorses this finding.

Summary

In this chapter, I presented themes arising from my hermeneutic literature review on adult survivors' experiences of the early stages of psychotherapy. Guided by survivors' voices, I began by delineating the historical backdrop for this study. Being believed, secrecy, and conflicting constructs regarding disclosing child sexual abuse surfaced as significant issues for ASCSA. These issues were reflected in first-person accounts found in the literature.

In addition, I covered psychotherapeutic tenets as experienced by ASCSA, including the significance of the therapeutic relationship, therapeutic neutrality, and therapists' affective response, as gleaned through first-person accounts. Lastly, I reflected on survivor accounts about current therapeutic approaches and possible reasons for survivors' attrition in psychotherapy, and highlighted issues pertaining to the gathering of information from those clients.

CHAPTER FOUR: DISCUSSION AND IMPLICATIONS

This study's findings highlight important areas for further discussion. In this final chapter, I explore the topics of 'child sexual abuse as a public health issue' and 'bias against survivors'. I discuss trauma-informed therapy in the context of 'generic psychotherapies', survivors' disclosure experiences, and the implications that my findings may have for the training and practice of the psychotherapy discipline in Aotearoa New Zealand. Furthermore, I provide a critical commentary on the research process and its outcomes, outlining the study's strengths and limitations, and touch on the issue of attrition in psychotherapy as mirrored in survivor accounts. Finally, I discuss ethical considerations and a gap in the research as revealed by this study.

Child Sexual Abuse – A Public Health Issue

The prevalence of child sexual abuse, together with its pervasive personal, relational and societal effects, has been identified in the literature as a significant public health issue around the world (Fergusson & Horwood, 2001; Fergusson et al., 1996; Fergusson et al., 2013; Letourneau et al., 2014). Of particular concern in Aotearoa New Zealand is the fact that the child sexual abuse rates among Māori are higher than in any other ethnic group (Fanslow et al., 2007). This has implications for frontline health and education workers who rarely ask about the possibility of child sexual abuse despite clients presenting with various symptoms indicating that it may be occurring (Briere, 1989; Cavenagh et al., 2004; McGregor, 2006; O'Brian et al., 2007). For example, school staff may not be trained to recognise the signs and to respond appropriately; indeed, several of my clients displayed symptoms and behaviours associated with sexual abuse during their high school years that were not identified as such and followed up.

First-person accounts reflect survivors' anger about some psychiatrists' apparent lack of understanding of the effects of childhood sexual abuse. Some adult survivors criticised these practitioners for being interested mainly in prescribing medication rather than addressing the underlying reasons for behaviour and symptoms that should have functioned as a 'red flag' indicating possible abuse. (O'Brian et al., 2007; Tucker, 2002).

My research suggests frontline health and education workers' inability to recognise indicators of sexual abuse, and respond with empathy to disclosures, can contribute to a survivor's low self-esteem (Chouliara et al., 2011; McGregor, 2003; O'Brian et al., 2007). Not being asked about sexual abuse, despite signs and symptoms, may cause ASCSA to doubt their worth. It may also reinforce coping mechanisms such as dissociation, minimisation and denial. These coping mechanisms may suppress survivors' feelings of shame, fear and anger, resulting in fragmentation (Herman, 1992; Rothschild 2000, 2010, 2017), thus delaying or preventing survivors from

seeking therapeutic support. My findings highlight the negative impact such failures may have on some survivors' experience of subsequent therapy, including the crucial beginning phase (McGregor, 2000).

Bias Against Survivors

Practitioners need to be aware of their biases and be willing to advocate on behalf of this client group. The notion that ASCSA are complex and demanding clients caught my interest and partially motivated this research. My findings strongly suggest the 'recovered memory debate' and Freud's early identification and subsequent denial of child sexual abuse have exerted a powerful influence in marginalising and stigmatising this client group. Follette et al. (2010) added that much research into child sexual abuse has focused on adverse outcomes for adult survivors which, in turn, has led to negative perceptions of survivors by both mental health practitioners and the public. Research also shows that despite these damaging perceptions, many survivors are invested in their own recovery with the potential for good outcomes if they receive appropriate treatment and support (Forde & Duvvury, 2021; Parry & Simpson, 2013; Polyne, 2018; van der Hart & Steele, 1997).

The diversity of the first-person accounts emphasises the uniqueness of every survivor/therapist relationship. As outlined in this study, adults who have experienced sexual abuse as children share many common symptoms. However, Nehls and Sallman (2005) emphasised there is no typical trajectory for these individuals who may present with a raft of complex issues. They warned that health practitioners must interrogate their assumptions about what it means for survivors to live with a history of sexual abuse, and not expect uniformity of behaviour, symptoms or response (Nehls & Sallmannp, 2005).

Implications

Trauma-informed Therapy in the Context of Generic Psychotherapies

This hermeneutic literature review investigated therapy guidelines for survivors and found therapists must be well prepared to provide a flexible and trauma-informed therapeutic approach from the beginning of their work with this client group (Courtois, 2001; Hermann, 1997; McGregor et al., 2006; Rothschild, 2000). The wide range of client accounts, which at times seemed contradictory, emphasises the need for flexibility and highlights how one size does not fit all in working with ASCSA. Survivor voices in this literature review reflect the diverse challenges that survivors face. My 'fore-understanding' correlates with Chouliara et al. (2013), whose research highlights how unique and deeply personal the therapeutic needs are for each survivor.

Nonetheless, both survivor voices and the literature agree that from the very beginning of therapy the interpersonal approach of the therapist is more important than the modality used (Olio & Cornell, 1993). Accordingly, this interpersonal approach must prioritise the significance of the therapeutic relationship, therapeutic neutrality, and therapists' affective responses. However, some psychodynamic and other psychotherapeutic researchers argue that a positive therapeutic relationship on its own is insufficient to bring about healing, recovery and change (e.g., Safran, 2003). Instead, practitioners must uniquely tailor trauma-informed therapy to each individual by collaborating with the survivor on the therapy's focus, pace and structure (McGregor et al., 2006).

For Māori survivors, cultural factors are crucial when healing and recovering from trauma and sexual abuse. Te Ao Māori (the Māori worldview) includes the importance of balancing the emotions, social relationships, spirituality and the body (Durie, 2003). Thus, bi-cultural and Māori-centred approaches promote positive cultural links and relationships by fostering survivors' confidence and strengthening cultural identity by emphasising the relational aspect of the therapy process. Additionally, if Māori survivors need to disconnect from whānau due to abuse, they may want to engage with a culturally sensitive therapist who uses a trauma-informed approach and find alternative ways to connect with Te Ao Māori.

Disclosure

The context and timing of sexual abuse disclosures is significant (Courtois, 1999; Harwell, 2013), particularly if the disclosure occurs at the beginning of therapy. For example, some people do not want to disclose to their therapist but feel pressured to, while others may wish to talk about their abuse but do not experience their therapist as being willing to listen (McGregor, 2003).

The circumstances around survivors' historical disclosures of their abuse are also pivotal for their therapy experience. If survivors have been disbelieved, threatened and dismissed in the past, it may be re-traumatising for them to disclose their abuse again (Harwell, 2013). The literature showed a range of responses about this issue in first-person survivor accounts (Anderson & Hiersteiner, 2008; Bass & Davies, 1988; Gardener, 2008; McGregor, 2003; Pearlman & Saakvitne,1995).

There is consensus, however, that the disclosure of sexual abuse must be client-led and that the therapist's response to that disclosure is critical to clients' therapy progress and mental health outcomes (Briere & Scott, 2013; Cantón-Cortés & Cantón, 2010; Chouliara et al., 2013; Dahlenberg, 1998; Finkelhor et al., 2009; Friesen et al., 2010; McGregor et al., 2006). Rothschild (2000, 2010, 2017) also contended that disclosure is not necessary to recover from trauma, and that clients should know they are not obliged to discuss the details of their abuse.

Psychotherapy Training and Practice

Given that child sexual abuse is endemic in the Western world, including in Aotearoa New Zealand, my findings suggest that all practising mental health workers and trainees should have a sound understanding of child sexual abuse and its possible consequences (McGregor et al., 2006). Beginning and experienced counsellors and psychotherapists are likely to find that a significant proportion of their clientele have a sexual abuse history, whether or not these clients remember and talk about their abuse. This means thorough training in trauma-informed therapy should be part of any counselling and psychotherapy training course and include an understanding of a Māori mental health approach when working with Māori survivors (Durie, 2003).

My findings also highlight that some therapists may not have the particular listening skills required when working with ASCSA (Gardener, 2008; McGregor, 2000, 2003; McGregor et al., 2006; Nehls & Sallmann, 2005). For instance, some therapists have been described as seemingly uncomfortable when hearing the details of child sexual abuse (Chunis, 2010), which can trigger devastating feelings of shame in survivors and negatively affect their self-esteem (MacGinley et al., 2019).

Therefore, mental-health-practitioner training courses should teach a process by which a client will be sensitively referred to a trauma specialist if the therapist cannot work with survivors (McGregor, 2006). Particular consideration should be given to the fact that some clients only disclose their abuse years into the therapy. Finally, therapists must engage in specialised supervision. Working with traumatised clients should only be undertaken with adequate support (Briere & Scott, 2013; Herman, 1992).

Strengths and Limitations

A Hermeneutic Approach is Subjective – A Story Emerges

I found the hermeneutic methodology was highly suitable for this literature review as Western society's view of child sexual abuse has changed, gradually but considerably, over the past 130 years. The hermeneutic approach allowed me to investigate first-hand accounts of how ASCSA have navigated their initial therapy experience, and to consider the historical context of their experience.

Smythe and Spence (2012) said "the act of understanding, therefore, requires not only a consciousness of one's historical horizon but an appreciation or examination of its effect" (p. 13). In the same way as the historical context has changed, so adult survivors' therapy experience may also have changed significantly. For instance, my findings suggest that some survivors are able to articulate and express their therapeutic needs rather than obediently accepting the authority of

their therapists as they might have done in the early days of psychotherapy (Chouliara, 2013; McGregor, 2003; Parry & Simpson, 2016).

However, change has been slow to happen and is by no means complete. The literature from the past 130 years highlights how some attitudes towards child sexual abuse have remained unchanged (McFarlane & van der Kolk, 1996). There is a reluctance in some quarters to believe child sexual abuse really exists, or that its effects are traumatising as reflected in references above to the 'memory war' (Geraci, 1993) and the sexual abuse perpetrated and condoned at the Auckland-based Centrepoint community in the 1980s and 1990s.

Nonetheless, most of the literature reviewed for this study supports the understanding that public debate has evolved in favour of backing survivors in their struggles to break the silence and heal themselves (Courtois, 2001; McGregor et al., 2006; O'Brian et al., 2014; Rothschild, 2010; van der Kolk, 2014). As such, there appears to be a considerable increase in survivors choosing to engage in psychotherapy to address sexual abuse trauma (McGregor, 2003).

This study looks at ASCSA's experience with the Western psychotherapy model and human development; therefore, most of the survivors quoted are of European origin. First-person accounts from Aotearoa New Zealand literature contained no reference to cultural or ethnic links; thus, the ethnicity and cultural background of the local survivors quoted above are unknown. This lack of information is acknowledged as a limitation for this review and requires further research.

It is likely, however, at least some of the first-person accounts in Aotearoa New Zealand's literature and studies are by Māori, given the overrepresentation of Māori adults in the Aotearoa New Zealand survivor population (Fanslow et al., 2007). Adult survivors of Māori descent may engage in mainstream psychotherapy or choose Māori-centreed approaches or engage with both cultural orientations to heal from trauma (Durie, 2003). More research specific to the psychotherapy experience of Māori sexual abuse survivors would certainly assist in providing better health outcomes for this group.

A further limitation of my research might be that, as a hermeneutic review, the selection of literature is subjective based on my own preferences and 'fore-understandings'. My choice of first-person accounts must also necessarily be subjective. It could be argued that each survivor quote only represents one individual experience and cannot be generalised. Schwandt (1998) stated that in an interpretivist approach, achieving an objective truth is neither possible nor desired; instead, interpretivism seeks to understand "what it is to be human and what meanings people attach to the events of their lives (Grant & Giddings, 2002, p. 16). Given this client group's

broad range of symptoms and life trajectories, a hermeneutic study works to increase clinical knowledge about the many ways survivors navigate the early therapy phase.

Nevertheless, a story began to emerge as I went back and forth between psychodynamic theory and research, the history of psychiatry and psychoanalysis, and survivor accounts. Survivors' voices drew me into their complex inner world of struggle, pain, defiance and resilience, as reflected in their therapy experiences; telling their stories of perseverance in the face of shame and disempowerment and the courage it takes to be a survivor.

Attrition and Further Research

This hermeneutic literature review has identified a gap in qualitative research on the beginning stages of adult survivors' psychotherapy experience. Since the 1980s, a growing body of academic research has evidenced the pervasive occurrence of child sexual abuse in the Western world (Courtois, 1999; Herman, 1992; Miller, 1990; van der Kolk et al., 1996), including Aotearoa New Zealand (Child Matters, 2022; Fanslow et al., 2007; Help, n. d.).

I gained deeper insight into the challenges of the initial therapy experience through first-person survivor accounts, but the gap in the literature dealing specifically with the beginning of treatment made it challenging to draw firm conclusions about survivors' experiences and therapeutic needs in this crucial phase of therapy. Research on the beginning stages of survivors' therapy is difficult to obtain as information about clients who leave psychotherapy prematurely is usually not captured or accessible. This lost information is valuable because it contains feedback on possible therapy errors and the impact systemic failures have on ASCSA. Based on the first-person accounts I did find, my conclusions are in line with McGregor (2003)—that these errors and failings may prevent survivors from continuing psychotherapy or from re-entering therapy at a later stage.

There is clearly a need for more research that draws attention to the initial phase of therapy. Having said that, more general findings from the survivor accounts in the psychotherapeutic literature and research, as discussed in the current study, may also apply to the early stages of treatment. Clinical knowledge would certainly be increased by accessing the experiences of survivors who did not continue as well as those who did.

Ethical Considerations

Guided by the New Zealand Association of Psychotherapists' Code of Ethics (n.d.), it was paramount to treat the sensitive and profoundly personal client accounts included in this study

with the utmost respect. Although all quoted first-person accounts reside in the public domain, it is acknowledged these were initially intended for a different purpose than this review, and I feel indebted to these survivors' generosity. This research was only possible because they spoke authentically about distressing life events.

Summary

In this chapter, I have discussed key findings from my hermeneutic research as they relate to my research question of how ASCSA navigate the early stages of psychotherapy. I have considered child sexual abuse as a public health issue, and accounted for bias against ASCSA. I reviewed trauma-informed therapy in the context of generic psychotherapies and examined the complex topic of survivors' disclosure of abuse. I evaluated the limits and strengths of my research approach. I also discussed the possible implications of my findings on psychotherapy training and practice, including in Aotearoa New Zealand's bi-cultural context.

In addition, I delineated how the model of the hermeneutic circle (Boell & Cecez-Kecmanovic, 2014) facilitated a broad look at survivors' psychotherapy experiences and enabled a discussion of findings based on data from different time periods. Lastly, I addressed the issue of attrition in psychotherapy, as well as a gap in the research indicating how further research on ASCSA's initial psychotherapy experience might improve outcomes for this client group, including Māori survivors who have particular needs not always covered by the Western model. Lastly, I considered ethical issues posed by this study.

CONCLUDING THOUGHTS

This dissertation explored how adults who survived sexual abuse as children experience the beginning of formally delivered psychotherapy. I began by defining relevant terms for this study and delineated the rationale for my research question. This was followed by an outline of the philosophical underpinnings that informed the research and examination of the suitability of a hermeneutic approach to investigate the research question. Both the strengths and limits of my approach were interrogated in the study.

I described how survivor accounts in the literature point to the significance of the therapeutic relationship, therapeutic neutrality, and therapists' affective responses in the context of trauma-informed psychotherapy. Other critical issues for survivors that were discussed included being believed, the terror of secrecy, and conflicting constructs around disclosing child sexual abuse. Overall, the study shows how survivors perceive current therapeutic approaches and possible reasons for survivors premature departure from psychotherapy.

The initial focus of this dissertation was survivors' voices, conveyed through first-person accounts in the literature. However, as I dug deeper into the subject matter, I found more questions than answers. These questions pointed towards the necessity of further research into ASCSA's experience of therapy—both those who leave therapy and those who stay—in order to improve health provision for this client group.

Trusting myself and trusting the research process, as described by Smythe et al. (2008), was a challenge at times. Immersed in survivor accounts, the hermeneutic circle worked to uncover my prejudices and 'fore-understandings', including attitudes observed and absorbed during my own upbringing, and my view of the historical context within which this study resides. It involved going right back to the earliest days of psychotherapy and Freud's fateful change of mind about the veracity of his clients' sexual abuse experience.

Contemplating the significance of Freud's turnaround on psychotherapy and psychiatry has been liberating, as I, too, continue to wake up from the many decades of amnesia that impact survivors and therapists to this day. I experienced the freedom and power in permitting myself to speak the unspeakable and counter the voices that require me to keep the topic under wraps as I continue the process of wondering, not-knowing, and remembering. I also realised that my desire to better survivors' experiences and difficulties had its roots in my own beginnings and the family and society in which I was raised.

Finally, after months of researching and writing about survivors' therapy experiences, I feel enriched in my clinical work and reinforced in my 'fore-understanding' that the early therapy phase, even those first few moments of meeting a client, is crucial.

I hope that sharing some of the troubling aspects of my early work with ASCSA may spark further interest in the complexities of this area of trauma therapy for beginning and experienced psychotherapists and counsellors. I hope, too, that my findings may support the reader in considering what it may mean for survivors to live with a sexual abuse history and how this large and heterogenous group can be better assisted by therapy and therapists in their journey towards healing.

The following phrase from a poem discovered during my reading on this topic has stayed with me because it embodies the potent idea that therapy can contain the possibility of rebirth and that the telling of each individual's story must not be hurried or forced but given time and care to emerge in a way that is empowering and healing for the one who finds the courage to tell it:

Like an ebony phoenix, each in her own time and with her own season had a story.

(Gloria Naylor, 1982)

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