

Osteopathy and Patients who have Experienced Sexual Violence: Management, Treatment and Self-Care

Esmé Michael-Anna

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Declaration

Name of candidate: Esmé Michael-Anna

This Thesis/Dissertation/Research Project entitled '*Osteopathy and Patients who have Experienced Sexual Violence: Management, Treatment and Self-Care*' is submitted in partial fulfilment for the requirements for the Unitec degree of Master of Osteopathy

Principal Supervisor: Alexandra Hart

Associate Supervisor: Julia Hollis

CANDIDATE'S DECLARATION

I confirm that:

This Thesis/Dissertation/Research Project represents my own work;

The contribution of supervisors and others to this work was consistent with the Unitec Regulations and Policies.

Research for this work has been conducted in accordance with the Unitec Research Ethics Committee Policy and Procedures, and has fulfilled any requirements set for this project by the Unitec Research Ethics Committee.

Research Ethics Committee Approval Number: 2017-1072

A handwritten signature in blue ink, appearing to be 'Esmé Michael-Anna', written over a light yellow rectangular background.

Candidate Signature: Date: 22 November 2018

Student number: 1131490

Abstract

This thesis is a preliminary inquiry into the knowledge, skills, attitudes and confidence held by New Zealand registered osteopaths when managing and treating patients who have experienced sexual violence. The overall intention is to benefit the New Zealand osteopathy profession by contributing to the improvement of osteopathic healthcare services for patients who suffer sexual trauma. While there is a large literature in the field of sexual violence and healthcare, little research has been undertaken to specifically explore the manual therapies, including osteopathy, in relation to this topic. The study aims to address this gap by investigating sexual violence from an osteopathic perspective. The project, employing a qualitative approach and descriptive phenomenological psychological method, undertook in-depth interviews with five practising osteopaths. An analysis of the resulting data identified seven themes related to sexual violence and osteopathic management and treatment: the illness experience, the mind-body connection, clinical relevance, scope of practice, therapeutic response, power dynamics and professional resilience. Overall, this thematic analysis revealed that all participants had encountered patients with a history of sexual violence, held favourable attitudes towards them and commendable knowledge, skills and confidence in this area of practice. However, all the respondents had initially experienced professional insecurity regarding sexual trauma due to a lack of formal training, and all had developed their current abilities through self-guided education, informal peer exchange and individual clinical experience that was sometimes negative. This research thesis therefore supports the contention, found in the current literature, that healthcare practitioners such as osteopaths frequently encounter victims of sexual violence in the context of clinical practice, that in some cases this history is impacting on patient health, and that practitioners are often not appropriately educated to manage such encounters. It concludes that the New Zealand osteopathy community would benefit from professional training, at the student level and beyond and possibly encompassing the themes identified in this preliminary investigation. Such training would ensure that osteopathy practitioners are formally prepared and therefore consistently able to manage the complexities of sexual trauma, and potentially make a more profound contribution to patient recovery from sexual violence.

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Chapter 1: Introduction

This chapter introduces the thesis, specifically providing a rationale for the research project, a description of the current social climate in which it is set, an outline of the research objectives including the way in which they developed over time, and an overview of the thesis structure. We begin with a personal narrative that reveals the initial inspiration, followed by a discussion of the rationale for undertaking this preliminary inquiry into the New Zealand osteopathy profession and the phenomenon of sexual violence.

As I was contemplating a master's thesis topic, I happened to encounter a woman who told me about her experience of feeling unsafe during a visit to the osteopath. Being in my fourth year of training in this profession, I was immediately alert. Although the woman professed to have completed many years of therapy to address past experiences of sexual violence, she had re-experienced traumatising during the osteopathic treatment. She emphasised the osteopath's "cold, detached and clinical manner", the way in which he treated her with little empathy and minimal consideration of historical trauma. It seemed that the osteopath, although well-intentioned, was unaware of the woman's experience of threat in his clinic and indeed, of the inadequacy of his response to a patient carrying a history of sexual violence. The woman's story caused me to ponder the number of times that osteopaths might encounter victims of sexual violence during their normal everyday practice. I knew that osteopaths, trained as they are in a biopsychosocial model of healthcare, are required to be capable of ensuring patient trust, confidentiality and safety in general. But I deliberated, are they adequately equipped to manage patients who arrive at their clinics with a specific and significant history of sexual traumatising, and all the complexities that might be involved in such a history. I wondered if perhaps the New Zealand osteopathy profession was inadvertently failing in its duty of care towards these particular patients. It was at this moment that I made the decision to investigate...

The World Health Organization (WHO) maintains that sexual violence is a global public health concern of considerable proportions (WHO, 2010). As Chapter 2's literature review will make clear, sexual violence is known to contribute to psychological disorders, psychiatric syndromes

and long-term chronic health conditions. Many people in New Zealand experience sexual violence during their lifetimes and make extensive use of primary healthcare services as a result. Thus, primary healthcare professionals, including manual therapists, are bound to encounter victims of sexual violence during their daily practice, often unknowingly. Furthermore, a scarcity of knowledge regarding a constructive response to patients who have been sexually traumatised is known to have detrimental effects on both victims and the practitioners who treat them. For this reason, WHO (2002) recommends that all primary healthcare workers develop knowledge, skills and confidence so as to adequately manage and treat patients who have experienced sexual violence. Despite this recommendation, and a large body of supporting literature, research indicates that the topic of sexual violence is often overlooked in primary healthcare settings, including that of osteopathy. This thesis begins to address the research gap for osteopathy, providing a preliminary investigation into the approach of the New Zealand osteopathy profession in relation to the phenomenon of sexual violence and sexual trauma.

The Current Climate

The subject of sexual violence has gained significant public attention recently, both in New Zealand and worldwide. On the global stage, this renewed focus on sexual violence has been triggered by the dishonouring of Harvey Weinstein and others and expressed through a ‘#MeToo’ social media campaign. In New Zealand, the renewed interest is partly attributable to the recent sexual harassment scandal in the legal profession, and has been articulated through a range of media including the women’s equality exhibition, ‘Are We There Yet?’, at the Auckland War Memorial Museum and Radio New Zealand’s ‘Venus Envy’ podcast series, which includes a discussion on the subject by New Zealand’s prime minister (Ardern, 2018; Auckland Museum, 2018; Carter, 2018; Farrow, 2017; O’Neil, Sojo, Fileborn, Scovelle & Milner, 2018). These developments have served to highlight the extent of sexual violence in society, which is considered by WHO to be at epidemic proportions (WHO, 2010). Although this research project was initiated prior to the recent wave of public interest, it was completed in this atmosphere of heightened social awareness of sexual violence. It seems timely, therefore, that the New Zealand osteopathy profession reviews its approach to the phenomenon of sexual violence and the resulting traumatisation of victims and looks towards the improvement of services in this area of healthcare practice.

Research Objective

This research thesis aims to investigate and identify the current knowledge, skills, attitudes and level of confidence displayed by New Zealand registered osteopaths when managing and treating patients who have experienced sexual violence. Although the initial research brief was somewhat narrowly focused on disclosure, referral and therapeutic touch in regard to sexually traumatised patients, an on-going thematic analysis of the research data uncovered a more complex picture and significant additional elements. Overall, seven inter-related themes were identified, specifically the illness experience, the mind-body connection, clinical relevance, scope of practice, the therapeutic response, power dynamics in the therapeutic relationship and professional resilience, all of which are addressed in the analytical chapters of the thesis. The larger intention of this preliminary inquiry is to benefit the New Zealand osteopathy profession by recommending improvements to osteopathic healthcare services for patients who have suffered sexual violence. It is hoped that the findings of the thesis will amplify awareness of this important topic in the osteopathy community, as well as contribute to current discussions regarding best healthcare practice in the field of sexual trauma.

Thesis Structure

The thesis is presented in eight chapters. This chapter, Chapter 1, has introduced the research, its background, rationale, aims and intentions. Chapter 2, to follow, provides a thorough review of the literature in relation to sexual violence, healthcare and osteopathy. Chapter 3 outlines and discusses the project's research design, specifically its qualitative methodology and descriptive phenomenological approach, as well as research methods, the research sample, data collection, data analysis, ethical considerations, the maintenance of rigor, limitations and challenges.

Chapters 4, 5 and 6, constituting the empirical heart of the thesis, present the research findings. The knowledge, skills, attitudes and confidence of the participant osteopaths in relation to the phenomenon of sexual violence are articulated in the form of seven themes that emerged during thematic analysis of the data. Chapter 4, incorporating the first three themes regarding the illness experience, the mind-body connection and the clinical relevance of sexual trauma, focuses upon the research respondents' perspectives on the patient experience of sexual violence and recovery from sexual trauma, and the ways in which these relate to osteopathic clinical practice. Chapter 5, encompassing the next three themes in relation to the osteopathic scope of practice, the therapeutic response and the negotiation of power in the therapeutic

relationship, addresses the osteopath participants' approach to their professional role when responding to patients who attend their clinics with a history of sexual trauma. Chapter 6 presents the seventh and final theme regarding the ways in which the osteopath respondents maintain professional resilience and manage their health and well-being in the face of the phenomenon of sexual violence amongst their patient cohort.

The final two chapters round off the thesis with a discussion and a conclusion. Chapter 7 constitutes a broader discussion of the themes as presented in the previous three findings chapters and in relation to the wider research context addressed in Chapter 2 and makes some suggestions for improving osteopathic practice. Chapter 8 offers a conclusion to the thesis regarding its findings, recommendations and benefits, along with ideas for further research regarding osteopathy, healthcare and sexual violence.

Chapter 2: Literature Review

Chapter 2 provides a review of the literature regarding sexual violence and the care of those who have experienced such violence. After describing the search process, the chapter will discuss key aspects of this literature, including terminology and definitions, parameters, personal and social costs, disclosure, recovery, the role of primary healthcare practitioners and professional resilience.

The Search Process

The search for literature regarding sexual violence and healthcare was initiated by formulating appropriate terms that defined the key elements relevant in this field of study, as recommended by Byrne (2017). This was achieved by an initial general search of the topic on the internet, after which the key elements found were organised into three categories, key terms, key words and key descriptors (Appendix A). Using these three categories in various combinations, multiple searches of databases and key publications were undertaken to identify relevant literature (Byrne, 2017). The search was augmented by consulting the reference lists of located articles and books. As the field of sexual violence and healthcare is broad and extensively researched, the initial search resulted in 330 articles and 46 books. The quality of the research was then assessed and only that which constituted peer reviewed articles and material from reputable sources was included (Allen, 2017; Byrne, 2017). The list was also shortened by excluding literature that was beyond the scope of the investigation, such as emergency care, perpetrators and prosecution in relation to sexual violence, material unavailable in English, and research published before 2004 unless of particular significance or specifically related to the New Zealand context. The material considered relevant in this review was drawn from the following databases: Unitec Articles-Express, Unitec Research Bank, Elsevier, ScienceDirect, EBSCO Health, Cochrane Library, Scopus, MEDLINE, ProQuest Science, Gale Academic OneFile, Google Scholar, Allied and Complementary Medicine and Sage Research Methods, and websites related to the World Health Organization (WHO), the Centres for Disease Control and Prevention, the Help Foundation, the Dunedin Multidisciplinary Health Research Unit and the New Zealand Family Violence Clearinghouse. The included literature was organised into various themes as the review proceeded, as recommended by Byrne (2017), and these themes eventually evolved into the subject headings of this chapter.

Sexual Violence: Terminology and Definitions

For the purposes of this research thesis, it is important to differentiate and clarify the terms sexual abuse, sexual assault, sexual harassment, sexual violence and sexual trauma. These labels are often used interchangeably but may designate slightly different meanings and variable contexts. ‘Sexual abuse’ involves perpetrators taking advantage of victims who are unable to give consent and is, therefore, the term usually applied to sexual violence experienced during childhood or adolescence (American Psychological Association (APA), 2018). ‘Sexual assault’, involving the use of force to achieve a sexual act and including rape, is the term usually employed by authorities to describe and report sex crimes (WHO, 2013). For example, the New Zealand Police (2018a) define sexual assault as “any unwanted or forced sex act or behaviour that has happened without a person’s consent”. Meanwhile, ‘sexual harassment’ is a term first used in 1979 to name requests for sexual favours and other physical or verbal conduct of a sexual nature that is often enacted within a relationship of unequal power (Fitzgerald, 1990; MacKinnon, 1979). This term is usually employed in claims of sexual misconduct that take place between staff and students within institutions such as universities, or between employers and employees in a work setting.

‘Sexual violence’ is a comprehensive term that incorporates all forms of sexual abuse, sexual assault and sexual harassment including rape, incest, child sexual exploitation, acts of indecent exposure, genital mutilation, trafficking and harassment (Garcia-Moreno et al., 2012). The World Health Organization (WHO) specifically uses this term, defining sexual violence as “any sexual act, attempt to obtain a sexual act, or other act directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object” (WHO, 2018). The label sexual violence also denotes acts of a sexual nature that do not include physical contact, as well as circumstances where an offender forces a victim to participate in sexual acts with a third party (Basile, Smith, Breiding, Black & Mahendra, 2014; Dartnall & Jewkes, 2013; WHO, 2012 & 2013). Overall, the phenomenon of sexual violence is understood to involve elements of control, coercion and force on the part of a perpetrator and a lack of consent by the victim (Basile et al., 2014; WHO, 2012). Indeed, there is wide consensus in the literature that sexual violence is motivated by a desire for power and control rather than by sexual desire (Baker, Campbell & Straatman, 2012; WHO, 2012). Due to its greater range of meaning, sexual violence is the term employed for

the purposes of this research thesis. In this context, sexual violence encompasses all unwanted sexual incidents, ranging from sexualised comments to sexual aggression, experienced by people of all genders. The term 'sexual trauma' is also used throughout the thesis to name the shock and distress that can be manifested in multiple ways as a result of sexual violence (APA, 2018; Basile et al., 2014; WHO, 2018).

The Parameters of Sexual Violence

Extensive research shows that the rate of sexual violence is high in most countries, including New Zealand. Sexual violence is known to occur across all social spectrums and genders and within any relationship, including those of partnership and marriage (Abrahams et al., 2014; Dartnall & Jewkes, 2013; DeGue et al., 2012). Although more often directed against girls and women, boys and men also experience sexual violence but are less likely to report it to authorities (Burrowes & Horvath, 2013; DeGue et al., 2012; Krug et al., 2002; Navarro & Clevenger, 2017; Scrandis & Watt, 2014; Von Hohendorff, Habigzang & Koller, 2017). The *World Report on Violence and Health* (WHO, 2002), one of the most comprehensive global studies of its kind, reports that up to one in four women experience sexual violence by an intimate partner and that the first sexual experience of up to one third of adolescent girls is forced (Krug et al., 2002). In New Zealand, crime statistics record 5889 reported incidents of sexual assault in 2017 (New Zealand Police, 2018b). Furthermore, a detailed report shows that at the last count of total population, completed in 2014, the lifetime experience of sexual violence was 23.8% for women and 5.6% for men (New Zealand Family Violence Clearinghouse (NZFVC), 2018a). However, sexual violence is often unreported to legal authorities, thus making it difficult to ascertain actual incidence (NZFVC, 2018a; New Zealand Police, 2018b; WHO, 2012). In this regard, several studies indicate that only 5% worldwide, and 9% in New Zealand, report sexual violence and that children who suffer sexual abuse are unlikely to report it at all or report it much later in life (Fan et al., 2016; Krug et al., 2002; NZFVC, 2017a, 2017b; Wilson & Miller, 2016; WHO, 2012). Of note, sexual violence is perpetrated by both those known and unknown to victims and false allegations are thought to be rare (Krug et al., 2002; NZFVC, 2017a, 2017b; WHO, 2018). The high prevalence of sexual violence in New Zealand indicates that healthcare professionals may regularly come into contact with its victims during the course of their everyday practice.

The Personal and Social Costs of Sexual Violence

As noted in Chapter 1, WHO (2010) maintains that sexual violence is a global public health concern of significant proportions. Although not every person will experience long-term distress or trauma due to the phenomenon, causal links between sexual violence, psychopathology, long lasting negative social consequences and an overall increase in detrimental health outcomes are widely identified. In the New Zealand context in particular, a large-scale study finds that sexual violence plays a significant role in women's mental and physical ill health (Fanslow & Robinson, 2004). This section will cover various aspects of the personal and social costs of sexual violence, including psychopathology, neurology, survival mechanisms, high-risk behaviour, diverse health conditions, the mind-body connection, male victims of sexual violence, and the social and economic consequences of sexual trauma.

Psychopathology

In terms of psychopathology, WHO reports across a number of years (WHO, 2002, 2003, 2010, 2012, 2013, 2018) consistently maintain that sexual violence is associated with post-traumatic distress disorder (PTSD), major depression, anxiety, self-harm, suicidal behaviour, and complex emotional problems such as shame, self-loathing and low self-esteem. Other studies support these WHO findings and also link sexual violence with substance and alcohol abuse, eating disorders, sleep disturbance and long-term health consequences including chronic pain (Aakvaag et al., 2016; Basile et al., 2014; Boroughs et al., 2015; Dworkin, Menon, Bystrynski & Allen, 2017; Fan et al., 2016; Feehan, Nada-Raja, Martin & Langley, 2001; Gibb, Chelminski & Zimmerman, 2007).

In particular, there is ample evidence to suggest that the experience of sexual violence is a significant risk factor for anxiety and depression. Research conducted with 557 women participants finds that childhood sexual abuse is associated with an increased risk of anxiety and depression over the life span (Carlson, McNutt & Choi, 2003), while Buzi, Weinman and Smith (2017) claim that depression begins at an earlier age in those who have experienced childhood sexual abuse. Aakvaag et al. (2016) show that depression and trauma-related shame and guilt are associated with all types of violence, including sexual violence, in both male and female victims, and Kucharska (2017) finds that women victims of sexual violence are more likely to experience lower levels of self-esteem alongside depression, when compared to women who have experienced other forms of trauma. Other studies indicate that victims of sexual violence experience feelings of hopelessness, failure, poor concentration and low

energy, and have been diagnosed with anxiety and/or depression (Choudhary, Smith & Bossarte, 2012; Machado, de Azevedo, Facuri, Vieira & Fernandes, 2011). In the New Zealand and Australian contexts, research demonstrates that exposure to sexual violence is associated with poor mental health outcomes such as depression, anxiety, suicidal ideation, suicidal behaviours and suicide attempts (Afzali, Sunderland, Batterham, Carragher & Slade, 2017; Fergusson, Boden & Horwood, 2008; Tarzia et al., 2017).

Furthermore, the occurrence of sexual violence is associated with PTSD and psychiatric illness. PTSD, a response to trauma that may last months to years, is characterised by a variety of physiological and psychological symptoms including anxiety and fear, flashbacks or reliving the incident, emotional and physical disassociation, emotional numbness, sleep disturbance and physiological arousal (Ashby & Kaul, 2016; Basile et al., 2014). Several studies highlight the way in which the experience of sexual violence can result in PTSD (Ashby & Kaul, 2016; Atwoli, Stein, Koenen & McLaughlin, 2015; Basile et al., 2014; Boroughs et al., 2015). Relatedly, a study conducted as part of the Dunedin Multidisciplinary Health and Development Study finds that people who have experienced severe childhood trauma, compared to those who have not, are more likely to develop PTSD when facing a second trauma in adulthood (Breslau et al., 2014). In terms of psychiatric illness, a systematic review of the literature highlights links between different types of childhood trauma and psychopathology (Coughlan & Cannon, 2017a). This review finds that a number of studies strongly associate childhood sexual abuse with both psychotic disorders and non-clinical psychotic experiences, including hallucination. Meanwhile, Chen et al. (2010) find that a history of sexual abuse is associated with an increased risk of multiple psychiatric disorders.

A further manifestation of sexual trauma that is experienced after rape is known as 'rape trauma syndrome'. Researchers Burgess and Holmstrom (1974) proposed this term to describe an inner crisis state in which rape victims experience 'intrapsychic disequilibrium' in two distinct phases. The first acute phase, lasting days to weeks, is characterised by disorientation, physical symptoms and a stress response ranging from confusion and anxiety to terror and the fear of being killed. The second phase, lasting months to years, involves a long-term process of reorganisation during which the victim can experience nightmares, flashbacks, phobias and a variety of physical complaints. Burgess and Holmstrom also describe a silent reaction to rape, in which victims experience trauma and show signs of anxiety but do not disclose due to fear,

repression, coercion, shame or guilt. Rape trauma syndrome shares physical, psychological and behavioural symptoms with PTSD (Burgess, 1983).

Neurobiology

Researchers have considered the effects of childhood and adolescent sexual trauma on neurobiology. Some studies suggest that the experience of sexual violence interrupts neurodevelopment in the brain, which can lead to long-term negative impacts on neural systems (Bacciagaluppi, 2011; Barbara et al., 2017). For example, Gillespie, Phifer, Bradley and Ressler (2009) illustrate the way in which high levels of early childhood trauma cause adult psychopathology via the interaction of genetic variants with the neural circuits that regulate emotion. Karstens et al. (2017) show that childhood trauma is associated with reduced memory and verbal learning skills. Meanwhile, Tesarz, Eich, Treede and Gerhardt (2016) find that sexual trauma can lead to long-term somatosensory changes, such as an increased sensitivity to touch and pain. This finding is particularly significant for manual therapists.

Survival Mechanisms

Research has also examined the survival mechanisms of sexually traumatised persons. For example, Cuevas et al. (2017) propose diverse biological responses to trauma, including hypervigilance or freeze-alert, fight-flight, tonic immobility or freeze-fright and a collapsed response of detachment or shutdown, all of which involve changes in the autonomic nervous system and affect the body's physiology and memory. This article was specifically written for osteopaths, with the intention of assisting them to avoid inadvertently re-traumatising patients during clinical examination and treatment. Noting that resistance is not a common response in events of extreme threat, theorists argue that most victims of sexual violence experience an autonomic nervous system state called 'tonic immobility'. Temporary motor inhibition occurs while in this state, leaving victims unable to vocalise or resist (Kalaf et al., 2017; Marx et al., 2008; Möller, Söndergaard & Helström, 2017). Möller et al. (2017) find that those who experience tonic immobility have an increased risk of subsequently developing PTSD and severe depression. Sanderson (2006) discusses a survival mechanism closely related to tonic immobility, known as 'dissociation'. Dissociation is indicative of severe trauma and involves victims in 'escaping psychologically' in the face of perceived external threats, which can later become a maladaptive response to stressful situations throughout life. Furthermore, Dale et al. (2009) find that women victims of sexual violence have a lower threshold for the expression of sympathetically driven fight/flight behaviours in response to stress, and have difficulty

moving from this state of autonomic neurological arousal to a state of calmness. This study also highlights the dysfunctional coping methods, diminished self-concepts and poorer overall mental well-being of sexual violence victims, compared to those who have not been sexually traumatised.

High-Risk Behaviour

Another important area of research is focused on the link between the experience of sexual trauma and increases in high-risk behaviours, further abuse and health complications. Several papers emphasise the finding that children and adolescent victims of sexual violence often display high-risk sexual behaviours that can lead to increased vulnerability and re-victimisation into adulthood (Ashby & Kaul, 2016; Barbara et al., 2017; Basile et al., 2014; Boroughs et al., 2015; Hannan, Orcutt, Miron & Thompson, 2017; Sumner et al., 2015). A New Zealand study indicates that both men and women victims of childhood sexual abuse are more likely to engage in high-risk sexual behaviours in adulthood, resulting in a greater number of unwanted pregnancies and sexual diseases (van Roode, Dickson, Herbison & Paul, 2009). Two specific studies link exposure to sexual violence with an increase in risky sexual behaviour, which can then lead to the development of HIV, high cholesterol levels, stroke, heart disease, and excessive nicotine and alcohol consumption (Santaularia et al., 2014; Smith & Breiding, 2011), while Hannan et al. (2017) show that the experience of sexual violence can lead to the tendency to regulate emotions through alcohol consumption and thus alcohol-related problems.

Adverse Health Conditions

Exposure to sexual violence is also associated with an increase in adverse health conditions. In terms of gender differences, Baker, Norris, Jones and Murphy (2009) find that male victims of sexual violence experience a variety of physical health symptoms, while female victims appear to suffer specifically from musculoskeletal, gastrointestinal and urinary illnesses. Another study links unwanted genital contact with an increased risk of invasive cervical cancer at or before the age of 25 (Jayasinghe et al., 2017). Meanwhile, specific research conducted as part of the larger Dunedin Multidisciplinary Health and Development Study shows that poor psychosocial experience and maltreatment in childhood increase the risk of the physiological inflammatory response, as well as long-term emotional, immune and metabolic abnormalities, which in turn may lead to a greater risk of age-related disease such as cardiovascular pathology (Danese et al., 2009; Danese, Pariante, Caspi, Taylor & Poulton, 2007).

The Mind-Body Connection

The mind-body connection, known in much of the literature as somatisation, somatic memory or somatic illness, is an important element in the field of sexual violence as well as a significant tenet of osteopathy, based as it is on a holistic biopsychosocial model of health. Although the medical and psychological disciplines bring different emphases, this body of literature makes a direct connection between trauma and physiological symptoms and suggests that pathology can be an expression of the psychological distress that patients are experiencing. Research from the field of psychiatry describes somatic memory as trauma that is stored in the body and later expressed through changes in biological stress responses (van der Kolk, 1994). This study claims that somatic memory is capable of providing many triggers not necessarily related to the original trauma, causing a relapse into a state of hyperarousal and emotional distress. Relatedly, Miller (2006) highlights the psychobiology of trauma, whereby the body retains the knowledge of the powerlessness associated with abuse causing long-term emotional and physical distress. Rothschild (2000, 2017), an expert in the psychological treatment of trauma and in particular PTSD, states that traumatic events constitute a psychophysical experience which takes a significant toll on the body. For patients to regain well-being, it is essential to treat the traumatised body alongside the traumatised mind, treatments that Rothschild claims can be approached in many ways and not just through touch. Broom (1997, 2007), a well-regarded New Zealand researcher who describes the mind-body phenomenon from a medical perspective, uses the term 'somatic illness' to highlight the way in which pathology and physical symptoms can be an expression of emotional distress and trauma. Broom, Booth and Schubert (2012), illustrating through case studies the way in which some patients require psychological intervention to heal from the pathology they experience, advocate a 'whole-person' model of healthcare in which all aspects of a person, not just their physical facets, are considered. Both Rothschild (2000) and Broom (1997, 2007) suggest that the Western medical model of healthcare, based as it is on a Cartesian dualistic model, creates an artificial separation between mind and body that is unhelpful in assisting patients to return to well-being.

In terms of the link between sexual trauma and somatic illness specifically, Paras et al. (2009) indicate that a history of sexual abuse is associated with lifetime diagnoses of multiple somatic disorders. A comprehensive literature review reports that such somatic complaints can include generalised aching, dizziness, heart palpitations, trembling, poor appetite, constant fatigue, low energy and weight change, along with chronic pain, headaches, migraines, infections, gastrointestinal disorders, hypertension, chronic musculoskeletal problems and chronic back

pain (Chrisler & Ferguson, 2006). Further studies link the experience of sexual assault with specific functional somatic conditions such as clinically worsening musculoskeletal pain, gastrointestinal disorders, fibromyalgia, chronic pelvic pain, psychogenic seizures and periodontal disease (Bland, 2010; Kirkengen & Lygre, 2015; Reiter, Shakerin, Gambone & Milburn, 1991; Ulirsch et al., 2014). Moreover, Kimerling and Calhoun (1994) find that victims experience higher levels of psychophysiological complaints than non-victims in the year following an episode of sexual violence. In terms of gender, both men and women experience elevated somatic symptoms following a sexual assault, although women's symptoms are found to be notably more severe (McCall-Hosenfeld, Winter, Heeren, & Liebschutz (2014).

Two important aspects of this body of research regarding the mind-body connection are significant for the osteopathy profession. The first is that the human body holds somatic memory and many undertakings, including osteopathic treatment, can trigger this memory and result in the experience of emotional distress and autonomic hyperarousal (Rothschild, 2000, 2017; van der Kolk, 1994). The second factor is that physical ailments can have a psychological basis that, at times, must be addressed before a patient can return to full health (Bland, 2010; Broom, 1997, 2007; McCall-Hosenfeld, 2014).

Male Victims of Sexual Violence

A field of study has specifically developed in relation to male victims of sexual violence. One large-scale American survey shows that men who have experienced sexual trauma report greater mental health issues, lower life satisfaction, activity limitations and decreased emotional and social support compared to other participants (Choudhary, Coben & Bossarte, 2010). Additional studies link childhood sexual abuse with male adult mental health disorders, suicidal ideation and suicide attempts, while also noting a low rate of health-seeking behaviour in this cohort (Burrowes & Horvath, 2013; Masho & Anderson, 2009; Peterson, Voller, Polusny & Murdoch, 2011; Turner, Taillieu, Cheung & Afifi, 2017). Compounding these mental health consequences, male victims of sexual trauma may also experience significant levels of public disbelief and discrimination, which arise from the prevalent myth that men do not suffer negative psychological consequences as a result of sexual violence (Burrowes & Horvath, 2013; Peterson et al., 2011; Von Hohendorff et al., 2017). Furthermore, Boroughs et al. (2015) find that men who have experienced childhood sexual abuse, and also have sex with men, participate more frequently in 'HIV sexual risk behaviour', indicating that this group is more at risk of contracting HIV.

Social and Economic Consequences

Another field is particularly concerned with researching the social and economic consequences of sexual violence. Chrisler and Ferguson (2006) examined data from the Centers for Disease Control and Prevention, and other studies, to estimate the social and economic costs of exposure to sexual trauma. They found a significant financial burden due to absence from work and loss of productivity, along with prolonged healthcare costs related to a direct injury and also long-term chronic illness. Another systematic review of longitudinal research found a relationship between childhood sexual abuse, leave of absence from work due to sickness, welfare receipt and financial insecurity (Bunting et al., 2018). Specific research undertaken by WHO and the Dunedin Multidisciplinary Health and Development Study shows that the experience of sexual violence can have a profound detrimental impact on economic well-being, education, employment and health across the lifespan, and in some cases across generations, both at a personal and social level (Feehan et al., 2001; Garcia-Moreno et al., 2015; Nada-Raja & Skegg, 2011; WHO, 2002, 2003, 2010, 2012, 2013). Overall, the research suggests that the consequences of sexual violence are often profound and long-lasting, affecting not only the individual but also the society in which that individual lives.

Disclosure of Sexual Violence

Disclosure is a crucial aspect of the experience of sexual violence, with studies drawing attention to the motivation of victims and to elements that assist or impede their willingness to disclose. Overall, research shows that disclosure is a complex and multifactorial experience for survivors, which may be delayed for many years (Demers et al., 2017; Klein, 2004; Lanthier, Du Mont & Mason, 2016; Lessing, 2005; Tener & Murphy, 2015). Several investigations indicate that many victims do not disclose sexual abuse and seek help, even when they are suffering from trauma-related symptoms (Carlson et al., 2003; Lessing, 2005; Masho & Anderson, 2009; Roberts, Watlington, Nett & Batten, 2010). Other studies indicate that victims often disclose only informally to trusted friends or family members rather than formally to authorities and professionals (Ahrens, Campbell, Ternier-Thames, Wasco & Sefl, 2007; Demers et al., 2017; Dolan & Raber, 2017; Lanthier et al., 2016; Roberts et al., 2010). Importantly, research finds that patients who do disclose their experiences of sexual violence and receive appropriate assistance are better able to recover and have more favourable long-term mental health outcomes, than those who do not (Ahrens et al., 2007; Hunter & Jason, 2012). Additional literature regarding disclosure of sexual violence is discussed below in terms

of three important aspects, barriers to disclosure, motivation to disclose and responses to disclosure.

Barriers to Disclosure

Researchers have sought to discover the barriers to disclosure of sexual violence. In the New Zealand context, reports by McPhillips et al. (2002) and Woodley and Metzger (2013) indicate that there is reluctance on the part of patients to disclose sexual violence and seek help due to a lack of trust in the ability of health professionals to honour confidentiality and/or provide a truly sympathetic environment. These reports also highlight patients' lack of knowledge and confusion regarding the availability, means and location of assistance. This finding has important implications for New Zealand health professionals, including osteopaths, in terms of guiding those patients who disclose sexual violence to appropriate services. In a wider context, delayed disclosure or non-disclosure can be caused by the negative psychological consequences of PTSD and rape trauma syndrome, which have been discussed previously. The 'silent rape response' or the 'freezing response' that can be part of rape trauma syndrome is another reason for delayed disclosure (Burgess & Holmstrom, 1974; Lessing, 2005). A systemic review undertaken by Lanthier et al. (2016) highlights several specific behaviours on the part of healthcare practitioners and authorities that can impede disclosure and lead to secondary re-victimisation of the survivor, including a cold or detached clinical manner, disbelief, minimisation or dismissal of the experience, and blaming the victim. Other impediments include explicit threats from the perpetrator, non-supportive cultural beliefs and societal myths about rape that can lead to feelings of self-blame, guilt and shame on the part of victims (Crisma, Bascelli, Paci & Romito, 2004; Hlavka, 2016; Klein, 2004; Lessing, 2005).

The phenomenon of rape myths as a deterrent to disclosure needs specific explanation here because it continues to negatively influence the attitudes of rape victims and those who help them. Rape myths is the term used to describe the widely held misconceptions and stereotypes, often reinforced by the media, which shape a social context within which sexual violence is minimised or distorted, and thus potentially perpetuated (Baker et al., 2012; Crisma et al., 2004; Klein, 2004; McCartan, Kemshall & Tabachnick, 2015). The most prevalent of these misconceptions include beliefs that victims provoke sexual violence, that victims are at fault or are liars, that sexual violence is perpetrated by strangers, that only women experience sexual violence, that men do not suffer if they are sexually violated, that male victims are gay and that sexual violation must involve actual violence (Baker et al., 2012; Hlavka, 2016). Research

shows that the internalisation of these false beliefs contributes to deep feelings of self-blame and shame on the part of survivors, which hinder disclosure and recovery (Hlavka, 2016; Lessing, 2005). It is therefore essential for healthcare professionals to understand that rape myths can have a detrimental effect on recovery by creating confusion in victims, who may find it difficult to fully comprehend that they have been sexually violated even while they are experiencing significant distress (Crisma et al., 2004).

Some research regarding barriers to the disclosure of the experience of sexual violence is specifically focused on young people. Hlavka (2016) and Lessing (2005) report that an unstable or unsafe home life, with an absence of trusted adults who are willing to listen and believe, are important factors impeding disclosure for children and adolescents, while Tener (2018) identifies the desire to prevent family disruption and to protect parents, even when they are the abuser. Furthermore, as Summit (1983) argues, sexual abuse accommodation syndrome, that is, the helplessness and entrapment a child may feel when encouraged by the abuser to keep the abuse secret, is also a significant barrier to disclosure. Several authors also point out that an abused child may experience disbelief, blame and rejection when they do disclose, resulting in the development of coping mechanisms such as self-blame, self-hatred and alienation and this may prevent further disclosures (Murray, Nguyen & Cohen, 2014; Summit, 1983). For adolescent victims of sexual abuse specifically, disclosure is often thwarted by feelings of shame, fear of being disbelieved and a mistrust of adults and healthcare professionals, with many who do disclose claiming to have received inappropriate responses and inadequate help (Crisma et al., 2004). Meanwhile, Hlavka (2016) finds that disclosure and recovery by male child and adolescent victims of sexual violence is hindered by feelings of shame, embarrassment, disempowerment and emasculation, exacerbated by the social norm that men cannot be victims and must be powerful, strong and self-sufficient. This study also indicates that male victims of sexual violence are often dismissed, disbelieved or blamed by those from whom they seek help.

Motivation to Disclose

The focus on barriers to disclosure leads on to the question of motivation to disclose experiences of sexual violence. Demers et al. (2017) identify four motivational factors for disclosure, which include the improvement of psychological or emotional well-being, the desire for information, the seeking of advice and legal action, and the fulfilment of social obligations such as preventing the perpetrator from hurting someone else. Ahrens et al. (2007)

find that disclosure is often not premeditated but rather prompted by the situation in which the victims find themselves. For example, survivors may consult professionals for other reasons and disclose rape and abuse as part of that process. This finding has important implications for osteopaths, who could well be 'one of those professionals'. Researchers Berry and Rutledge (2016) discovered that most of the women in their participant cohort, who had been sexually violated, felt comfortable being questioned about their experiences, while also claiming that the negative attitudes and demeanour of healthcare practitioners raised barriers to the likelihood of disclosure.

Responses to Disclosure

The responses that victims receive when they are motivated to disclose the experience of sexual violence can have a considerable impact on their ability to begin a process of recovery. Two reviews of the literature find that a negative, stigmatizing or over-emotional response, from either authorities or loved ones, can exacerbate the consequences of sexual violence for the victim and lead them to avoid seeking further help or recovery (Kaukinen & DeMaris, 2009; Roberts et al., 2010). Kaukinen and DeMaris (2009) maintain that attitudes held by professionals, especially the belief that a person will never fully recuperate from the experience of sexual violence, can be detrimental to a victim's long-term recovery and ability to cope. In similar vein, Klein (2004) maintains that a poor response to disclosure can be destructive for the recovery process, while Ahrens et al. (2007) indicate that negative reactions and a cold or detached manner can have a 'silencing effect', whereby victims cease to talk about their experiences altogether or to seek further assistance. Providing greater nuance to the matter of disclosure and response, McElvaney, Greene and Hogan (2012) argue that confiding childhood sexual abuse is not usually undertaken in a 'linear and sequential manner' but is instead a process that occurs over a life-time with each subsequent disclosure influenced by the experience of the responses of others to the previous disclosure. These studies underline the crucial importance of avoiding a stigmatizing or over-emotional response when patients disclose sexual trauma during a healthcare consultation.

Overall, the literature highlights the importance of an adequate response to patient disclosure of sexual violence on the part of healthcare practitioners. Stiller and Hellmann (2017) indicate that belief is crucial to victim recovery, while Dolan and Raber (2017) state that along with belief, emotional support, empathy, the use of clear and accurate terminology and reiteration to the person that they are not at fault, are also essential. Participants in one research project

identified the elements of safety, validation and feeling understood as constituting the most useful support during disclosure of sexual violation (Starzynski, Ullman & Vasquez, 2017). Ahrens et al. (2007), specifically focusing on a professional's demeanour during a disclosure, note that emotional support and empathy are beneficial in terms of victim recovery. Baker et al. (2012) argue that an adequate response to disclosure should include normalising the experience, treating the victim with dignity and respect, and allowing them complete control over the means and timing of disclosure. In addition, the offering of practical aid and tangible resources is also necessary to facilitate survivor recovery (Ahrens et al., 2007; Baker et al., 2012; Dolan & Raber, 2017).

Furthermore, studies highlight the importance of determining a patient's psychological and/or physiological state when disclosure of sexual abuse occurs and recommending referral to appropriate services, especially when there is evidence of distress such as sleep disturbance or gastrointestinal disorders (Dolan & Raber, 2017; Lessing, 2005). In this regard and as Lanthier et al. (2016) point out, healthcare providers are in a unique position to act as a gateway to services such as counselling and support networks. They therefore advocate enhanced training for healthcare professionals regarding the ways in which to follow up disclosure of sexual violence in a patient-centred and culturally appropriate manner. Osteopaths, as members of this wider community of healthcare professionals, do not directly treat the psychopathologies caused by sexual violence. But as this review of the literature makes clear, they do have an important part to play in responding adequately to patients who disclose experiences of sexual violence, and therefore an important part to play in those patients' recovery and well-being.

Recovery from Sexual Violence

In the previous section, the importance of an emotionally supportive and practical response to disclosure of sexual violence was emphasised, especially as it relates to the possibilities of recovery. Research recognises that recovery from sexual trauma is multifactorial, complex and often lengthy. However, the literature also maintains that individuals who seek professional help through counselling, psychotherapy, support groups and body work such as massage are better resourced to recover, better able to achieve good mental health outcomes, and less likely to suffer long-term psychosocial difficulties (Cohen, Deblinger, Mannarino & Steer, 2004; Kaukinen & DeMaris, 2009; McPhillips et al., 2002; Price, 2006). This literature is discussed in terms of aspects that nurture and aspects that hinder recovery from sexual violence.

Nurturing Recovery

Research identifies the specific elements that assist in recovery from sexual trauma, including validation, support, empowerment and resilience. Demers et al. (2017) demonstrate that recovery is nurtured by trauma-informed interventions that encourage empowerment by giving victims a voice and validating their experiences through belief and understanding, while Dolan and Raber (2017) argue that the growth of empowerment is crucial in nurturing recovery and decreasing the risk of re-victimization. In other research, Banyard and Williams (2007) demonstrate that the quality of resilience, that is, the ability to adapt and grow in response to life events, offers protection against re-exposure to trauma and can greatly assist in recovery. Moreover, the participants in their longitudinal study describe recovery as an ongoing process rather than as a goal to be reached. Further studies highlight the significant role of family, social and community support in encouraging resilience and promoting recovery (Campbell, Dworkin & Cabral, 2009; Reis, Lopes & Osis, 2017). Specifically regarding children and adolescents, Guerra, Farkas and Moncada (2018) find that family support and the development of self-efficacy, a quality similar to resilience and described as the individual's belief in their ability to cope with adversity, are significant factors in recovery from sexual trauma.

In terms of professional treatment, experts currently favour a patient-centred, multidisciplinary team approach to sexual trauma (Campbell et al., 2009; Dolan & Raber, 2017; Herz, Stroshine & Houser, 2007). Trauma-focused cognitive behavioural therapy (TF-CBT) is the most widely researched and endorsed treatment, while eye movement de-sensitization and reprocessing (EMDR) is also advocated (Black, Woodworth, Tremblay & Carpenter, 2012; Cohen et al., 2004; Dorsey et al., 2017; Hegarty, Tarzia, Hooker & Taft, 2016; Korotana, Dobson, Pusch & Josephson, 2016; Murray et al., 2014; Oram, Khalifeh & Howard, 2017).

Hindering Recovery

The literature also draws attention to those elements that exacerbate symptomology and hinder recovery from the experience of sexual violence, including shame and stigma. As discussed in previous sections, shame often emerges when victims believe that they are to blame for the experience of sexual abuse (Baugher, Elhai, Monroe & Gray, 2010). Kennedy and Prock (2016) specifically link shame and stigma, describing stigma as a “dynamic social process that discounts certain groups or individuals based on their perceived inferior moral status and rationalizes animosity toward them”. They illustrate the process via which stigmatization can lead to internalized feelings of shame and self-blame, which then prevent victims from seeking

help, increase the risk of re-victimization and hinder recovery. These studies emphasise that acceptance and understanding are crucial, and that those who provide support need to assist victims to overcome shame and stigma by reinforcing the concept that they are not at fault (Baugher et al., 2010; Campbell et al., 2009; Kennedy & Prock, 2016).

Primary Healthcare, Manual Therapy and the Management of Patients Who have Experienced Sexual Violence

This section of the chapter is particularly relevant for the research project, as it reviews the literature regarding the response to, and management of, patients with a history of sexual violence in the primary healthcare domain, which includes the manual therapies such as osteopathy. In New Zealand, primary healthcare is understood to refer to services provided in the community by a range of health professions, rather than to public institutions such as hospitals (New Zealand Ministry of Health, 2018). Osteopaths are considered primary healthcare providers and must perform this role appropriately within their scope of practice (Osteopathic Counsel of New Zealand (OCNZ), n.d.). Specifically, the Osteopathic Counsel of New Zealand stipulates that osteopaths, as primary healthcare practitioners, must be knowledgeable about disease management and health promotion, while also able to facilitate patient access to appropriate health and community services when required to do so (Stone, Hager & Boud, 2009). This section will review primary healthcare in relation to sexual violence, the therapeutic relationship in primary healthcare, the negotiation of power in the therapeutic relationship, the maintenance of professional boundaries, manual therapy, osteopathy and the education of healthcare practitioners.

Primary Healthcare

The requirement of knowledge and the facilitation of access to services on the part of primary healthcare practitioners is especially important when it comes to the phenomenon of sexual violence. Victims of sexual trauma make extensive use of primary healthcare services, with studies indicating that health consultations among this group are higher than others (Basile & Smith, 2011; Bunting et al., 2018; Chrisler & Ferguson, 2006; Feehan et al., 2001; Kimerling & Calhoun, 1994; Koss, Heise & Russo, 1994; WHO, 2003, 2013). Indeed, as previously discussed, WHO asserts that primary healthcare providers frequently come into contact with patients affected by sexual violence, often unknowingly. In this regard, García-Moreno et al. (2015) maintain that the role of the healthcare system is to provide supportive care for victims of sexual violence, care that prevents the re-triggering of trauma symptoms and that also mitigates biopsychosocial consequences. Specifically, they state that the actions of healthcare

providers should include identification, recognition and acknowledgement of the violence, a supportive response to disclosure, provision of clinical care and/or referral and follow-up care. Especially important in terms of trauma, including sexual trauma, Clardie (2004) and Elliott et al. (2005) argue that an absence of knowledge regarding the impact of sexual violence can result in healthcare procedures and practices that inadvertently re-traumatise patients. To address this problem, they advocate a ‘trauma-informed’ service, in which care is influenced by an understanding of the overall impact that violence and victimisation have on a patient’s life and development. Using data collected from questionnaires at multiple healthcare service centres, they have developed a ten-step approach to trauma-informed care, which aims to minimise traumatisation through increasing primary healthcare practitioner knowledge, collaboration and patient empowerment. A recent report, arguing for the adoption of trauma-informed practices in the New Zealand healthcare system, suggests several evidence-based approaches to trauma-informed service delivery, with specific attention given to Maori and Pacific populations (Donaldson, Jury & Poole, 2018).

The Therapeutic Relationship in Primary Healthcare

The research underlines the relationship between the primary healthcare practitioner and the patient, referred to as the therapeutic relationship, as central in providing patient-centred, trauma-informed care. The therapeutic relationship is understood as incorporating a non-judgmental, caring and supportive attitude from the practitioner and promoting a feeling of safety for the patient (Kornhaber, Walsh, Duff & Walker, 2016). Meanwhile, patient-centred care is that which respects and considers the individual needs of a patient while also promoting self-management that empowers the patient and prevents their dependency on practitioners (Little et al., 2001). Studies emphasise empathy, good communication and listening as important aspects of the therapeutic relationship (Kornhaber et al., 2016; Little et al., 2001; Travaline, Ruchinskas & D’Alonzo, 2005). The safety provided by a healthy therapeutic relationship within a patient-centred culture can be especially significant for survivors of sexual violence, who have often experienced a previous betrayal of trust. Draucker and Martself (2004) note that because victims have usually been silenced in the past, they may fear losing control and have difficulty expressing feelings and needs. The functional therapeutic relationship, when developed correctly, can provide a corrective emotional experience for such patients and enhance their recovery. Tener (2018) also highlights the secrecy and silencing that surrounds childhood sexual abuse. This phenomenon of silencing provides a particular challenge for healthcare professionals. This is so both in the matter of gaining adequate

informed consent and in allowing patients to maintain control, even while their bodies are being examined and treated.

Negotiating Power in the Therapeutic Relationship

The role of power within the therapeutic relationship, as it affects those patients who carry sexual trauma, is an important theme in the literature and in the findings of this research project. Fox (2007) maintains that a power imbalance is inherent in all healthcare practitioner-patient relationships, due to the practitioner's qualifications and professional knowledge and the fact that the patient is the person seeking help, often in circumstances of ill health and pain. These dynamics of power are crucial in the field of sexual violence and healthcare. Perpetrators of sexual violence usually exploit power imbalances to carry out abuse and this can have wide-reaching implications for survivors, leaving them feeling powerless long after the abuse has occurred (Tener, 2018). Indeed, during healthcare treatments victims may re-experience the powerlessness, loss of control, disassociation and vulnerability associated with the abuse, especially in situations which require the patient to recline in a submissive position while a practitioner touches their body (Havig, 2008; Roberts, Reardon & Rosenfeld, 1999; Schachter, Radomsky, Stalker & Teram, 2004; WHO, 2003, 2010). This is especially so in the manual therapies, where the patient is usually required to undress and lie on a plinth and treatment inevitably involves one-way touch (Fox, 2007).

Literature in this field therefore attempts to address imbalances of power within the therapeutic relationship. WHO (2003) maintains that healthcare professionals should be free of bias or prejudice and must be especially attuned to the patient's reactions to dominance, rejection and disapproval, as these might trigger past trauma. Fox (2001), meanwhile, recommends that practitioners understand power as neutral, that it is the way in which it is used, either to enable and help or to control and dominate, that makes a positive difference. Of particular note, some research indicates that humour can benefit the therapeutic connection between patient and practitioner by highlighting their common humanity and thus helping to equalise power (Dean & Major, 2008; Haydon, van der Reit & Browne, 2015). Other studies suggest that an understanding of professional relationship boundaries is important in navigating power within the therapeutic relationship, especially when the consequences of sexual violence are a factor. Draucker and Martsof (2004) point out that, without due care, the invasion of the victim's physical and psychological boundaries that occurs during sexual violence can be inadvertently re-enacted within the therapeutic relationship. This requires, they argue, that practitioners and

therapists maintain robust professional boundaries. Wright (2006) argues that these boundaries protect the patient but also the practitioner and recommends that healthcare professionals set limits on their involvement with patients as over-involvement can hinder the beneficial effects of the therapeutic relationship, and that they seek guidance if they experience uncertainty regarding professional boundaries and imbalances of power. The subject of professional boundaries is explored further below, in connection with the phenomenon of transference.

Professional Boundaries

Research indicates that the maintenance of robust professional boundaries within healthcare is especially necessary for victims of sexual violence, due to the phenomenon of transference. Transference describes the positive and negative emotions and attitudes, based on past relationship templates, that a patient may develop towards authority figures such as healthcare practitioners (Levenkron & Levenkron, 2007; Russell, Jones, Barclay & Anderson, 2008; Sher & Sher, 2016). For those who have experienced childhood sexual abuse, transferences can result in distorted templates that may affect perceptions, expectations, behaviour and one-sided power dynamics in adult relationships (Russell et al., 2008). Harper and Steadman (2003) draw attention to the likelihood that sexual trauma victims “may associate love with abuse, have distorted relationship boundaries and re-enact traumatic dynamics in adult relationships”, while Courtois (2010) describes several common transference themes in relation to sexual abuse survivors, including betrayal, mistrust, shame, self-hatred, guilt, grief and anger. Levenkron and Levenkron (2007) argue that if a practitioner or therapist is inattentive to the dynamics of transference and countertransference, then either they or the patient may begin to ‘act out’ misplaced feelings and unrealistic attitudes or cause patients to unconsciously seek to re-create abusive relationships with them. Meanwhile, Alpert and Steinberg (2017) argue that, due to their greater receptiveness to boundary violations, victims of childhood sexual violence account for a higher percentage of patients who become involved in sexual relations with their therapists. Healthcare practitioners, they state, must therefore guard against this possibility by maintaining robust professional boundaries. Specific to the manual therapies, Sher and Sher (2016) caution that due to the intimate physical nature of treatment, transference can become erotic in nature and the patient may misinterpret professional empathy and care as personal affection and love. This, they warn, can lead to flirtation and expectations of personal involvement or to feelings of dependency on the practitioner, all of which can hinder trauma-informed, patient-centred care.

Manual Therapy

In the manual therapies, there is less research regarding the management of patients who have experienced or disclosed sexual violence. The current literature, sourced from the fields of physiotherapy, chiropractic, massage therapy and osteopathy, tends to be focused on sexual violence perpetrated by manual therapists against patients (Priest, 2016), patients against practitioners (Stone, 2005), or on the avoidance of allegations of sexual abuse and the maintenance of ethical professional boundaries (Kinsinger & Sutton, 2012; Steinecke, 1994). However, there is some research to support the significant part that massage therapy can play, not only in the management but more importantly in the successful treatment of those who have experienced sexual violence. Older research examined the effects of massage on women victims of sexual violence and found that salivary cortisol levels (stress hormones) decreased after treatment, along with a reduction in anxiety and depression (Field et al., 1997). Price (2006) indicates that massage, along with body work, mind-body integration, body awareness education and psychotherapy, significantly improves general psychological health and reduces physical symptoms and PTSD. In following research, Price (2007) finds that body work decreases emotional and physical disassociation for survivors of sexual trauma. In another study, massage, acupuncture, reiki and healing touch are found to improve quality of life for those suffering PTSD and mental health symptoms (Collinge, Wentworth & Sabo, 2005). Hayes (2018) advocates four skills for massage practitioners to provide trauma-informed treatment: being fully present with the patient, being aware of not just verbal consent but body language and subtle cues from the patient, understanding that pain and tension can have a non-physical component, and remembering one's scope of practice alongside working in collaboration with other professionals for the benefit of the patient.

In the field of physiotherapy, Schachter, Stalker and Teram (1999) find that sexual abuse survivors often feel unsafe during physical therapy sessions, that clinician responses to disclosure affect the patient's sense of safety, and that safety, partnership and practitioner knowledge regarding trauma is crucial to the patient having a beneficial experience. They strongly advocate that physiotherapists improve their understanding of the consequences of sexual violence so as to better understand patient reactions during treatment, which is likely to result in a safer environment and better health outcomes for these patients. Another paper, by the same authors, suggests that an awareness of the complications that sexual violence survivors experience, especially during touch therapy, will increase the ability of manual therapists to provide effective care and also potentially increase the benefits of manual therapy

sessions (Stalker, Schachter & Teram, 1999). In similar vein, Dunleavy and Kubo Slowik (2012) indicate that physical therapy interventions can trigger memories of sexual violence, leading to overwhelming visceral and emotional responses and the exacerbation of PTSD symptoms. They highlight the need for a patient-centred approach, with the practitioner paying close attention to hyperarousal and dissociation of the patient during treatment. They further allude to the importance of referral and professional collaboration, stating that an adequate response to disclosure from the physiotherapist can be a catalyst for a patient to seek treatment and support.

Osteopathy

Osteopathy, as one of the manual therapies, has received much less attention in terms of research into the phenomenon of sexual violence. Maddick, Feld and Laurent (2014) indicate that osteopaths have a role to play in safeguarding children from abuse and neglect, and thus need to be able to recognise indicators, signs, symptoms and risk factors so as to understand different types of abuse and report them when necessary. These authors also provide information regarding the management and reporting of suspected cases of child abuse via conversations with social workers and family doctors (Feld, Maddick & Laurent, 2015). Another aspect of osteopathy research is focused on trauma-informed care. As discussed previously, Cuevas et al. (2017) highlight the different biological and autonomic nervous system responses to trauma and indicate that these can be re-triggered through osteopathic touch. The response of tonic immobility, in which patients are re-traumatised and unable to vocalise their distress, has particular implications for osteopathic consent and treatment processes. Cuevas et al. advocate a trauma-informed practice model, which includes an understanding of the relationship between physical symptoms and psychological well-being, the possible effects of osteopathic touch on patients who have suffered sexual violence, as well as referral to and collaboration with other healthcare professionals. While this literature represents a useful beginning, further research and wider education is required to expand the osteopathy profession's understanding regarding the management of patients who are sexually traumatised or who disclose the experience of sexual violence during clinical treatment.

Education and Training for Healthcare Practitioners

A further field of research is focused on education for healthcare practitioners in relation to sexual trauma, an area that is particularly relevant to osteopaths as the findings of this thesis will highlight. Sigurdardottir and Halldorsdottir (2018) maintain that healthcare professionals

frequently fail to provide trauma-informed care or understand the connection between chronic health conditions and sexual violence. Other research finds that the experience of survivors is negative when healthcare workers appear to lack knowledge, understanding and sensitivity regarding sexual violence (Havig, 2008), or indicates that traumatised patients often report feeling disappointed and betrayed by their therapists (Dalenberg, 2000). It seems that healthcare practitioners themselves identify a lack of knowledge regarding the treatment of sexual abuse victims (Di Giacomo et al., 2017), and that despite sexual violence being an important determinate in the professional reaction to and care of survivors, education regarding this topic is minimal or absent (Scriver & Kennedy, 2016). WHO recommends that all practitioners working in any spectrum of healthcare be trained through specialised post-graduate courses, so as to gain greater knowledge and improve abilities to manage cases of sexual violence disclosure with ‘sensitivity and efficiency’ (Krug et al., 2002; WHO, 2002). In the New Zealand context, McGregor, Gautam, Glover and Jülich (2013) suggest that healthcare workers be thoroughly trained in sensitively and successfully managing disclosure from patients who are survivors of sexual violence. The literature especially emphasises that healthcare professionals be educated in the link between victim-blaming and shaming, re-victimization and the exacerbation of conditions such as rape trauma syndrome and PTSD (Kennedy & Prock, 2016). Evidence exists regarding successful educational interventions that have significantly enhanced the understanding and awareness of healthcare trainees regarding the complexities involved in caring for victims of sexual violence (Kennedy, Vellinga, Bonner, Stewart & McGrath, 2013).

Professional Resilience

Professional resilience is an important topic in the field of sexual violence and healthcare. Research indicates that healthcare workers frequently experience powerlessness and report more trauma symptoms when faced with ‘the enormity of sexual violence’, but often feel ill-equipped to deal with the experience (Brady, Guy, Poelstra & Brokaw, 1999; Correa, Labronici & Trigueiro, 2009). This section will address various aspects that are a challenge to professional resilience, including countertransference, vicarious traumatisation, compassion fatigue and burnout, along with recommended strategies for maintaining professional resilience.

Countertransference, Vicarious Traumatization, Compassion Fatigue and Burnout

Countertransference is a term used to describe practitioners' emotional responses towards patients (Sher & Sher, 2016). Studies identify a number of countertransference responses amongst healthcare professionals towards victims of sexual violence, ranging from detachment and avoidance to over-identification and idealisation (Rothschild, 2002; Wilson & Thomas, 2004). Goldfeld (2008) finds that hearing about sexual abuse is associated with more negative countertransference reactions than listening to a story of loss and grief. Other literature indicates that countertransference responses of over-involvement and over-identification increase the risk of vicarious traumatization and compassion fatigue (Rothschild, 2002, 2006; Tabor, 2011; Trotter-Mathison & Skovholt, 2014; Wilson & Thomas, 2004). Vicarious traumatization describes a condition whereby practitioners 'take on' the patient's distress and neglect their own discomfort, whereas compassion fatigue describes a practitioner experience of indifference towards victims that emerges with over-identification and over-exposure (Rothschild, 2002; Trotter-Mathison & Skovholt, 2014; Wilson & Thomas, 2004). Researchers point out that the unconscious tendency to idealise sexual trauma victims and elevate their needs results in vicarious traumatization because it leaves insufficient room for practitioners to reflect on their own emotional reactions and frustrations (Eisenmann, Bergher & Cohen, 2000; Etherington, 2009). This literature suggests that practitioner self-awareness is key to understanding trauma-related countertransference and protecting against the vicarious traumatization and compassion fatigue, as well as the burnout, that can result. Authors describe burnout as the emotional, mental and physical exhaustion brought about by a lack of personal and professional support for healthcare practitioners and identify it as a major barrier to assisting victim recovery from sexual trauma (Rothschild, 2002; Tabor 2011; Ullman & Townsend, 2007). Baird and Jenkins (2003) find that inexperienced and younger practitioners are more likely to experience burnout, which suggests that recent graduates would benefit from education regarding the maintenance of professional resilience.

Maintaining Professional Resilience

The literature highlights several methods for maintaining the professional resilience of healthcare practitioners. Several studies recommend undergraduate and graduate programmes to educate healthcare workers about the personal impacts of exposure to stories of sexual violence and the avoidance of trauma-related countertransference and burnout (Correa et al., 2009; Milliken, Paul, Sasson, Porter & Hasulube, 2016; WHO, 2003). Milliken et al. (2016) suggest that education can indeed act as a buffer against vicarious traumatization in

practitioners who experience emotional distress, greater relationship closeness and confusion in regard to patients who disclose experiences of sexual violence. Etherington (2009) argues that self-knowledge is crucial to working with victims of sexual violence, and in this regard recommends professional supervision, that is, regular meetings with an independent person who has the training to help practitioners reflect on their work and offer education and support. Harber, Podolski and Williams (2015) also promote self-reflection and discussion regarding encounters with victims, indicating that this can decrease victim-blaming and allow moderation of negative social beliefs about sexual violence. Rothschild (2002) advocates reflection on and supervision about the processing of patient information, interactions with patients, and personal issues affecting the practitioner's work. Overall, Tabor (2011) and Trotter-Mathison and Skovholt (2014) emphasise the importance of education, training, supervision, support networks, the development of healthy coping strategies and the maintenance of clear boundaries as the means of maintaining professional resilience when working with survivors of sexual violence.

Summary

Chapter 2 has conducted an extensive review of the literature regarding sexual violence and healthcare, specifically focusing on terminology and definitions, parameters, personal and social costs, disclosure, recovery, the role of primary healthcare practitioners and professional resilience. In summary, leading experts in the field estimate that the incidence of sexual violence is high in New Zealand, that it carries long-term detrimental impacts on physical, mental and social well-being, and that these can be lessened with appropriate professional assistance. However, many patients delay or never disclose sexual violence and therefore do not embark on a process of recovery. These circumstances mean that primary healthcare practitioners, including manual therapists, will often unknowingly encounter patients who carry a history of sexual abuse. The literature also reveals that when patients do disclose experiences of sexual violence to healthcare professionals, they may receive an inadequate response which could hinder their path to recovery.

In relation to the osteopathy profession specifically, the chapter highlights significant gaps in the literature. It is important that these gaps are addressed, as osteopathic treatments invariably involve bodily positioning and therapeutic touch that carry the possibilities of re-traumatisation and/or disclosure for patients who have experienced sexual violence. Osteopaths must be well equipped, through research and education, to manage such circumstances sensitively and to

make effective referrals to appropriate services. To this end, this research thesis is focused on the current knowledge, skills, attitudes and confidence of New Zealand osteopaths when working with patients who have been sexually traumatised. Overall, it will make a strong case for osteopaths, and indeed for all primary healthcare workers, to receive more adequate training in the management and treatment of patients who have experienced sexual violence, including the matter of professional resilience.

Having addressed the relevant literature in the field of sexual violence and healthcare in Chapter 2, the thesis now moves on to describe the research design of this inquiry in Chapter 3.

Chapter 3: Research Design

Chapter 3 encompasses the research design of this preliminary inquiry into the New Zealand osteopathy profession and the management and treatment of patients who have experienced sexual violence. It is structured in two sections, with the first section outlining the methodology and the second section focusing on the specific methods and processes that were undertaken to complete the research.

Methodology

A qualitative methodology was selected as the most appropriate for this preliminary study, with descriptive phenomenology chosen as the most suitable investigative avenue within this tradition. This section provides a critical discussion of the conceptual underpinnings of this methodology and justifies its use in this particular research project.

Qualitative Research

A qualitative methodology was employed to undertake this preliminary investigation. A review of the existing literature, presented in Chapter 2, revealed that little is known about the osteopathy profession's response to and management of patients who disclose experiences of sexual violence. The qualitative approach provides a suitable platform when such a gap in knowledge is apparent because it is designed to thoroughly explore a topic without constraints or previous assumptions that might impact on the working hypotheses generated and therefore the data obtained (Morse & Field, 1995; van Manen, 1997). Moreover, such an approach in under-explored areas of knowledge will potentially reveal relevant data that can later be tested through quantitative forms of research (Corbin & Strauss, 2015; Green & Thorogood, 2014). Overall, it was decided that the open and flexible characteristics of a qualitative methodology would achieve the objectives of the study by facilitating a deep exploration of osteopaths' knowledge, skills, attitudes and confidence in the management of patients who have experienced sexual violence. The results, presented in Chapters 4, 5 and 6 and discussed in Chapter 7, offer valuable insights that it is hoped will contribute to the overall improvement of osteopathic healthcare services in relation to the phenomenon of sexual violence amongst its patient cohort.

A qualitative methodology offers many exploratory avenues, including ethnography, grounded theory, narrative inquiry, case study inquiry and phenomenology. The first two of these methodologies are mostly used for larger cohorts of participants, with ethnography often the

method of choice for studies of people in the context of culture (Bassett, 2006; Silverman, 2006) and grounded theory seeking to move beyond the description of a phenomenon to the generation of theory (Creswell, 2013; Given, 2008). Narrative inquiry focuses on the lives of individuals as told through their stories, while case studies usually examine a single case to illustrate an issue (Creswell, 2013). These four investigative possibilities were critically considered but found unsuitable for this study, focused as it was on the experience of a small cohort of participants. A phenomenological approach was eventually adopted, for reasons that are discussed in the next section.

Phenomenological Research

Phenomenology, originally established as a 20th century European philosophy, developed into a method of inquiry within the qualitative tradition in the human sciences (Connelly, 2010; Given, 2008). Phenomenological research attempts to unveil the world as experienced by the subject (Connelly, 2010). It aims to provide rich descriptions of the lived experience of individuals and groups in relation to a particular phenomenon of interest (Bassett, 2006; Creswell, 2013; Finlay, 2009). As a research approach, phenomenology is appropriate in the healthcare field in general, and the investigation of sensitive topics such as sexual violence in particular, as it offers a respectful and socially relevant way of understanding the common experience of several individuals, along with their interactions with others and the environment (Creswell, 2013; Lopez & Willis, 2004). Furthermore, phenomenological inquiry takes a holistic perspective (Creswell, 2009) that is consistent with the holistic principles of osteopathy, making it well suited to an investigation of the lived experience of the practising osteopaths who participated in this study.

There are two main approaches to phenomenological research in the healthcare field, descriptive phenomenology and interpretive phenomenology. Descriptive phenomenology, also called eidetic or transcendental phenomenology, was devised by German philosopher Edmund Husserl (1859-1938) as he considered the nature of science and the best way in which it might be explored (Given, 2008). Husserl, observing that people usually proceed through life without critical reflection on their experience, developed descriptive phenomenology as a means of examining the essential elements of lived experience specific to different groups of people (Connelly, 2010; Lopez & Willis, 2004). Interpretive phenomenology, also known as hermeneutic phenomenology, was an adaption and expansion of Husserl's descriptive phenomenology by his student Martin Heidegger (1889-1976) (Creswell, 2013; Finlay, 2009;

Given, 2008; van Manen, 1997). There are important differences between Husserl's and Heidegger's approaches. Husserl believed that to fully understand the lived experience of others, researchers must maintain a state of transcendental subjectivity via the adoption of an attitude of phenomenological reduction, in which bias and prior knowledge are suspended (Lopez & Willis, 2004). Appreciably, this methodology focuses on a description of the themes that emerge from an account of the experience, as given by participants, without interpretation. Heidegger, meanwhile, argued that it is impossible to 'rid the mind' of previous understandings, and that the expert knowledge of the researcher is in fact valuable to an inquiry (Lopez & Willis, 2004; van Manen, 1997). In his methodology, phenomenology is seen as an interpretative process that goes beyond mere description (Creswell, 2013; Lopez & Willis, 2004; Kafle, 2011). Later philosophers and scholars, such as Maurice Merleau-Ponty and Max van Manen, expanded on the works of Husserl and Heidegger respectively (Finlay, 2009; Given, 2008), and both branches of phenomenology have been adapted for use in different fields of human science research. In particular, psychologist Amedeo Giorgi developed the 'descriptive phenomenological psychological' method, based on the work of Husserl and Merleau-Ponty, to provide a rigorous and yet non-reductionist framework for studying people and human experience.

Of these different approaches, the descriptive phenomenological psychological method was identified as the most suitable for this preliminary investigation. This method is known to engender a comprehensive process of phenomenological reduction, description and search for essence that is well suited to topics constituting a complexity of biopsychosocial elements (Finlay, 2009; Giorgi, Giorgi, & Morley, 2012; Lopez & Willis, 2004), such as the osteopathy profession's response to and management of patients who have experienced sexual violence. It was also likely to facilitate a clear description of the research participants' experience, as presented to the researcher, without the intrusion of assumptions that can arise when interpretation takes place (Giorgi et al., 2012; Lopez & Willis, 2004; Koch, 1999). The participants' experience could thus be directly revealed and reflected upon without the researcher's bias 'polluting the data', especially given the emotive power and the many myths and misconceptions that are associated with the phenomenon of sexual violence. Moreover, the descriptive phenomenological psychological method was likely to provide a meaningful way in which to rigorously investigate osteopathic knowledge, skills, attitudes and confidence in a non-reductionist manner, which is well suited to the holistic philosophy that underpins osteopathy (Willis, 2017; Koch, 1999). The approach also provides clear concise steps for the

collection and analysis of meaningful data, steps that will be demonstrated in the later methods section of this chapter in relation to this particular inquiry. The descriptive phenomenological psychological method is also known to be suitable for the exploration of sensitive topics (Lopez & Willis, 2004). For this project, it seemed to offer a more formalised data collection process that would ensure an adequate level of protection for respondents when discussing the potentially distressing topic of sexual violence.

The Research Sample in Phenomenological Research

Phenomenological inquiry usually aims for an in-depth understanding of a phenomenon of interest through examination of the particular experiences and perspectives of a representative sample of the population, rather than quantification of that phenomenon (Englander, 2012). Therefore, the data required for phenomenological research can be gathered from a small number of participants (Smythe & Giddings, 2011), which was the case in this study. Phenomenological description seeks a diversity of information rich cases that can reveal much about the phenomenon of interest, as well as a pool of respondents who have a range and depth of lived experience regarding the phenomenon (Creswell, 2013; Englander, 2012; Giorgi, et al., 2012; Lopez & Willis, 2004; Holloway, 2008). These prerequisites led to a recruitment process of self-selection, whereby those who held a genuine interest in, and could provide a purposeful account of, the phenomenon volunteered to participate (Creswell, 2013; Englander, 2012). This process of self-selection seemed an important way of ensuring that the participant sample in this inquiry contained an adequate level of experience regarding the phenomenon of interest.

Data Collection in Phenomenological Research

In phenomenological research, the primary data collection process is via in-depth interviews and this was considered an appropriate means of gaining a comprehensive description for this project (Creswell, 2013). The process, facilitating a two-way interchange between interviewee and interviewer, can be undertaken on an individual basis so as to directly reveal and reflect upon the subject's experience, as required by descriptive phenomenology (Creswell, 2013; Giorgi, et al., 2012; Lopez & Willis, 2004). An individual semi-structured interview process, as was used in this investigation, can probe for depth and elicit richness and fine detail, while permitting the researcher to guide the direction of the interview (Fossey et al., 2002). Meanwhile, the semi-structured nature of an interview can permit digressions that generate new and unanticipated material of interest to the inquiry (Taylor & Francis, 2013).

Data Analysis in Phenomenological Research

Qualitative research offers an array of methods to analyse data. Discourse analysis explores the ways in which language mediates psychological and social realities (Liamputtong, 2009), whereas semiotic analysis is concerned with the signs and symbols in communication systems (Ringham & Martin, 2000). Narrative analysis investigates the ways in which people create meaning in their lives and is more suited to projects that require a chronological understanding of data (Esin, Fathi & Squire, 2013), while thematic analysis examines communications for recurring ideas, patterns or topics that facilitate deep insights into a phenomenon (Boyatzis, 1998; Hawkins, 2017; Liamputtong, 2009). Of these four methods, thematic analysis seemed to offer the best choice for coding the data and identifying the recurring themes in this preliminary study. Moreover, thematic analysis is often employed when investigating a phenomenon for which little prior knowledge exists, which was the case in this project. It can prove helpful in highlighting areas of strength and targeting areas for improvement within that field of research (Hawkins, 2017). A structured step-by-step process, as described by Giorgi et al., (2012) and Liamputtong (2009) and set out systematically in the methods section below, can be used to undertake a thorough thematic analysis of the data. This analysis usually constitutes an iterative process whereby various dimensions of the data, and the dynamic relationships between them, develop cyclically and cumulatively until a point of thematic saturation is reached (Green et al., 2007; Grbich, 2013). Specifically, thematic saturation refers to that point in data collection where sampling is unlikely to lead to new information related to the research question, when there is enough data to replicate the study and when additional coding is no longer practical (Fusch & Ness, 2015; Green & Thorogood, 2014).

Rigor in Phenomenological Research

A qualitative methodology requires rigor to ensure that the research is sound and that the findings are trustworthy. There are several processes that can be employed to maintain rigor, including transparency, validity, reliability, comparativeness and reflexivity (Bassett, 2006; Given, 2008). Transparency refers to the provision of an audit trail or clear descriptions of the research process that would allow others to replicate studies, to see the ways in which researchers have arrived at their conclusions and to assess whether the chosen methods were appropriate to the research questions (Creswell, 2013; Given, 2008). Validity is maintained through purposeful and diverse sampling processes and data that is represented accurately and fairly, so as to provide a rich account of the phenomena investigated and to promote confidence that the findings extrapolated from the analysis are representative and applicable to a wider

population (Bassett, 2006; Creswell, 2013; Given, 2008). Reliability requires rigorous testing of data, and discussion of codes and emerging themes with others, to ensure that the themes extracted are dependable and the researchers' interpretations accurate (Given, 2008). Comparativeness adds to rigour by relating the findings of studies to their broader research contexts (Given, 2008). Finally, rigorous qualitative research promotes reflexivity, requiring researchers to give accounts of the ways in which their biases, values and experiences may have influenced outcomes (Creswell, 2013; Given, 2008). A subsection below will describe the ways in which this preliminary study went about maintaining rigor through addressing the elements of transparency, reliability, validity, comparativeness and reflexivity.

Methods

The first section of this chapter outlined the main tenets of the descriptive phenomenological psychological methodology, within the qualitative research tradition, that was utilised in this research thesis. This second section will describe the specific methods and processes that were undertaken to complete the inquiry, focusing specifically on the research sample, data collection, data analysis, ethical considerations, the maintenance of rigor and limitations and challenges.

The Research Sample

Inclusion and Exclusion Criteria

In line with descriptive phenomenology, as discussed in the methodology section above, the researcher set out to gather in-depth description from a small sample regarding the phenomenon of osteopathic treatment of patients who have a history of sexual violence (Smythe & Giddings, 2011). The inclusion criteria therefore identified registered osteopaths working in New Zealand. To ensure compliance in this regard, checks were made through the official register maintained by the New Zealand Osteopathic Council. No exclusion limits were placed on age, gender, ethnicity or cultural background, as a representative sample was sought. However, the study stipulated that potential participants be practising as osteopaths for more than three years, so as to attract a depth of lived experience (Holloway, 2008) and respondents who were likely to have broadened their views beyond their initial training. Due to the small response of interested parties, two participants fell outside the three years of practice limit, having one and two years of experience respectively. However, both contributed a wealth of thoughtful commentary that contributed to the richness of the data that was collected. The

ethical considerations of these and the other methods procedures, as well as issues and challenges, are specifically addressed in later subsections.

Recruitment

A notice advertising the research project (Appendix B), electronically linked to an information letter (Appendix C), was placed in relevant osteopathic Facebook pages and publications. Potential participants then emerged through a process of self-selection, ensuring that the sample contained the experience and interest that this qualitative project sought (Englander, 2012). Specifically, four interested parties made email contact, while a fifth expressed interest during a conversation with the researcher. The researcher emailed a copy of the information letter to the five willing respondents, requested that they consider its implications carefully before agreeing to participate, and arranged interview timeframes. A potential sixth interviewee was suggested to the researcher, constituting a form of recruitment known as 'snowballing' within a social network (Creswell, 2013; Small, 2009). However, timeframe difficulties prevented this respondent from taking part in the inquiry and by then, data collection was achieving some sense of thematic saturation.

The Participants

A description of the characteristics of the five respondents in this study is provided with care, to protect their identities in what is a relatively small community and a sparse distribution of registered osteopaths in New Zealand. The participants represented a range of genders, with two identifying as female and three as male, while their practices were situated in different locations in the North Island of New Zealand. They also represented a range of osteopathic education and specialisation, with three participants having qualified in overseas institutions and two trained in New Zealand. The respondents were characterised by a diversity of osteopathy experience, ranging from one to 25 years, and one had previously qualified and worked as a massage therapist. Of particular significance in this inquiry, all five participants had treated patients who had directly disclosed a history of sexual violence, and four had experience of suspecting a client history of sexual abuse. Although the sample was small, its representative spread indicates that the common themes that emerged from the data analysis are likely to be applicable to the wider population of New Zealand osteopaths.

Data Collection

A semi-structured in-depth interviewing method was utilised to gather descriptions and understandings of the perspectives of the five research participants in relation to their

osteopathic practice with patients who have experienced sexual violence. These interviews, from 45 to 75 minutes duration, were conducted individually as this was considered more likely to reveal the interviewee's direct experience. Every effort was made to generate a sense of comfort so that respondents felt able to share their views openly. Four of the interviews were undertaken face-to-face in a private space convenient to the participants so as to maintain confidentiality, while the fifth was conducted via phone. The researcher began each interview with informed consent procedures for participation in the study and recording of the material. The interviews were recorded using a digital voice recorder and later transcribed using the Unitec Osteopath Department's approved service, Scribie Audio Transcription Services.

A schedule of questions was employed to guide the interviews (Appendix D), which proved effective in helping to mitigate the sensitive nature of sexual violence. This schedule also elicited deep reflection and rich detail, while permitting the researcher to maintain some directional control over the interview and keep the interviewee on topic (Fossey et al., 2002). However, the semi-structured format allowed for digressions that brought forth new and unanticipated material significant to the inquiry (Taylor & Francis, 2013). The researcher also maintained a research journal, in which she recorded detailed reflections following each interview. These reflections were specifically focused on challenges, recommended improvements in interview techniques and the interview schedule, evaluations of the nature of the data, preliminary hunches regarding emerging themes and the maintenance of an attitude of phenomenological reduction. Moreover, while collecting the data, the researcher initiated a simultaneous process of preliminary analysis to assess for the possibilities of thematic saturation (Fusch & Ness, 2015; Green & Thorogood, 2014). The researcher, in collaboration with her supervisor, found that five in-depth interviews had facilitated a satisfying density of data in this preliminary inquiry, and the decision was made that further sampling was unlikely to reveal significant new themes related to the research question.

Data Analysis

As with most qualitative inquiry, and as indicated in the previous subsection, data analysis in this project commenced from the beginning of data collection. It entailed a non-linear flexible process whereby various themes, and the dynamic relationships between them, emerged cyclically and cumulatively (Green et al., 2007; Grbich, 2013). Through the iterative process of listening and re-listening to interview recordings, reading and re-reading interview transcripts, coding data, writing, reflecting and also in discussion with supervisors and

colleagues, patterns and themes were gradually identified (Green et al., 2007; Liamputtong, 2009). These themes and ideas were further refined during the process of writing the thesis, particularly in relation to broader concepts regarding the osteopathic care of patients who have been sexually violated.

More specifically, the researcher followed various steps prescribed by qualitative research experts to undertake a rigorous thematic analysis. She listened to each audio recording while simultaneously reading the transcript text, correcting transcription errors and re-familiarising herself with the context of the interview and the personality of the interviewee. Individual transcripts were then re-read in their entirety to facilitate a broader and deeper sense of the whole description (Giorgi et al., 2012; Lopez and Willis, 2004). The researcher then assumed an attitude of ‘phenomenological reduction’, as described in a later subsection, and entered into a coding process. This process entailed reading the transcript text line by line and delineating it into ‘single meaning units’, that is, single words, phrases or whole paragraphs that relate to significant categories or concepts. The subsequent step involved searching these units to locate different categories of meaning, and colour coding the repeating patterns and thematic possibilities (Giorgi, et al., 2012; Lopez & Willis, 2004; Green et al., 2007; Liamputtong, 2009).

A document was then created to record these categories or thematic possibilities, and the various sets of data were gathered together under tentative theme labels. These provisional themes were re-checked against the data sets to ensure that they made sense in relation to the original meaning units. The researcher also used a process of ‘imaginative variation’, that is, an exploration of the data from ‘different perspectives and varying frames of reference’ so as to arrive at a comprehensive description of the phenomenon (Giorgi, et al., 2012; Moustakas, 1994). The different perspectives adopted included that of the patient, the osteopathic practitioner, the osteopathy profession as a whole, other healthcare practitioners and the healthcare system. The frames of reference that were considered included those areas highlighted by the literature as critical in the field of sexual violence and healthcare, such as the personal and social costs of sexual trauma, disclosure, recovery, power disparities, and the education, training and professional resilience of healthcare workers. In this analytical process, seven areas of practice emerged and solidified as the most important for the osteopath respondents when managing and treating patients who had experienced sexual violence, specifically the illness experience, the mind-body connection, clinical relevance, scope of

practice, the therapeutic response, power dynamics in the therapeutic relationship and professional resilience. These areas were further defined, refined and eventually named as the essential themes of the research thesis in relation to its aims (Liamputtong, 2009), that is, in relation to the knowledge, skills, attitudes and confidence of the osteopaths in this area of practice. At this point, the researcher discussed the results of the thematic analysis with supervisors and, utilising the seven themes that had been delineated and named, began structuring and writing the findings chapters of the thesis.

Ethical Considerations

As with all human research undertaken at Unitec Auckland, ethical approval for this study was sought and gained from the Unitec Research Ethics Committee for a specified duration (Appendix E). Participant confidentiality was ensured in all the research procedures through anonymised data and the use of pseudonyms throughout the text of the thesis. Participants were informed about the research via an information letter (Appendix C), which set out the research intentions and the voluntary nature of participation. Informed consent was gained through the signing of a consent form prior to the interview process (Appendix F), whereby participants agreed to voluntary participation in the research and the recording of material, and were provided with a copy. These forms and the interview data were stored separately and securely, with printed material being deposited in a secure location and electronic files protected by computer password.

Sexual violence is a sensitive topic, potentially entailing trauma, which needs to be approached with care and consideration. Cook et al. (2011) suggest that a thoughtful approach to such trauma-related research can prevent a negative impact on the participants. Therefore, extra steps were taken to mitigate the risk of psychological disturbance or trauma. To begin with, the informed and voluntary nature of participation was specifically emphasised in the information letter (Appendix C), including an explanation of the sensitive and potentially distressful nature of the subject matter and a prompt to carefully consider participation for this reason, as well as an invitation to ask questions and clarify issues. This letter was delivered by email to allow respondents time, without pressure or coercion, to consider the implications of participation in a study about osteopathy practice and sexual violence. Furthermore, participation was restricted to the cohort of registered osteopaths, all trained practitioners who were likely to be conversant with challenging healthcare subject matter. The interview was semi-structured with carefully devised questions to ensure that discussion would remain within the domain of

professional experience and not delve into interviewees' personal circumstances. Participants were invited to cease the interview at any point for any reason, without explanation, if they so wished and at its close were provided with a list of sexual violence support services (Appendix G). The researcher also made available relevant contact information should a respondent wish to discuss concerns with her or her supervisor at a later time. The researcher also adopted self-care strategies to prevent vicarious traumatisation while delving into the topic of sexual violence. These strategies, recommended by literature (Etherington, 2009; Fox, 2007; Harber, Podolski & Williams, 2015; Milliken et al., 2016; Rothschild, 2002; Tabor, 2011; Trotter-Mathison & Skovholt, 2014), included regular supervision sessions with a mental healthcare professional, the daily use of a reflective diary, and open discussions with supervisors regarding areas of concern as they arose during the research process.

Maintaining Rigor

This qualitative study addressed factors such as transparency, validity, reliability, comparativeness and reflexivity, as identified in the methodology section above, to maintain rigor. A transparent account of the research process, presented here in the preceding subsections, reveals the way in which the study was undertaken and the appropriateness of its methods in relation to the inquiry focus, while the following findings and discussion chapters of the thesis will bring to light the ways in which the researcher arrived at certain conclusions. To maintain validity, relevant data is presented accurately in the three findings chapters of this thesis and care taken to provide a comprehensive account of the phenomenon of osteopathic treatment with patients who have been sexual abused, as well as a diverse sample of material gathered during participant interviews. As discussed earlier, although the sample was small and the exclusion criteria unable to be fully observed, the findings extrapolated from the analysis of the qualitative data are likely to be applicable to a wider population. To ensure reliability, emerging themes were tested for dependability and accuracy through discussion with and assessment by the researcher's supervisors. Reliability was further enhanced through imaginative variation, as detailed in the earlier subsection regarding data analysis. The researcher's interpretations of the outcomes of this preliminary inquiry are also compared with the main body of literature, as it is presented in Chapter 2 and discussed in Chapter 7 of the thesis, to establish the relevance and comparability of these findings to the broader research context.

Rigorous Reflexivity through a Phenomenological Attitude

Given that the subject of sexual violence is a potentially controversial and emotive topic, rigorous reflexivity was of particular importance in this inquiry, aiming to highlight the ways in which personal biases and values may have influenced the research outcomes. In this regard, the researcher followed a descriptive phenomenological process known as epoché, that is, phenomenological reduction or bracketing (Gearing, 2004; Giorgi, et al., 2012), during the literature review, data collection, data analysis, discussion with others, oral and written reflection and thesis writing. Phenomenological reduction requires the researcher to suspend preconceived ideas, judgements, assumptions and previous experiences, and proceed with an open mind so as to clearly see and describe the phenomenon of interest. To gain this ‘state of consciousness in which attitudes other than the phenomenological attitude are put aside’ (Giorgi et al., 2012), the researcher examined her own ‘epistemological position and ontological perspective’ (Gearing, 2004) regarding sexual violence and osteopathy. This examination was undertaken through reflective conversations and the use of a reflective research journal, which allowed the researcher to bring her subjective presuppositions into consciousness. These presuppositions were then reflected upon, written down and ‘put aside’ or bracketed. This process of self-reflection and reflective discussion assisted the researcher to maintain objectivity and avoid unconscious bias throughout the research process (Johns, 2017). For example, the researcher initially experienced indignation that healthcare workers, including osteopaths, might be inadequately prepared in terms of their knowledge, skills and confidence in relation to sexual trauma, or might display negative attitudes that could adversely affect the recovery of victims of sexual violence. This indignation, and other similar feelings and premises, were ‘bracketed’ so as to avoid pollution of the data collection and analysis processes. The maintenance of ‘a phenomenological attitude’ was sometimes challenging, as described in the following subsection.

Limitations and Challenges

A number of limitations are associated with this research project. Due to the preliminary and qualitative nature of this study, the sample size was small, which can be understood as a limitation. It is suggested that future research, possibly with a quantitative focus, could expand the pool of participants and thus generalise the findings to the population of New Zealand osteopaths. The recruitment process of self-selection could also be seen as a limitation, but also a strength. Osteopaths who had a particular interest in the management of patients who have experienced sexual violence tended to offer themselves as interviewees. Therefore, it could be

assumed that they had greater knowledge, skills and confidence, and more favourable attitudes, regarding this subject than other osteopaths, which may have brought a skew to the data. On the other hand, these factors tended to enrich the data collection process. A third limitation lies in the fact that two of the participants fell outside the three-years of practice parameter set by the recruitment process. However, these respondents did contribute a wealth of thoughtful insight that they had gained from practice and from their interest in the subject matter, which added depth to the data and which is likely to be applicable to the wider community of osteopaths.

Several challenges also presented themselves during the project. For example, the initial response to the invitation to participate in the research was limited, which required the researcher to 'hold her nerve' and reassess the project's promotion and participant inclusion and exclusion criteria. The issue was addressed through an expansion of the networking process, a request to the researcher's advisor to advertise on the osteopathy Facebook page, and an alteration of the criteria to include osteopaths who had been practising for only one year. A satisfactory number of respondents eventually came forward, including newer practitioners who held a specific interest in the topic, which led to the garnering of much thoughtful commentary. Another challenge arose regarding the researcher's ability to maintain 'an attitude of phenomenological reduction', as discussed above, during one interview. The interviewee had hinted at victim-blaming while discussing patients who had been sexually violated, which resulted in the researcher experiencing discomfort and temporarily losing the attitude of phenomenological reduction. This challenge was overcome through reflective practice, which included an in-depth discussion with a supervisor and the use of reflective writing. These actions assisted the researcher to overcome negative feelings towards that particular participant and return to an impartial examination of the data.

Chapter 3 has outlined and discussed the methodology and methods used to conduct this investigation into the osteopathy profession and its management and treatment of patients who have experienced sexual violence. The thesis now moves on to Chapter 4, the first of the three findings chapters, which will present a thematic analysis of the research respondents' perspectives on the patient experience of sexual violence and the ways in which these relate to osteopathic clinical practice.

Chapter 4: The Patient and the Experience of Sexual Violence

As introduced in Chapter 1, this research thesis sets out to ascertain the knowledge, skills, attitudes and confidence held by New Zealand registered osteopaths when managing and treating patients who have experienced sexual violence. Seven themes regarding these aims emerged from the thematic analysis of the research data and have been organised into three findings chapters, with each chapter containing two or three closely related themes and subthemes. It is important to note, however, that while this organisation was decided upon to provide an easily accessible presentation of the research outcomes, all seven themes are inter-related in complex ways. Chapter 4, the first of these findings chapters, comprises three themes that are linked by their focus on the patient experience of sexual violence in osteopathic practice. These themes, presented in three separate sections, are the illness experience of sexual violence, the mind-body connection in relation to sexual violence and the clinical relevance of sexual trauma.

The Illness Experience

There's a lot of grief for [the sexual abuse], depending on when the trauma occurred. And to be fair, the ones that I've seen have all been in childhood, like they've been quite young. And so, there's a lot of grief for what they've lost, that innocence in the childhood. And probably guilt that they didn't say anything. And I would imagine there's a lot of anger that they felt, like they couldn't tell people... anger at the person that hurt them. (Ryley)

This excerpt from the interview transcripts expresses particular knowledge regarding the complex illness experience that is associated with sexual violence, the theme analysed in this first section of Chapter 4. Overall, respondents named emotions such as grief, loss, shame, guilt, self-doubt, self-blame, feeling overwhelmed, anger, worry, anxiety and fear when describing a patient's possible reactions in this regard. Ryley, whose expression is presented above, used the specific terms “emotionally volatile” and “emotionally turbulent”, noting that there are “just a lot of levels” associated with sexual trauma. In terms of the neurobiology of the brain, four participants demonstrated the knowledge that sexual trauma can cause severe anxiety, clinical depression and psychiatric disorders. Some interviewees specifically noted the link between the experience of sexual violence and depression and PTSD, which they also

understood to be associated with chronic pain conditions. Here is a relevant extract from the interview with Jordan:

Well, in terms of psychological manifestations on their own, yes, there's depression. There's anxiety. There's the entire spectrum of mood disorders, right up to ... what's it called? Personality dissociative disorder, schizophrenia, the whole range, because there's no limit to what trauma can do to a (human) being. So, if they've been traumatised enough, then their brain can do whatever it likes. It needs to.

The interview transcripts reveal a depth of comprehension in relation to the phenomenon of secrecy that is usually associated with the experience of sexual violence. Respondents used specific terms such as hidden, secret, denial, repression and doubt to express their appreciation that sexual abuse may be suppressed or concealed for many years. Ryley observed: “Often when children or young people, when they have been abused, it’s a secret for a long time. They really hold that”. Interviewees also named the experience of guilt, shame and doubt when discussing the barriers to disclosure of sexual violence, aspects of which will be elaborated in Chapter 5 in a section specifically focused on disclosure. For example, Jordan, in describing patients who had “bottled it” and who were “in denial”, noted the ways in which shame can be part of the experience of sexual violence: “Happens a lot. Somebody discloses that and they’re ashamed of it”.

The participants also shared knowledge of the connection between sexual trauma and chronic health conditions. Quoting research, Hayden noted that the experience of sexual violence can be a component of chronic pain. Patients with a history of sexual trauma had presented in his clinic with a number of chronic health conditions such as inflammatory bowel syndrome, chronic regional pain syndrome, chronic pelvic pain and depression. He observed that people tend to follow predictable life-stages such as attending university in their early twenties or having babies in their late twenties, “that’s the sort of rhythm of life”, and that “catastrophic life events” such as sexual violence can interrupt “normal life trajectories” and change these rhythms, which in turn can lead to “a knock-on effect into their health or their well-being”. Ryley also understood the link between trauma and chronic pain: “They really shut down their body. ... They’ll be in some ways super sensitive to chronic pain”. Meanwhile, Eden commented:

They've already been through the GP, the physio, maybe the chiropractor, sometimes the pain clinic. And they're exhausted. They've gone through everything and they don't know what else to do. That's what I mean by complex picture, that chronic pain that's happening. And obviously that has massive implications to their mental health as well.

Furthermore, the interviewees had noticed certain traits and behaviours associated with the illness experience of sexual trauma. They specifically identified vulnerability, neediness, poor awareness of social cues, distorted or inadequate relationship boundaries, and the display of transference and dependency behaviours towards therapists including the misinterpretation of therapeutic care as love. While discussing patients in this category, Ryley noted: "All had alcohol problems, [were] really promiscuous, [had] real body weight issues or body issues". Eden and Hayden identified a tendency in patients who had experienced sexual violence to over-disclose intimate details, and to do so 'very quickly' when they were still at the beginning of their recovery process. Ryley related a story about a regular patient, a victim of childhood sexual abuse, who consistently crossed professional relationship boundaries by asking for personal information that she did not feel comfortable in sharing. She described the client's behaviour as somewhat manipulative but unconsciously driven, an "over-familiarity" due to "a poor understanding of social cues". Initially, Ryley struggled to manage this patient's behaviour and sought support from a mentor, who referred her for professional supervision with a counsellor. Through this supervision, she was able to learn ways in which to manage such challenging behaviours. The important topic of professional supervision is elaborated in Chapter 6.

In relation to the phenomenon of transference, Hayden described an incident during his early years of practice. A patient, with an extensive sexual violence history, "fell in love" with him after misinterpreting his therapeutic care as love: "I received a letter from her, basically disclosing that she felt feelings for me. She felt the closest to a man she'd ever felt since she was assaulted, and she felt she was in love with me". Hayden considered that the transference occurred because the patient had experienced very little kindness or compassion from men in her life: "That was a sad but classic example of somebody taking their own personal and emotional feelings and projecting those out to me, the practitioner". Looking back, Hayden noted that while he was able to follow the correct professional steps, he had managed the situation poorly in terms of the patient's overall care. He reflected that, at the time, he had felt

himself ill equipped to manage this kind of issue with a patient, but has since used the knowledge, skills and confidence gained from this clinical experience to relate more adequately to patients in his current practice. Hayden emphasised the importance of maintaining excellent clinical records as a professional protection in these types of cases. Moreover, he now understands that some patients continue to carry repressed memories and “a lack of awareness cognitively of some of their history”, while others have worked through the trauma and have healthier relationship boundaries. In the following excerpt, Hayden describes this differentiation in his own words:

What I found is, over the years you get better at spotting those patients that may have some form of emotional or physical [or] sexual history, which puts them in a quite vulnerable place particularly when they're being worked on in a very close, intimate and physical manual therapy basis. So, these days I tend to be very aware of the dynamic of projection, countertransference and also dependency. So, it's something I may not overtly express with them, but I'll often manage them in a way that limits that from happening.

Analysis of the research data found a range of attitudes amongst the respondents in relation to the illness experience of sexual violence. For example, Kingsley expressed a somewhat critical attitude regarding what he saw as a habitual “sick role”, which might be preventing patients who have a history of sexual trauma from “getting well”. In his view, this phenomenon involved patients expressing “an external locus of control”, that is, “people who rely on other people to get them right ... and it doesn't matter what you do but they want to stay sick”. Encapsulating a more sympathetic attitude, Jordan expressed compassion for the victim but anger towards the perpetrator of sexual violence: “It is something to be ashamed of, but it is not for them [the victim] to feel the shame. It's for the other person [the perpetrator] to feel the shame”. At the empathic end of the continuum, Eden expressed an “overwhelming sense of admiration” for the ability of her patients to carry on in life despite having faced horrific experiences such as war crimes, rape and gang rape. She specifically used the word “extraordinary” to describe the survival instincts of victims.

The Mind-Body Connection

The second section of Chapter 4 concerns the theme of the mind-body connection. This theme might have been included in the previous section regarding the illness experience, in that it too demonstrates the multiple layers of distress associated with the experience of sexual violence.

However, it is assigned a separate section in this chapter because of the particular significance that the mind-body connection, the basis of whole person healthcare, has for the osteopathic profession, including those practitioners who participated in this research. Indeed, close analysis of the data revealed high levels of awareness amongst the participants in relation to the powerful and often unconscious influence that thoughts and emotions can have on the body. Hayden used the phrase “being somaticized”, explaining this to mean “where the particular anxiety or distress is manifesting physically”. In his view, the pain experienced by some patients is “maintained by the anxiety and the emotional distress they're under”. In terms of the capacity of bodily tissues to retain past trauma, Ryley commented:

Often emotions seem to be held ... in a protective way. They're [patients are] really trying to protect themselves. And I don't think sometimes they even realise they're doing it.

Interviewees also discussed the ways in which touch to certain areas of the body can cause this past trauma to manifest itself emotionally. Terming this the “psychological treatment reaction” and the “body manifestations of psychological issues”, Jordan emphasised the importance of manual therapists knowing which areas of the body most often ‘hold trauma’, so as to avoid re-traumatising the patient:

And then you go and poke their psoas and it all comes out, that they've not actually gone and addressed any of it [the trauma]. ... So, knowing about which parts of the body will tend to respond to psychological trauma [is important].

Ryley maintained that the touching of bodily areas that had been involved in sexual violence could create a crisis for patients, causing them to dissociate from those parts of the body during osteopathic treatment and “triggering memories and issues that could really send them into a downward spiral”. Reflecting on what dissociation might feel like for her patients, she stated: “It's not a part of me. I'll put it aside over here, so I don't have to deal with it”. Eden also expressed a view on the mind-body connection in relation to past sexual trauma and the implications this had for patients receiving touch therapy:

There's physical trauma that's obviously gone on through there, and I think once you've had that area violated there's a protection mechanism that kicks

in. You don't want people touching that area. You want to try and have some control back.

In terms of specific bodily areas, the respondents indicated that the neck, throat, lower back, sacrum, pelvis and pelvic muscles, especially the iliacus and psoas muscles, were implicated more often in cases of sexual trauma:

And by treating their psoas, you'll likely (to) bring up a lot of the abuse, or at least memory and psychological reactions that they had 30 years ago. (Jordan)

So pelvic floor, around there's (there are) all these muscles. They would just really hold on. (Ryley)

Quite often they [sexual violence victims] all have chronic lower back pain [and] pelvic pain. There's a lot of stuff that gets held in that area. ... If I'm doing iliacus or psoas or something like that, which is a pretty sensitive area anyway, but that's generally the area where [emotional trauma] will come out. ... The sacrum holds a lot of stuff too. ... Sometimes also [sexual trauma is held] up around the throat. So, if I'm doing any anterior neck work, I always check in with them first. (Eden)

I performed a technique on her [the patient] around the front of the neck, into the clavicle [and] anterior ribs, and she got very distressed. (Hayden)

Moreover, Jordan and Ryley displayed knowledge that sexual trauma could affect, not only the injured areas, but the entire body through its detrimental impacts on the autonomic nervous system. Ryley, in particular, emphasised the heightened sympathetic response of the autonomic nervous system to such trauma. Overall, the research participants agreed that the connection between mind and body entails the osteopath in taking special care when treating the body, and particular bodily regions as identified above, because of the possibility of an emotional response from patients who have been sexually traumatised. Hayden narrated the experience of one such clinical episode as a recently graduated osteopath. While treating a patient's neck and clavicle (collar) bones, the patient became "very distressed" and then disclosed that she had been partially strangled during an attack. Eden described an occasion when her application of a particular treatment technique resulted in the patient suddenly becoming rigid and fearful, which she understood to be a possible sign of disassociation connected to the triggering of past

trauma. She also recounted a story regarding a patient who began to “silently weep” as she worked on their iliacus muscle. Eden considered herself to have “dropped the ball” in this case because she was not paying enough close attention to, and had not provided an adequate explanation about, treatment of this bodily area that is known to be associated with the ‘holding of sexual trauma’. In this regard, Ryley commented: “I’ve always had patients that cry or patients that tell me a lot of stuff, so I’ve always had to deal with emotional patients”. She described one such incident while treating a patient’s coccyx (tailbone), while the patient was lying on her side. The patient quickly became upset and disclosed that she had been sexually abused as a child, the side-lying position having reminded her of the experience. Ryley expressed an intention to further her education regarding this phenomenon so as to “understand why these people are holding emotions or why they’re triggered to express them”.

Clinical Relevance

The first two sections of Chapter 4 have featured the themes of the illness experience and the mind-body connection in relation to sexually traumatised patients. This third section in the chapter’s analysis encompasses a theme related to the clinical relevance of a history of sexual violence for a patient’s current presentation, treatment and management in osteopathic practice. This theme emerged early on in the research as participants described their responses to, and decision-making processes about, patient disclosures of sexual violence. Through these descriptions, and as discussed in the previous two sections, they understood clearly that sexual trauma can contribute to the illness experience and the mind-body link. Analysis found that the respondents rely upon two measures to ascertain how much and in what ways trauma is influencing the patient’s current health issues, specifically the duration of time that has passed since the occurrence of the abuse and the person’s location on the recovery journey. These two approaches assist the osteopathic practitioners to decide whether the disclosure of sexual violence is ‘therapeutically relevant’ in terms of the management and treatment of the patient’s current presentation, or if they can simply acknowledge the abuse and move on. In relation to time elapsed since the abuse, most interviewees professed to the assumption that more recent episodes of sexual violence are more clinically important, while ‘historical’ episodes are less relevant. For example, Jordan remarked:

There might be situations where once they disclose that, we acknowledge it, but its 20, 30 years ago. It has practically no bearing on what they [have] come to see me for.

Regarding recovery status, participants attempted to determine whether patients had addressed the past trauma and if they had, tended to consider it as having almost no bearing on the management of current symptoms. Jordan described his consideration thus:

Put it aside, 'cause it's not relevant, at least clinically with what they're coming [to see me for] today ... they seemed quite happy with that being in the past and it being over. ... They seemed to have, at least psychologically, closed that chapter. ... And whatever sexual abuse they had, occurred 30 years ago and has absolutely no relevance on who they are as a person now, because they have got full closure.

However, this situation is made more complex by the fact that some of the interviewees demonstrated a keen awareness that the experience of sexual violence, historical or recent, might have significant clinical relevance for pain presentation. In this regard, Hayden emphasised that “chronic pain has a psychological profile” and that, in some cases, this needs to be addressed so that the patient can regain health. He indicated that this might be as simple as the osteopath drawing the patient’s attention to the link between emotions and pain, or it might mean referral to a mental health expert such as a counsellor or psychologist. Eden shared her knowledge that trauma, sexual or otherwise, can be part of the patient’s clinical picture:

Well, I definitely wouldn't [ask about trauma] if somebody came in and said, "Hey, I was lifting that heavy box and my back's hurt". I'd be thinking, hey well, there's a really clear mechanical issue going on there. [But] if its chronic long-term pain [and] no one can put their finger on it, then I'm starting to think what else is going on there? What's the bigger picture? Who's the human behind that? What's their story?

Jordan also illustrated this approach. He noted that he might choose to respond differently to two patients who both arrive for treatment with similar calf muscle strains if he knows that one has a history of sexual violence, because ‘the psychological aspect might be affecting the physical healing’: “The actual treatment of the calf [muscle] will be the same, but the treatment of the person will be different”. Overall, the respondents’ approach to the clinical relevance of sexual trauma can be viewed as a balancing act between ascertaining an adequate amount of information for appropriate clinical management, including the expression of understanding

and the possibility of further referral, but not overstepping this line to go beyond the scope of osteopathic practice.

Chapter 4, the first findings chapter of the thesis, has analysed the participants' understanding of the patient experience of sexual violence in osteopathic practice through the delineation of three related themes, the illness experience of sexual violence, the mind-body connection in relation to sexual violence, and the clinical relevance of sexual trauma. Additional aspects regarding these topics will be further elaborated in Chapter 5 where the thematic analysis continues, this time in relation to the role of osteopathy in patient recovery from sexual violence.

Chapter 5: The Role of Osteopathy in Recovery from Sexual Violence

The previous chapter presented analysis of three themes that were associated through their focus on the patient experience of sexual violence in osteopathic practice. Chapter 5 will continue the analysis, this time presenting three themes that incorporate the role of osteopathy in relation to patient recovery from sexual violence. These themes, presented in three separate sections, are the osteopathic scope of practice in cases of sexual trauma, the therapeutic response to victims of sexual violence, and the dynamics of power in the therapeutic relationship with patients who have experienced sexual violence.

Scope of Practice

This first section focuses on the theme of the osteopathic scope of practice in cases of sexual trauma. The research participants demonstrated an astute awareness in this regard, naming four specific components that they considered relevant. These components constitute those aspects that fit within the scope of osteopathic practice, those elements that do not, the ways in which osteopaths manage referral when they judge that a patient is in need of assistance that they are unable to deliver, and the level of confidence they experience regarding the treatment of these patients. As discussed in the previous chapter, the interviewees understood that in some instances sexual trauma has specific clinical relevance to treatment and patient well-being, particularly in cases of chronic pain or when working with certain sensitive areas of the body. In these cases, a history of sexual violence was judged to be within the scope of osteopathic practice. In other cases, where patients displayed symptoms of psychological distress, participants were keenly aware that treatment was outside their scope of practice. However, the data revealed that this is a complex area where the boundaries regarding scope of osteopathic practice are not always clear cut. The following subsections will attempt to tease out some of this complexity.

Within the Scope of Osteopathic Practice

For the respondents, it seemed that the safety of and support for patients who disclosed sexual violence was well within the scope of osteopathic practice, even if not within the realm of actual treatment. From their perspective, disclosures of many sorts may be forthcoming as trust builds within the therapeutic relationship between the healthcare practitioner and the patient. Interviewees recognised the importance of developing additional skills, beyond osteopathic techniques, so as to respond appropriately to disclosures and thus promote the health and well-

being of patients who had experienced sexual violence. For example, Ryley emphasised that, while it is not the job of the osteopath to treat psychological symptoms, an adequate response to patient disclosures may be important for their recovery process:

I suppose the biggest thing is that it's not your problem [within osteopathic scope of practice], but you need to acknowledge it because it's a big deal for them.

Meanwhile, Kingsley commented: “If part of their treatment is to let you know their experience ... I think as a practitioner, we should be able to sit there and be non-judgemental and take that on and treat appropriately”. Here is Eden, specifically commenting on the osteopath’s responsibility to ensure safety and support in the face of patient disclosure of sexual trauma:

Cause you're leaving them vulnerable and you're sending them out the door. And you haven't given them options to support them. ... It's like you've picked a scab, and you've let them walk out bleeding. And you haven't offered them a plaster. I think that's what I mean by unsafe, that you've left somebody in a really vulnerable state and you haven't followed up, where you've missed the boat entirely. You haven't even seen it. You didn't even know what was happening and off they go.

Eden took the requirement for patient safety and support even further. She expressed a passionate view that, given the prevalence of sexual violence in New Zealand, osteopaths must be able to manage disclosure adequately, indeed that a lack of understanding in this field contributes to unsafe practice. By way of illustration and as discussed in the previous chapter, Eden noted that sexual trauma might be inadvertently triggered by treatment on the psoas muscle, pelvis or viscera of the body, and that without awareness of this there is the potential to “open a can of worms emotionally for the patient” that leaves them in a vulnerable state. Jordan also drew attention to the sexual violence statistics in New Zealand, concluding that up to 70% of his patients may have been victims of sexual violence: “So I'd say, we need to be a whole lot more aware of how to pick it [sexual trauma] up, aware of how to explore it [and] how to respond to it if it does become shared”. Kingsley simply stated: “People are going to tell you stuff and you gotta be prepared to deal with it”. On the topic of safety and support as well, Ryley emphasised the importance of knowing about sexual violence:

You should be in the position to understand and support your patients [who have experienced sexual violence]. I think it would also make us [osteopaths] safer.

The research participants demonstrated a keen understanding that the holistic philosophy central to osteopathy encompasses a person-centred approach within a biopsychosocial model of healthcare. Some respondents used the analogy of ‘the patient versus the person’, explaining that treating ‘just the patient’ was unlikely to be enough to promote recovery because the psychological symptoms associated with trauma can have an impact on physical symptoms, as discussed in the theme regarding the mind-body connection in Chapter 4. For example, Eden commented:

So, remembering that they’re a whole person. They’re not just their injury or their presentation. They are a much more complete package than that, and to not lose sight of that.

Jordan maintained that in some cases he must “deal with the person before I actually address the patient’s needs”. The patient is an actual “live person” with “a complex history of experience”, including a possible history of sexual abuse that may be impeding their healing. Hayden also highlighted his understanding that osteopathy is based on a holistic philosophy that goes beyond manual therapy:

Osteopathically, as a practitioner, jiggling and wiggling joints, whether that's structurally or cranially, is a strong component of what we do. But often osteopathy is much more than just a physical technique, that osteopathy is actually about health and wellness. So, my understanding would be that, as an osteopath, there's a much wider and broader perspective on patients.

Beyond the Scope of Osteopathic Practice

While the interviewees identified patient safety and support as within their professional realm, they were keenly aware that specific treatment in relation to the emotional and psychological manifestations of sexual trauma was beyond their scope of practice:

If it looks like the conversation is moving from the disclosure to that of dealing with it, then at that point, I have to stop because I'm not trained for that, and

the amount of damage that I could do as a result is at least as bad as the original abuse. (Jordan)

I am very aware that I haven't had psychological training ... because my realm of practice does not go into there. (Ryley)

So, I am mindful that I'm not a psychologist. I'm not a psychiatrist. I don't have that skill set. (Eden)

I'm not a counsellor. I'm not a psychotherapist. (Hayden)

If I think I'm out of my depth, then I'm gonna suggest that they go talk to somebody about it. I'm not a therapist in that regard. I'm quite happy to talk to people if they wanna talk to me but that's just my sort of life experience and my opinion. But I don't know how to deal with sexual trauma, so I'd rather they spoke to somebody who was trained in that sort of field. (Kingsley)

These excerpts illustrate the participants' understanding of the dangers of straying into the psychological domain. Each was ardent in the belief that mental health professionals, and not osteopaths, should manage psychological ill health as they have the training to address the complications that may arise. Jordan noted that it would be 'easy' for an osteopath to further damage a patient's psychological health by viewing counselling in simplistic terms:

It can be very easy to think that counselling is simple, and that anybody who's been trained as a health professional can do counselling because you 'just have to listen'. But I know just enough to know that I know nothing about any kind of psychological intervention.

Moreover, Eden maintained that delving into areas of psychology that are beyond the osteopath's scope of practice can lead to practitioner burnout, an important topic that will be addressed in Chapter 6:

When I've seen it in other [manual] therapists, I've seen it where they've got lost in that journey of that person, and they've just ended up investing a lot of time and energy into doing something that is not their place. Well, it's not their scope, and it's not their place to be a counsellor to them. They don't have to do all of that stuff for that person. There are other people out there who are more skilled

at that. Yeah, I've seen people get lost in that, and I think that would burn you out, too. It would drain you.

Relatedly, the respondents knew that placing too much attention on a history of sexual violence carries the potential to re-traumatise a patient. On this theme, Kingsley commented: “I don’t try and pry stuff out of them that they’re not willing to disclose”. Ryley reflected: “Given the lack of any direct link to their presenting pain, I didn’t wanna go digging any further at that point. ... I don’t think it’s fair to stir up these memories and not have adequate support for these people”. Meanwhile, quoting Alice Miller’s concept regarding “traumatising a trauma” (Miller, 2006), Hayden asserted:

You end up, in a well-meaning way, opening up Pandora’s box and then it's all out there and you just don't have the capacity to deal with that trauma.

Referral

The interviewees, while understanding that psychological treatment was beyond their scope of practice, considered referral to appropriate services to be an important aspect of their professional role for those patients with a history of sexual trauma:

But I think as an osteopath, we're not trained [as counsellors and psychologists]. We don't have the competencies or the certification to actually be playing with people's histories and past emotional trauma. So, in a lot of respects we're much safer to actually refer them on to somebody that can actually work that through [with the patient]. (Hayden)

So that means that if somebody is talking about sexual trauma, for example, and they have just finished explaining what happened, then other than acknowledging it or asking further questions as relevant to the clinical case or the care of that patient, we have no business saying anything else and we certainly have no business advising them on what they should be doing, outside of referring [them for appropriate help]. (Jordan)

Indeed, the participants were unanimous in considering it their professional responsibility to be proactive regarding referral when a patient discloses specific experience of sexual violence or displays continued emotional distress due to past sexual trauma:

But I always make sure they have talked to their doctor perhaps, and asked if they have somebody else [they] might want to talk to. (Kingsley)

So, if a patient acknowledges a history of trauma, I might ask them whether they've received any kind of treatment for that and if they tell you they haven't, I would probably even most likely say that it would be a good idea for them to seek that kind of care. (Jordan)

Here is Hayden suggesting the actual words that might be used when a patient discloses an experience of sexual violence during an osteopathic consultation:

I'm your manual therapist. I am sincerely sorry that you've been through what you've been through. I can't help you with that. I can help you with your musculoskeletal pain. But the person that will be much better suited to look at that aspect of who you are and where you've been, will be this counsellor or this psychologist.

In terms of specific referral, Ryley and Kingsley offer business cards for local counsellors and therapists, while Eden is part of a professional network to which she directly refers patients. She situates their business cards in a visible location so that patients can access them without her suggestion. Furthermore, two respondents, Eden and Kingsley, were conscious that some patients are unable to finance professional counselling and psychotherapy. In such cases, they refer patients to their general practitioners for assistance in accessing public funding for mental health services. Eden also refers patients to a local not-for-profit organisation, which offers services based on income level. She also demonstrates proactivity in advising patients and pointing the way towards tools, resources and options, including computer applications (Apps) such as Headspace and Budhify that are designed to improve mental health via mindfulness and meditation practices: "So that they (the patients) don't feel isolated. ... There's always help out there if you need it".

Confidence

During the early days of their careers, the osteopath interviewees professed to an initial lack of confidence and sense of 'being unprepared' during encounters with patients who disclosed sexual violence. Ryley maintained: "I was probably not overly confident in some ways". Hayden emphasised that he experienced being "utterly, utterly out of my depth, utterly", adding that "he made it [the encounter] all about himself" and "became a complete narcissist".

Kingsley noted that he did not experience disclosure of sexual abuse until later in his career but on reflection, he chuckled and said: “As a student I probably would have panicked ... that’s more than I want to know.” Significantly, the participants did not recall having ever been formally taught about sexual trauma in clinical practice classes or been prepared for the likelihood that they might need to deal with disclosures of sexual violence during osteopathic consultations and treatments:

I feel like my training didn’t really ... we didn’t really talk about sexual abuse and the fact of, you’re going to be dealing with people that have PTSD or ongoing emotional and psychological scars from life. (Ryley)

Clinical exposure and experience seem to have been the respondents’ greatest teachers in this regard. Kingsley put it like this: “Oh, just over time, you get a bit more confident about how you deal with stuff”. Most interviewees also indicated that they had educated themselves informally, by reading literature regarding sexual violence or discussing the matter with other healthcare practitioners. Hayden noted that it had “been a very fluid evolution of getting an understanding and knowledge of this material really”.

The Therapeutic Response

The second section of the chapter is centred upon a theme that encompasses the osteopath’s therapeutic response in cases of sexual violence. Sitting alongside the previous theme regarding the osteopathic scope of practice, a focus on the therapeutic response emerged throughout the interviews, both in the osteopaths’ stories regarding the experience of listening to disclosures of sexual abuse, and also in response to direct questions regarding the skills that they employed in these situations. As discussed in earlier sections, the participants recognised the unique situation of intimacy that emerges when working with, and touching, a person’s body during osteopathic examination and treatment, and the potential of this to elicit disclosure regarding past abuse and/or to produce an emotional release associated with the trauma. During their careers, all the respondents had encountered patients who had disclosed some type of sexual violence episode, and three had also experienced cases where they suspected a history of sexual trauma that was not explicitly disclosed by the patient. Here is Hayden reflecting on the privilege, but also the responsibility, that such knowledge carries:

My first line of thought would be basically, if somebody is disclosing that, sometimes you can be the first person they've disclosed it to, which is an immense privilege. It's also an immense burden.

Similarly, the interviewees understood that trust builds in the ongoing therapeutic relationship between the healthcare practitioner and the patient, which may often result in further personal disclosures over time. The following two excerpts from interview transcripts illustrate this phenomenon:

With time comes trust, and patients disclose more about themselves. ... Often what will happen is, the history and the chronology of who they are and where they come from evolves as their trust in you evolves. (Hayden)

We spend half an hour with patients. Other professions spend 10 to 15 minutes. So, you're gonna have people that talk and particularly when you see them, like, every week for two months or every few weeks for six months to a year with ongoing work. And they start talking to you and you start building familiarity. (Ryley)

The participants initially claimed to make no special accommodations in their management and treatment processes when sexual trauma was disclosed. However, on deeper reflection, some respondents did comment on several inter-related elements or skills that they considered key in providing an effective therapeutic response to patients who have experienced sexual violence.

Establishing a Therapeutic Relationship

Firstly, interviewees highlighted the establishment of a therapeutic relationship as an effective response to patients who have been sexually traumatised. Ryley referred to this therapeutic relationship as “creating a space where patients experience safety and support”, while Hayden was especially persuasive regarding the inter-personal skills that assist in establishing a beneficial therapeutic relationship, and the positive impacts of this relationship on patients’ health outcomes:

Some of the better osteopaths I have come across over the years are the ones that ... their capacity inter-personally has a big role to play in why people get better. So, whether that's placebo or whether that's just the idea of attachment,

that if [there is] a positive attachment to somebody [the practitioner], that positive attachment does have a beneficial knock-on effect into (the patient's) emotional state and physical state.

Hayden understood the inter-personal skills required to establish a therapeutic relationship as 'empathy, respect, kindness and treating patients as we would want to be treated'. Eden maintained that being "fully present" and "genuinely caring" are essential in building rapport and supporting survivors of sexual abuse. Two participants particularly highlighted empathy as a core inter-personal element in building rapport, working therapeutically and therefore promoting the well-being of patients, especially in cases of trauma:

Then we need to tell them, make the patient aware that we have the empathy. ... It also requires an open mind that something might have happened that has completely turned their world upside down, and acknowledging that that has happened, and acknowledging that their world may still be upside down and having empathy for that even if you've never had your world turned upside down before. (Jordan)

So, for me, empathy is very much tied in with professionalism and therapeutic effectiveness. They go to you, they feel safe. They go to you, they feel heard. They go to you, they feel respected. ... And it picks up their spirits. And so, essentially, there's that interplay between humanity, professionalism, inter-personal skills and empathy. (Hayden)

The respondents identified two further elements, the ability to listen and an adequate timeframe, as essential in developing a therapeutic relationship with those who have experienced sexual violence. Kingsley noted that, "it is about having an ear", that patients are often not seeking an answer but "just want to be listened to". He illustrated this belief with a story about an older patient who described her sex life frustrations during osteopathic treatment. Kingsley listened without judgement and at the end of the consultation, the patient thanked him for 'just listening to her'. Meanwhile, Eden described the value of the "talking aspect" at the beginning of an osteopathic consultation, the importance of 'taking time', 'not rushing the process of taking a patient history' and 'really listening', what might be called active listening, when the patient tells a story as part of that history:

My experience is that a lot of people don't get listened to. And so, when they finally have the opportunity to sit down, it's really relieving for them and they feel validated and heard. And that's so important.

Acknowledging Disclosure

The interviewees in this study identified an adequate acknowledgement of disclosure as a second important element in providing an effective therapeutic response to patients who have experienced sexual violence:

So, there's acknowledging that it's [sexual violence has] happened and accepting that. But then it's also trying to ... making a conscious effort to show the person who's shared that information that they're not being judged for it. And so, accepting them. ... Accepting that they're no different now that they've told you that than they were before they did. (Jordan)

I think it's important to acknowledge them and where they've been and where they come from and what they've endured, and not in a way that's like "poor you". But you're here and you're the sum of your experiences. ... There's nothing wrong with you. (Ryley)

As these interview excerpts demonstrate, the participants identified acceptance, non-judgement and the communication of belief as essential factors in acknowledging disclosure of sexual abuse. Ryley stressed the significance of responding to disclosure in such a manner that the patient would be encouraged to begin or continue a journey of recovery: "Acknowledged in the right way so that they keep going, as opposed to shut down again". In a similar vein, Eden noted the importance of refraining from displaying shock, of "not freaking out if someone talks about it [sexual violence]" and thus maintaining a professional attitude. In addition, the respondents emphasised the significance of believing a patient's disclosure of sexual violence, as exemplified in this extract from the interview with Jordan:

I think one of the things that Western culture is particularly bad at is just taking somebody's word for it, when it comes to any kind of verbal abuse or sexual abuse or anything like that. ... And so, [we] try and make a big point of accepting it and behaving as though we accept it as well.

Moreover, the interviewees underlined the importance of refraining from asking for further information when accepting a disclosure of sexual abuse, so as to avoid a patient experiencing pressure or coercion. Kingsley referred to this as ‘not pushing’:

So, again, I don't try and push anything, particularly (during) the first visit. They'll tell me what they wanna tell me. ... We talk about it and we talk about it sensibly and quietly.

Touch

The participants in this inquiry considered consciousness of touch to be a third important aspect of a successful therapeutic response to patients who have experienced sexual violence. As mentioned in previous sections of these findings chapters and as Kingsley clearly states below, touch is an integral aspect of osteopathic consultation:

We're in a very unique situation where we're quite intimate with people. We're touching people all day and we've gotta bear in mind how they feel about being touched. We're used to doing it. We're used to doing what we do but we don't know how they feel about us doing what we're doing.

Jordan commented on the way in which a patient history of sexual trauma has a particular relevance for osteopathic touch:

And it's also relevant because we [osteopaths] touch people. And a lot of the time, sexual abuse involves touch and the breaking of consensual barriers for physical touch. And that needs to be acknowledged and dealt with quite carefully.

Most respondents initially claimed to make no distinction between victims of sexual violence and other patients when using touch during osteopathic examination and treatment. However, they then went on to describe various modifications that they may make for patients who they know or suspect to have been sexually traumatised. These modifications include being more ‘thorough’ in terms of communication and consent, beginning treatments with a lighter touch, initiating touch with one hand only and then verbally checking in with the patient, slowing touch down, checking in more frequently regarding the pressure of their touch, and keeping touch to a minimum. Here is an illustrative passage from the interview with Jordan, whereby

he explains the way in which he maintains awareness of ‘conscious and non-conscious touch’ and also clearly communicates his osteopathic treatment to the patient:

So generally speaking, I try and make sure that whenever I touch somebody, that they know very clearly what I'm going to be touching and why. They also know how, whether I'm using my hands, my fingers, my elbow, my forearms, etcetera. And then I try and make sure that I keep non-conscious touch to a minimum. So non-conscious touch is ... it's the classic, you're treating ... you're doing lumbar soft tissue with one hand to stabilise their hip, and they ask you a question, you stop treating, but the hand on the hip stays there.

Some interviewees indicated that they do not ask those who they know to have been sexually violated to undress, but rather work their osteopathic treatments through the patient’s clothes where possible. Ryley referred to this as ‘giving more space to the patient’. Moreover, in comparison to her normal stance of working close to the osteopathic plinth, Ryley tends to allow more physical space between herself and these patients.

Being Present to Body Language and Non-verbal Cues

As a fourth component of their therapeutic care of patients who have experienced sexual violence, the participants understood the importance of paying close attention to body language and non-verbal cues, such as facial expressions, during osteopathic examination and treatment:

The hidden cues of the body, not just the words spoken or actions give. (Ryley)

And so obviously, the explanation, the getting their consent, the reading body language. The patient might say yes, and their entire body is screaming no. (Jordan)

Eden described the way in which patients who have been sexually traumatised often experience disassociation or a freezing response to touch, ‘locking-down’ and ‘disappearing’ during osteopathic treatment even though the informed consent process has been properly undertaken. Understanding this to be a trauma response, “because that’s how they’ve had to cope when they were being assaulted”, she ceases treatment and renegotiates consent. Jordan noted that he treats these patients in a supine (face up) position so that he can see their facial expressions. In the interview extract below, Jordan uses the term ‘hand’ because palpation through the hands is an essential aspect of the way in which osteopaths assess the patient’s body:

I generally tend not to treat people prone [face down] regardless, because they can't see me. And more importantly, I can't see them. I rely a lot on non-verbal language and facial expressions, so it's like cutting off half my hand if I can't see their face.

Assisting the Patient to Make the Mind-Body Connection

Respondents highlighted education about the mind-body connection, as first discussed in Chapter 4, as a fifth feature of conveying an effective therapeutic response to, and assisting in the healing of, patients who have experienced sexual violence. In this regard, Hayden narrated the story of a patient whose physical health was, in his opinion, negatively impacted by anxiety associated with historical abuse. During the third appointment, he suggested this possible mind-body link. The patient initially rejected the idea but later, on reflection, came to realise that there was a significant connection between her past trauma and current health conditions. Over several treatments thereafter, Hayden and the patient discussed this mind-body relationship, which aided her healing process and her ability to make healthy life changes.

Similarly, Eden maintained that explanations to patients about the normality of the connection between emotional or sexual trauma and chronic pain or ill health can reassure patients and allow them to find some relief: “And that will be enough to get their brain ticking over”. She also provided an illustration of the way in which her ability to listen and establish a mind-body connection had assisted a patient in their healing journey:

I had a woman come in who had been to a whole lot of different [manual] therapists and she booked in with me. And I actually had a phone call ... from another therapist in the community saying, "Don't treat her. She gets treatment and then she refuses to pay and complains about you and la la la". ... This was the pattern that was happening. So, I saw her, 'cause I thought, "Well I don't know her, so I'm gonna go in with fresh eyes". And she [the patient] was pretty abrupt. She was wanting pain. ... She wanted intense, heavy treatments. And she said, "Yeah, I don't like this fluffy stuff ". And my hackles went up immediately and I thought, I'm uncomfortable treating her. I feel like this is abuse. I feel like she's asking for me to abuse her. And I know that sounds extreme, but I got that real sense that it didn't feel right. And so, I actually stopped. I stopped treating her and I said, "Do you know what? I just don't think this is right for you at the moment" and we sat down and had a chat. "What's

going on? What's this about? 'Cause I feel like you're wanting me to be really intense treating you. And I'm not comfortable doing it 'cause I'm gonna hurt you. ... And she just broke down and ended up telling me her story and I was, "Okay, so here's what we can do". ... I have a really good network of people that I can refer (you) to. ... So, I didn't charge her for that treatment. She left. She went and sought the appropriate help that she needed. And she emailed me about two weeks later and said, "Thanks. No one had ever stopped and listened and broken that cycle". She was rolling around trying lots and lots of different therapists. Everyone was getting pissed off with her and kicking her out the door and hating her. But she was hurting.

Encouraging Resilience

Honestly, some of the stuff that those women went through was horrific. And it would be very easy to just give up. Yeah. But they don't. That's their resilience. And I think that's their survival instinct. And I want to support them in that journey rather than bring them back to a place of pain. (Eden)

This extract from an interview with Eden illustrates a sixth factor, the promotion of resilience, which the interviewees considered important for the development of a beneficial therapeutic relationship in cases of sexual trauma. They professed to employ several methods to encourage resilience, including acknowledging past experiences of sexual violence while simultaneously recognising that patients have resilience and are capable of facilitating their own healing with help, as well as focusing on positive aspects of patients' lives and emphasising their futures:

But that survival instinct, and that moving forward and focusing on the future, is such an important part of them getting on with life, that I don't wanna drag them back down. ... They're already survivors. They're already capable of extraordinary things, but sometimes they just need a bit of a help on the way. ... So, acknowledge it [the trauma]. Don't ignore it. But focus on the future. (Eden)

Ryley specifically described the way in which she directs the patient's attention towards the future and the positive elements in their lives to help "shake patients out of negative thought patterns" associated with historical trauma. Most of the participant osteopaths also pinpointed the use of humour in this regard. In Ryley's words: "And we have a good laugh. So, we use a lot of humour and that seems to help a lot [in encouraging resilience in patients]".

Power in the Therapeutic Relationship

The chapter's first section was concerned with the theme of the osteopathic scope of practice in cases of sexual trauma, while the second section encompassed the theme of the osteopath's therapeutic response in such cases. This third and last section of Chapter 5 concentrates on the theme of power in the therapeutic relationship between osteopath and patient because, as discussed in Chapter 2, power imbalance is a central concern in the field of sexual violence.

Power Imbalance and Victims of Sexual Violence

Analysis of the interview transcripts found four respondents who viewed the dynamics of power, especially loss of power and power imbalance, as significant factors when treating patients with a history of sexual trauma. The following two excerpts exemplify this understanding, including the phenomenon that perpetrators of childhood sexual abuse have often been authority figures holding socially sanctioned positions of power:

Specifically, with patients that have had a history of sexual abuse, more often than not, it's power that's been taken away from them. (Jordan)

The biggest thing with any sort of abuse is that you lose the sense of control and power ... particularly because in a lot of those situations, it was a person in authority that inflicted the pain and abuse. (Ryley)

As certified 'white coat' authorities in the field of healthcare, the interviewees understood the potential for sexually abused patients to re-experience a sense of disempowerment and a loss of autonomy in the osteopathic clinical setting. In the extended interview extract below, Jordan eloquently expresses this dilemma whereby the 'white coat syndrome' and the vulnerability of the patient combine to generate power differentials, and indeed the possibilities of further abuses of power, within the confines of the therapeutic relationship:

We have power. We're wearing the white coats. We're getting paid. We're the ones who've done the studying. Inherently, the second our patient calls us, we have more power. So, one of the most obvious examples of it was the fact that we have somebody coming to us who is in pain, and who seeks advice and help and pain relief. By the very fact that they've come seeking that, and that we are the people who have done the studying, who hold the knowledge, we have more power over them. And so if we don't acknowledge that, and we abuse that power by not giving them agency over their treatment choices, by not getting

appropriate consent from them when we want to do something because we know better, then we're breaking the trust that they've given to us because they will inherently know, subconsciously or otherwise, that there isn't an exchange of trust and [there is] an imbalance of power. But if we then go and abuse that, then that's where the problems start.

Negotiating Power Imbalance

The participants comprehended the complex nature of negotiating the power imbalance that is inherent in the therapeutic relationship between healthcare practitioners and patients who came with a history of sexual violence. Jordan maintained that such negotiation required open acknowledgement of power disparities and thoughtful management:

Reacting accordingly [to the patient] may be as simple as acknowledging the fact that there is a power imbalance, and not abusing it. And that could be the smallest intervention. Or conversely, it can be acknowledging that there's a power imbalance, and taking active steps to either remove the power imbalance because it is detrimental to either one of the two parties involved or making it very clear where it is and how to circumvent it.

Respondents identified several specific capacities or skills that they use to navigate power imbalances when treating patients who disclose experience of sexual violence. These capacities include maintaining the practitioner's professional role and a transparent process, building the patient's trust, respecting patients, encouraging patient autonomy and empowerment, and ensuring that patients are listened to, feel safe and in control and understand the therapeutic relationship as a mutually inclusive endeavour. As Eden noted:

I just really stress that they are safe in this environment. Nothing's gonna happen to them that they don't want. And I think that is a huge part of building trust with them as well.

In terms of maintaining a professional role and linked to the previous discussion regarding the way in which perpetrators of sexual violence have frequently been people in authority who have abused their position of power, Hayden commented: "Abusers are manipulative and controlling and play power games, so you [the healthcare practitioner] instead are clear, out in the open, clinical and professional". Ryley explained the way in which she uses rapport and

practitioner transparency as a means of reconciling power disparities in the therapeutic relationship:

It [the sexual violence] was [perpetrated by] someone in a trusted position. And I think it comes into the trying to build rapport because you want them to trust you. But then they've [the victims have] been let down and really hurt so badly by someone they trust. So, it's really important to go slowly and be transparent, be really open.

Hayden recognised that patients carrying sexual trauma may be “in a vulnerable place” and actively promotes their autonomy by assisting them to “feel safe and heard and respected”. Further interview extracts follow, which illustrate the interviewees’ understanding of their professional role in negotiating power imbalances through the promotion of patient autonomy and empowerment, and the establishment of a mutuality of purpose between practitioner and patient:

So, what I would do at the very beginning [of the consultation] is just make sure that they [patients] feel completely in control of the situation because I know that they have had that taken away from them in the past. (Eden)

So, I look at my therapeutic relationship with my patients as a mutual relationship. Well, not mutual but I am a facilitator to help them get better, as opposed to I am better and know more than them. I do, but my job is to help them to help themselves as opposed to telling them what to do. (Ryley)

Jordan and Ryley made a significant distinction between retaining an awareness of the power disparities between healthcare practitioners and their patients, while also behaving in such a manner that patients who have experienced sexual violence are encouraged to maintain their autonomy. In this regard, Ryley makes every effort to ‘give the power back’ to the patient: “So you are trying to encourage them to take ownership of themselves and their voice”. Jordan described a similar approach, along with the importance of clear communication:

{It is} even more important to make clear that we're giving them power and we're not taking it away. So, there's two things. There's not taking power away from them, and then making it clear to them that we're not taking power away from them. And whilst the first one might be enough for the vast majority of

patients, it's not enough for them [sexual violence survivors]. You have to do both.

The Role of Consent in Navigating Power

The research participants highlighted the informed consent process as an effective means of navigating the complexities of power in the therapeutic relationship. While advocating a thorough process of informed consent with all patients, they emphasised its particular importance in countering the possibility of patient disempowerment in cases where sexual trauma is a factor. Ryley, understanding that sexual violence can have a silencing effect on victims, underlined the challenging nature of managing this consent process: “Cause they [patients who have been sexually violated] often struggle to verbalise and they don't like confrontation”. The osteopaths' methodical approach to gaining consent from sexually abused patients includes clear and repetitive communication, more frequent requests for consent during treatment, more regular checks for patient understanding, and more ready offering of alternative techniques. For example, Kingsley commented: “You might make a bit more of an effort to make sure what you're saying is understood ... just explain things a little bit more”. Meanwhile, Ryley expressed the importance of allowing patients to say no to treatments: “So with that, there is explaining more ... you give them more room for autonomy, [for] saying no”.

Furthermore, where sexual trauma is a consideration and as discussed in the section on the mind-body connection in Chapter 4, respondents described the ways in which they are particularly vigilant in gaining informed consent to treat the bodily areas, such as the pelvis and psoas muscles, that are likely to produce an emotional response. Eden explained the care she takes in gaining fully informed consent when working on such sensitive areas:

I explain very carefully what I am gonna treat, how I'm gonna treat it. ... I will show them on the skeleton the area that I'm gonna work on. I will show them on the muscle chart on the wall what I'm gonna work on. So, they fully understand what I'm gonna do before I do it.

Similarly, Hayden described the way in which he carefully explains his actions during osteopathic treatment and what the patient might experience as a result: “A lot of it's about establishing clear boundaries and clear descriptors”. He also makes a point of suggesting to patients that they ask a trusted person to accompany them to the consultation when treatment

on sensitive areas of their bodies is required. Jordan gains informed consent in cases of sexual trauma by discussing with the patient beforehand the potential for sensitive areas of the body to hold emotion: “Because if you're going to treat an area, and you're going to cause a psychological treatment reaction, the patient needs to know about that”. He went on to declare that working on these sensitive areas without discussing the possibility of a psychological reaction is tantamount to a failed informed consent process: “That's not informed consent. That's lack of consent”. Eden described having learnt this salutary lesson early on in her career as an osteopath:

I think when I first started treating, when I was working on, I think it was the iliacus. I didn't pay enough attention when I was pretty new to the game. And somebody just started silently weeping. And I thought, "Shit, I dropped the ball [in terms of informed consent and explanation of treatment]". I just totally didn't explain enough of what might be going on through this area.

This brings us to the end of Chapter 5, the second findings chapter of the thesis, which has presented an analysis of the role of osteopathy in patient recovery from sexual violence through the differentiation of three related themes, the scope of practice in cases of sexual trauma, the therapeutic response to victims of sexual abuse and the dynamics of power in the therapeutic relationship with patients who have experienced sexual violence. Chapter 6, to follow, will conclude the thematic analysis by bringing a focus to the topic of professional resilience in relation to the management and treatment of patients who have been sexually traumatised.

Chapter 6: Professional Resilience in Relation to Sexual Violence

The previous two findings chapters have presented thematic analyses regarding the patient experience of sexual trauma in osteopathic practice and the role of osteopathy in patient recovery from sexual violence. Chapter 6, the final and somewhat shorter analysis chapter, focuses on the theme of the osteopath's professional resilience in relation to patients who have experienced sexual violence. This theme emerged as the research participants reflected upon the relationship between healthcare work and practitioner well-being. It encompasses the concepts of vicarious traumatisation, countertransference, compassion fatigue and burnout, as discussed in Chapter 2. Although the interviewees often used different terminology, they demonstrated a knowledge of these concepts and an awareness that treating trauma patients and hearing about sexual violence can take a toll on their physical and mental health.

Caring Too Much

The respondents in this study maintained that the healthcare field tends to attract those 'who care' and 'who want to help', with implications in terms of placing practitioners at greater risk of vicarious traumatisation, compassion fatigue and burnout. In terms of vicarious traumatisation, Ryley explained that, although osteopaths must always maintain a professional attitude, patient disclosures of sexual violence 'can be upsetting': "You're not an island. ... You can't help but be sad when someone tells you [about experiences of sexual abuse]". Ryley also shared insights into the associated phenomena of compassion fatigue and burnout, especially the challenge of offering compassion while also maintaining self-care:

Everyone becomes a health professional because they sort of want to help people. ... They take on too much of their patient's problems because they really want to help them, with such good intentions. ... It's working out how you can do that [be compassionate] without sacrificing yourself.

Both Ryley and Eden understood that 'caring too much' was problematic. As Ryley put it: "And they [the osteopaths] find it emotionally draining and then that whole idea of going to work is tiring. You're emotionally drained. Life's tiring. It just spirals out of control". Eden echoed this theme:

Generally, anybody in this [healthcare] industry is a caring person anyway, otherwise you wouldn't be doing what you're doing. And so, probably we're all

vulnerable to taking on too much. ... So, you're just giving, giving, giving, giving, and then one day, there's nothing left, nothing left to give people. ... I've seen it. I've seen it a lot. ... People who have started in the industry with the best of intentions, and [then] a lot of people have [burnt out and] just ended up having to walk away.

Strategies to Maintain Resilience

The analysis of data found that the research participants had a good knowledge of, and employed, several strategies to sustain resilience in the face of patients' sexual trauma. One practical strategy involves the maintenance of good boundaries regarding patient numbers and working hours. For example, Eden held a strong opinion regarding the ethics of osteopaths working 12-hour days and treating more than 12 to 14 patients a day: "I don't think it's fair on the patients. I think that [by] the 12th person, you're not looking after [them] as well as you did the first person". A second strategy is focused on the maintenance of professional boundaries in clinical management. In this regard, Hayden underlined the importance of developing skills that enable the osteopath to preserve a professional persona and keep personal disclosures to a minimum:

So often it's about understanding where there's a clear boundary between the professional me, and then the personal human [who would] be intimate with your partner or your best friend. So, it's understanding at what point does [self] disclosure and relating to that patient begin and end.

In the section on the illness experience of sexual violence in Chapter 4, Ryley specifically described the way in which she preserved a professional boundary in relation to a patient who had become over-familiar: "I really had to make sure I had clear [professional] boundaries". She has learnt from that and other clinical experience and is now able to sustain a balance between 'being friendly' and 'being professional': "Be human, be real and forward, but still have boundaries". Eden also explained the way in which she maintains professionalism by simultaneously empathising with patients while also separating herself from their suffering: "You've gotta remember that it's their journey. ... You can't make it about you. It's not about you. It's about them". In Eden's view, this ability to uphold robust professional boundaries while managing complex patient phenomena, including sexual trauma, develops with experience:

Probably just life experience, and exposure to that stuff [in the clinic], and not being overwhelmed by it and not trying to shut it down and not freaking out if someone talks about it or starts crying. Not getting [over] involved in it myself.

As well as upholding professional boundaries, the interviewees professed to employ other means of maintaining their resilience in relation to patient sexual trauma and other challenges. These strategies include formal and informal supervision, peer engagement and mentorship. While the individual osteopaths have particular preferences regarding these activities, the data revealed a consensus that undertakings such as these are vital to safeguard professional resilience. In the words of Hayden:

The minute, as a practitioner, you step away from feeling able to cope ... that's when, as practitioners, we feel isolated and unsupported. So, making sure ... we are supporting the practitioners when they go through those sorts of things.

Kingsley 'counted himself lucky because he tends to be fairly resilient' and is able to "go home and generally turn off" at the end of each work day. However, Ryley, noting that it was patient over-familiarity, as described above, that first prompted her to seek formal supervision, now regularly consults a professional supervisor and is a strong advocate for this service:

I had no idea about professional supervision to be honest, till the counsellor told me. And I have told everyone that I can about it because I think it is so useful and I cannot believe we do not know about it. I think it stops burnout and it helps put [support] stuff in place.

Other respondents in the study also recommended formal supervision, along with peer groups and mentorship, as ways of reflecting on their practice and maintaining professional resilience. Eden had initiated supervision with a psychologist prior to becoming an osteopath and retains this habit: "I really think that's [that formal supervision is] something super valuable [which] they should push more of in our training too". Hayden has sought professional supervision in the past and now maintains connections with local healthcare professionals, seeking advice and peer support from them as needed: "I think even those really simple, informal relationships with other osteopaths, or other health professionals, make a big difference". Jordan is aware of professional supervision services but prefers to engage in "non-official supervision" with colleagues, as well as participate in peer groups with fellow osteopaths. Ryley and Eden are also members of peer support groups, which meet on a regular basis to reflect on professional

practice and discuss current directions in osteopathy. In addition, Ryley receives guidance from an osteopathy mentor. Hayden particularly supports mentorship, offering himself as a mentor to others and recommending that newly registered osteopaths seek supervision within a mentoring relationship:

Develop [mentoring] relationships within the [osteopathy] profession, with people [who] you respect and trust, and [who] you know that you're gonna get sound professional advice from.

Self-care regimes were a further means of maintaining professional resilience amongst some of the research participants. Eden is a particular advocate of self-care techniques, which she described as “filling up that bucket” and which for her include meditation, exercise, eating well and socialising outside the work environment: “Making sure that your life is full, and you're not filling it with (just) your work”. Furthermore, Eden employs certain visualisation and mediation methods to help her maintain resilience for the benefit of her patients and herself.

This brings us to the end of the thematic analysis of the research data, as it has been presented in the last three chapters. Chapter 4 focused on the first three themes that were associated by their focus on the patient experience of sexual violence in osteopathic practice, specifically the illness experience of sexual violence, the mind-body connection in relation to sexual violence, and the clinical relevance of sexual trauma. Chapter 5 continued the analysis by exploring the next three themes that were linked by a focus on the role of osteopathy in relation to patient recovery from sexual violence, specifically the scope of practice in cases of sexual trauma, the therapeutic response to victims of sexual violence, and the dynamics of power in the therapeutic relationship with patients who have experienced sexual abuse. Chapter 6 concentrated on the seventh and final theme identified during analysis of the research data, that of the professional resilience of osteopaths in relation to patients who have experienced sexual violence. The thesis now moves on to Chapter 7, which offers a discussion of the thematic analysis as it has been presented in Chapters 4, 5 and 6.

Chapter 7: Discussion

This research project set out to investigate the current knowledge, skills, attitudes and confidence held by New Zealand registered osteopaths when managing and treating patients who have experienced sexual violence. Literature claims that healthcare practitioners, such as osteopaths, will regularly encounter victims of sexual abuse in clinical settings, either knowingly or otherwise, and therefore have a duty to be adequately educated about the phenomenon and the appropriate care of sexually traumatised patients (Ahrens et al., 2007; Basile & Smith, 2011; Chrisler & Ferguson, 2006; Dolan & Raber, 2017; WHO, 2003, 2013). An important initial finding of this preliminary inquiry supports this claim, with all five respondents having encountered patients who had experienced sexual violence. While the study's lens was originally focused on three particular aspects of the phenomenon, that is, disclosure, referral and therapeutic touch, the thematic analysis of the research data revealed a more complex picture, with seven inter-related themes eventually identified and presented in the previous three findings chapters of the thesis. Chapter 7 will provide a discussion of these findings in relation to the knowledge, skills, attitudes and confidence held by the osteopaths who participated in this inquiry, and in relation to the wider research context of sexual trauma as it was presented in Chapter 2. It will also offer some suggestions and recommendations for improving osteopathic practice based on this discussion.

The Patient and the Experience of Sexual Violence

The study located a reasonable level of knowledge, skill, confidence and positive attitudes regarding the patient experience of sexual violence in osteopathic practice. This topic will be discussed here in terms of the three themes analysed in Chapter 4, the illness experience, the mind-body connection and clinical relevance.

The Illness Experience

The investigation found a good level of knowledge regarding the multiple layers of emotional and psychological distress that are associated with the illness experience of sexual violence. Evidenced in much of the current literature (Feehan et al., 2001; Garcia-Moreno et al., 2015; Nada-Raja & Skegg, 2011; WHO, 2003, 2018), the osteopaths in this study had witnessed and made sense of the complex inter-relationships between the experience of sexual violence, poor mental health and chronic health conditions. As discussed in Chapter 2, research has found that sexual trauma can negatively affect the neurobiology of the brain, causing specific psychological illnesses such as depression, anxiety and PTSD, as well as complex psychiatric

disorders (Afzali et al., 2017; Bacciagaluppi, 2011; Baker et al., 2009; Barbara et al., 2017; Chrisler & Ferguson, 2006; Coughlan & Cannon, 2017; Gillespie et al., 2009; WHO, 2002). This study found a satisfactory comprehension of these disorders as sequelae of sexual violence, especially the conditions of PTSD, depression and psychiatric distress. A large body of literature highlights two other vital aspects of the illness experience of sexual trauma, that of secrecy and suppression (Crisma et al., 2004; Hlavka, 2016; Klein, 2004; Lessing, 2005; McElvaney et al., 2012; Summit, 1983; Sumner et al., 2015; Tener, 2018). Victims are known to feel shame, denial and self-blame, to fear disbelief and maintain secrecy, and to experience repressed memories. This inquiry found a keen appreciation of this phenomenon amongst its respondents.

Furthermore, research maintains that victims of sexual violence engage in high-risk behaviours more frequently than others as a way of coping with the aftermath of trauma (Ashby & Kaul, 2016; Barbara et al., 2017; Basile et al., 2014; Boroughs et al., 2015; Sumner et al., 2015). The findings of this study support these conclusions, with participants noting high-risk behaviours in patients who had a history of sexual violence and specifically commenting on high alcohol consumption and promiscuity. Relatedly, the literature suggests that victims of sexual violence often hold distorted or inadequate relationship boundaries, display transference or dependency behaviours towards healthcare practitioners, and misinterpret therapeutic care as love (Harper & Steadman, 2003; Levenkron & Levenkron, 2007). This project found that patient transference behaviour, relationship boundary violations and the misinterpretation of care as love had all occurred in osteopathic clinical settings. Moreover, participants expressed an initial lack of confidence and skill in responding appropriately to such occurrences. This significant finding suggests that, while osteopaths have some knowledge regarding the illness experiences of sexual violence, they do not graduate with sufficient knowledge, skills and confidence to manage the complex patient behaviours that may be displayed as part of this presentation.

On the whole, the study found favourable attitudes towards patients who had experienced sexual violence, including admiration, compassion and empathy towards victims, and anger towards perpetrators. However, an attitude of victim-blaming, expressed through an emphasis on the 'sick-role', was evident to some extent at least. As discussed in Chapter 2, research shows that blame is a common response to victims of sexual abuse, especially when healthcare practitioners feel helpless or overwhelmed in the face of patient disclosure (Baker et al., 2012; Harber et al., 2015; Hlavka, 2016; Klein, 2004). The literature recommends that healthcare

professionals be educated so as to have in place tools to manage the complex range of responses, both positive and negative, that they may experience when patients disclose sexual trauma (Kennedy et al., 2013; Kennedy & Prock, 2016). The findings of this inquiry suggest that osteopaths would benefit from this type of education to clarify attitudes and responses to patients who have experienced sexual violence.

The Mind-Body Connection

As discussed in Chapter 2, literature highlights two important concepts regarding the mind-body connection or somatic illness, which are both inherent in osteopathic philosophy. The first is the idea that trauma can cause the human body to hold somatic memory and touch can trigger this memory, resulting in an experience of emotional distress and hyperarousal (Rothschild, 2000, 2017; van der Kolk, 1994). The second focuses on the idea that physical ailments can have a psychological base that, at times, must be addressed before a patient can return to full health (Bland, 2010; Broom, 1997, 2007; McCall-Hosenfeld, 2014). The osteopaths in this study appear to employ these concepts skilfully, applying a biopsychosocial model of healthcare and avoiding re-traumatisation of patients through conscious touch of sensitive body areas. This finding suggests that New Zealand osteopaths are well placed to provide trauma-informed care to victims of sexual violence. However, it is evident that this mind-body knowledge and skill base was at times acquired through negative clinical experience, whereby the osteopaths had inadvertently triggered past trauma in patients during treatment or come to the realisation that a patient's physical ailment was connected to emotional distress. This finding indicates that formal osteopathic education may be needed regarding somatic illness and trauma-informed touch, both at trainee and practitioner levels, so as to protect patients from possible experiences of re-traumatisation and promote their understanding of the link between psychological and physiological ill health.

Clinical Relevance

The findings regarding this theme highlight the complexity involved in understanding the clinical relevance of a history of sexual violence for patient treatment and care. Analysis identified two methods to decide clinical relevance, the first focused on assessment of the time that has elapsed since the occurrence of the abuse. However, this may be a deficient measure, as experts indicate that the psychopathological and health consequences of sexual trauma can last a life-time (Ashby & Kaul, 2016; Atwoli et al., 2015; Boroughs et al., 2015; Breslau et al., 2014; Burgess & Holmstrom, 1974; Lessing, 2005). The second method for deciding the

clinical relevance of sexual trauma is to consider the amount of psychological treatment that a patient has undertaken. Some authors argue that this is a better indicator, as psychological treatment is known to greatly assist healing (Campbell et al., 2009; Dolan & Raber, 2017; Herz et al., 2007). However, other researchers maintain that care must be taken in using this as a measure because recovery is understood to be a lengthy, varied and ongoing process that is unique to each individual (Banyard & Williams, 2007; Cohen et al., 2004; Price, 2006). This finding of the inquiry suggests that the formal education of osteopaths in terms of the clinical relevance of sexual trauma, and the complexities involved, requires attention.

The Role of Osteopathy in Recovery from Sexual Violence

Overall, this research project discovered a commendable level of knowledge, skill, confidence and positive attitudes regarding the role of osteopathy in recovery from sexual trauma. The topic will be discussed in terms of the three themes delineated in Chapter 5, scope of practice, the therapeutic response and power in the therapeutic relationship.

Scope of Practice

Literature indicates that the empathetic nature of the therapeutic relationship can prompt patient disclosures of sexual trauma, the response to which requires adequate management and interpersonal skills on the part of the healthcare practitioner (Ahrens et al., 2007; Sher & Sher, 2016). Through clinical experience, the osteopaths who participated in the study had gained a thorough working understanding of this concept, were well aware that specific psychological treatment lay beyond the scope of their practice and demonstrated adequate knowledge about referral. Experts in the field strongly recommend this type of responsible management when patients disclose sexual abuse, including an appropriate response, an awareness of scope of practice, and the offering of tangible aid such as referral to psychological services (Ahrens et al., 2007; Baker et al., 2012; Dolan & Raber, 2017; Lessing, 2005). However, there was also a sense in which the osteopaths regarded themselves inadequately prepared and lacking in confidence to manage patients with a history of sexual violence. This finding is consistent with literature, which notes that most healthcare workers feel ill-equipped to address the needs of those suffering sexual trauma (Brady et al., 1999; Correa et al., 2009). Moreover, this inquiry found that the means of improving osteopathic knowledge, skills, confidence and attitudes in this area was restricted to individual clinical experience, informal education and discussion with peers. This finding highlights the ‘ad-hoc’ and fluid nature of osteopathy education about

sexual violence and suggests that osteopaths be better trained and supervised to manage this important area of healthcare practice.

The Therapeutic Response

Research underlines the particular significance of the therapeutic response in the field of sexual violence and healthcare, recommending a set of standard therapeutic and inter-personal skills for use in clinical interactions with patients who express trauma (Ahrens et al., 2007; Dolan & Raber, 2017; Starzynski et al., 2017; Stiller & Hellmann, 2017). This inquiry shows an adequate level of knowledge and skill in this area, including the expression of empathy, compassion and kindness in response to patient disclosures of sexual abuse. Research also highlights the crucial importance of an attitude of belief and a process whereby patients feel listened to, acknowledged and supported when disclosing sexual trauma (Dolan & Raber, 2017; García-Moreno et al., 2015; Stiller & Hellmann, 2017). Again, this investigation found a high level of understanding and skill regarding these elements. Likewise, and consistent with expert recommendations (McElvaney et al., 2012), attempts to normalise the experience of trauma and allow patients to disclose abuse at their own pace, without pressure or coercion, was evident. The literature further emphasises the importance of empowering victims through education and the encouragement of resilience (Banyard & Williams, 2007; Campbell et al., 2009; Field et al., 1997; Haydon et al., 2015; Kaukinen & DeMaris, 2009; Price, 2006; Reis et al., 2017). There was ample evidence in this study of such endeavours, including the encouragement of resilience through the use of specific skills. Overall, these findings indicate that osteopaths appear to have developed effective therapeutic skills in the management and treatment of patients who have experienced sexual violence.

However, as discussed in Chapter 2, research in the field indicates that a negative or inadequate response to disclosure of sexual violence can generate a silencing effect, whereby victims cease to seek help (Ahrens et al., 2007; Dolan & Raber, 2017; Kaukinen & DeMaris, 2009; Stiller & Hellmann, 2017). Similarly, responses that communicate disbelief, doubt, stigmatisation or over-emotionality, thought to occur due to inaccurate knowledge regarding sexual violence, can have a long-lasting and detrimental impact on a victim's ability to begin a process of recovery (Baker et al., 2012; Crisma et al., 2004; Klein, 2004; Roberts et al., 2010). Thus, while the study found worthy therapeutic skills that are transferable to a range of situations, as discussed above, knowledge of the negative consequences of an inadequate response to sexual trauma was largely absent. It is recommended that osteopaths be formally trained in this regard,

so as to pre-empt the possibilities of a negative response to sexual trauma and promote the prospects of patient recovery through an adequate response.

Precise knowledge and skills regarding the role of touch in the therapeutic response to sexual trauma is of particular importance in the field of osteopathy. The literature emphasises the possibility that touch can re-traumatise a patient by triggering the original experience of powerlessness, loss of control, disassociation and vulnerability (Dunleavy & Kubo Slowik, 2012; Havig, 2008; Schachter et al., 2004). The study highlights knowledge and a variety of skills that are employed to navigate osteopathic touch during treatments, including paying close attention to a patient's body language and non-verbal cues. However, the findings identified inconsistencies, with just two participants demonstrating knowledge about the autonomic response known as tonic immobility and the role of touch in causing disassociation in trauma patients. As discussed in Chapter 2, tonic immobility and disassociation can engender a state whereby patients are unable to vocalise discomfort when it arises or retract consent even when they wish to (Cuevas et al., 2017; Kalaf et al., 2017; Sanderson, 2006). It would seem evident that formal education is required to provide touch therapists, such as osteopaths, with greater knowledge, skills and confidence regarding the complexities of trauma-informed touch, a recommendation already proposed in an earlier section regarding the mind-body connection.

Power in the Therapeutic Relationship

The literature considers that the phenomenon of power is central in the field of sexual violence and healthcare (Baker et al., 2012; Draucker & Martsolf, 2004; Tener, 2018), specifically in terms of three aspects. These are that perpetrators of sexual violence often occupy roles of authority (Basile et al., 2014; Tener, 2018; WHO, 2018), that victims can experience a lasting sense of disempowerment (Hlavka, 2016; Tener, 2018), and that patients may re-experience this loss of power due to the inherent power differentials within a therapeutic relationship (Havig, 2008; Schachter et al., 2004). The results of this preliminary investigation into the osteopathy profession confirm an adequacy of knowledge and skill regarding these aspects. Power imbalance in the therapeutic relationship was navigated through the honouring of patient autonomy, the encouragement of patient empowerment and a diligent attendance to the informed consent process, all factors that are recommended by the literature (Demers et al., 2017; Kornhaber et al., 2016; Stalker & Teram, 1999). Significantly, the findings demonstrate particular vigilance in gaining informed consent when treating sensitive areas of the body, and comprehension of the silencing effect that can prevent victims from expressing themselves and

their needs (Draucker & Martsof, 2004). Furthermore, humour was used to enhance the therapeutic connection. Unbeknownst to the participants, experts consider this use of humour to be beneficial in equalising power imbalances between patients and healthcare practitioners (Dean & Major, 2008; Haydon et al., 2015). Although these findings highlight a comprehensive understanding of power differentials in the therapeutic relationship with patients who have experienced sexual violence, the phenomenon of power dynamics could well be included in future education programmes to ensure that osteopaths are consistently equipped to manage this complex aspect of healthcare with all patients.

Professional Resilience in Relation to Sexual Violence

Analysis of the data collected in this project uncovered a good level of understanding regarding the maintenance of professional resilience in relation to patient experience of sexual violence, the theme addressed in Chapter 6. Although the interviewees often used different terminology, they were familiar with current research that shows that professionals who treat trauma patients and hear stories of sexual violence are at greater risk of countertransference, vicarious traumatisation, compassion fatigue and burnout that can negatively affect physical and mental health (Tabor, 2011; Wilson & Thomas, 2004). Literature identifies several strategies that can mitigate these risks and safeguard professional resilience, including the maintenance of professional boundaries, regular supervision, peer support, peer groups and self-reflection. The efficacy of these strategies is supported by research (Draucker & Martsof, 2004; Etherington, 2009; Wright, 2006). This study highlights regular engagement with these activities, which indicates a good level of understanding of the importance of maintaining professional resilience in relation to sexual trauma. However, these favourable attitudes had mostly emerged through negative clinical experience, and some lamentation was forthcoming that formal osteopathic training had omitted to address this topic. This again suggests that the ad hoc and varied nature of osteopathic education in this area of practice is inadequate, and a more formal approach is called for that includes supervision.

Summary

The previous three sections of this chapter have provided a discussion of the findings of this preliminary inquiry into the knowledge, skills, attitudes and confidence held by New Zealand osteopaths in relation to sexual trauma, citing relevant literature and making recommendations for improvement along the way. Critical research in the field of sexual violence suggests that primary healthcare workers are often ill equipped to manage sexual trauma, often fail to provide

trauma-informed care, and sometimes exhibit negative attitudes such as victim-blaming which are known to hinder recovery (Di Giacomo et al., 2017; Kennedy & Prock, 2016; Scriver & Kennedy, 2016; Sigurdardottir & Halldorsdottir, 2018; WHO, 2003). The literature also argues that an absence of knowledge regarding sexual trauma can result in healthcare procedures and practices that inadvertently hinder the recovery of, and in some cases re-traumatise, patients (Clardie, 2004; Elliott et al., 2005; García-Moreno et al., 2015; WHO, 2003). This research thesis supports the literature. As evidenced in this chapter's discussion of the seven key themes and findings of this inquiry, it suggests that New Zealand osteopaths do not graduate with sufficient knowledge, skills and confidence to adequately manage patients who have experienced sexual violence. It also finds that subsequent education is usually of an ad-hoc nature, prompted through individual clinical experience which is sometimes negative and obtained through self-guided education and informal peer exchange. Furthermore, the thesis finds that a negative attitude of victim-blaming may sometimes hinder good osteopathic practice, and that the inadvertent re-traumatisation of sexual abuse victims and the unintended hindering of their recovery sometimes occurs in the New Zealand osteopathy profession.

Experts, both in New Zealand and worldwide, promote the education of healthcare professionals regarding sexual violence, trauma-informed care and professional resilience as one of the most effective means of addressing this inadequate situation (Donaldson et al., 2018; Kennedy & Prock, 2016; McGregor et al., 2013). In fact, the World Health Organisation recommends that all professionals working in any spectrum of healthcare be trained so as to improve their abilities to manage disclosure of sexual violence with 'sensitivity and efficiency', and to avoid attitudes and behaviours that exacerbate the illness experience of sexual violence (Krug et al., 2002; WHO, 2002). There is evidence that such educational interventions are successful (Kennedy et al., 2013; Krug et al., 2002). Based on the results of this research project and the recommendations of current literature, this thesis advocates for improvements in this regard in the New Zealand osteopathy community. It recommends the provision of formal education for osteopaths regarding sexual violence, trauma-informed care and professional resilience, from undergraduate through to professional development levels, as well as a consideration of professional supervision in this area of practice. Given that osteopathic treatment inevitably involves touch, it is especially important that such formal training be undertaken. Practitioners would then be better able to provide consistently sensitive and effective care for victims of sexual violence, care that prevents the re-triggering of trauma

symptoms, that mitigates biopsychosocial consequences and promotes recovery, and that protects practitioners.

Chapter 7 of the thesis has constituted a discussion of the findings of this investigation in relation to its aims and the relevant literature introduced in Chapter 2, as well as suggesting improvements to osteopathic education and practice based on these findings. The concluding chapter, to follow, will provide an overall summary of these findings and recommendations for the New Zealand osteopathy profession in relation to the phenomenon of sexual violence, as well as make some suggestions for further research.

Chapter 8: Conclusion

This thesis has presented a preliminary investigation into the knowledge, skills, attitudes and confidence of New Zealand registered osteopaths regarding their management and treatment of patients who have experienced sexual violence. While Chapter 1 constituted an introduction to the thesis, Chapter 2 presented a thorough review of the literature pertaining to sexual violence and healthcare, specifically the key aspects of terminology, parameters, personal and social costs, disclosure, recovery, the role of primary healthcare practitioners and the maintenance of professional resilience. This review revealed that the incidence of sexual violence is high worldwide and in New Zealand, that it engenders long-term detrimental consequences for physical, mental and social well-being, and that these impacts can be lessened with appropriate professional assistance. However, many victims delay or never disclose experience of sexual violence and therefore do not seek assistance to embark on a process of recovery. These circumstances mean that primary healthcare practitioners, including manual therapists, will knowingly and unknowingly work with patients who have a history of sexual violence. Indeed, all the osteopath participants in this research project had encountered sexually traumatised patients. The literature also indicated that healthcare professionals may provide an inadequate response, including victim-blaming which is known to hinder recovery, when patients disclose experiences of sexual violence or are inadvertently re-traumatised by treatment. In terms of osteopathy practice in this area, little research has been undertaken to date. This is of concern given that osteopathic treatments invariably involve therapeutic touch that may inadvertently generate re-traumatisation and/or disclosure for patients with a history of sexual abuse. This research thesis has offered a preliminary glimpse into this area of practice, in the hope that improved practice and further research will result in the future.

The investigation reported in this thesis employed a qualitative methodology and descriptive phenomenological psychological method, as described in Chapter 3. The participants, recruited through a process of self-selection, constituted New Zealand registered osteopaths who represented a range of professional experience. Although the sample size was small, its representative spread and the project's in-depth thematic analysis indicates that the findings are likely to be applicable to the wider population of New Zealand osteopaths. Data was gathered using an individual semi-structured interview format and explored via a thematic analysis related to the osteopath respondents' knowledge, skills, attitudes and confidence when caring for patients who have been sexually violated. The analysis identified seven themes, the

illness experience, the mind-body connection, clinical relevance, scope of practice, therapeutic response, power dynamics and professional resilience, which were presented in Chapters 4, 5 and 6 of the thesis. Chapter 7 constituted a discussion of the results of these analyses as they relate to the osteopathy profession and the field of literature presented in Chapter 2, and made some suggestions and recommendations for improvement in New Zealand osteopathic practice in relation to the phenomenon of sexual violence. This concluding chapter, Chapter 8, offers a summary of these findings and recommendations, along with suggestions for further research regarding osteopathy, healthcare and sexual trauma.

Chapter 4, presenting the three themes of the illness experience, the mind-body connection and clinical relevance, highlighted a reasonable level of osteopathic knowledge, skill and confidence regarding the patient experience of sexual violence in relation to clinical practice. In terms of attitudes to the illness experience, the osteopathy profession appears to express a positive stance towards victims of sexual violence, although a tendency to blame the victim lingers in some quarters. However, while osteopaths display mostly favourable attitudes, it seems that they do not graduate with sufficient knowledge, skills and confidence to adequately manage the complex patient behaviours that may manifest as part of the illness experience of sexual violence. This finding suggests that osteopaths would benefit from formal education to better understand the illness experience of sexual violence, including the complex range of attitudinal responses, both positive and negative, that they may experience when patients disclose sexual trauma.

The project's findings also highlight effective knowledge, skills and confidence in terms of the biopsychosocial model of healthcare, suggesting that New Zealand osteopaths are well placed to provide trauma-informed care to victims of sexual abuse. However, this mind-body knowledge and skill set may be acquired through negative clinical experience, whereby an osteopathic practitioner inadvertently triggers emotional release in a patient during treatment or comes to the realisation that a patient's physical ailment is linked to emotional distress. This finding indicates the need for formal osteopathic education regarding somatic illness and trauma-informed care so as to promote better patient management, to protect patients from possible re-traumatisation, and to educate patients about the link between psychological and physiological ill health related to sexual trauma. The third theme in Chapter 4 concerned the complexity involved in understanding the clinical relevance of a history of sexual violence for patient management and treatment, with osteopaths employing two assessment measures, time

elapsed since the occurrence of the abuse and the amount of psychological treatment undertaken by the victim. Both measures are characterised by advantages and deficits, which indicates that the formal education of osteopaths in terms of the clinical relevance of sexual trauma, and the complexities involved, requires attention.

Chapter 5, incorporating the three themes of scope of practice, the therapeutic response and power in the therapeutic relationship, highlights generally comprehensive knowledge and positive attitudes regarding the role of osteopathy in patient recovery from sexual violence. Specifically, there is commendable awareness of the osteopathic scope of practice in relation to sexual trauma, and the limitations of that scope. Scope of practice is found to encompass the responsible management of sexual trauma, including adequate referral to psychological and other services. However, an initial lack of confidence, inadequate inter-personal skills and a sense of 'being ill-equipped' are evident in this regard, especially during the early phases of an osteopathic career. Moreover, post-graduate professional development in this area of practice seems to be limited to an ad-hoc process of individual clinical experience that is sometimes negative, informal education and discussion with peers. This finding underlines the need for a more adequate preparation of osteopaths so they can better manage and treat patients who have been sexually traumatised, within their scope of practice, and thus make a more effective contribution to their recovery.

The findings of this inquiry also demonstrate a valuable set of therapeutic and educative skills that are essential in clinical situations where sexual trauma emerges. However, knowledge of the impacts of an inadequate or negative response to sexual trauma is somewhat overlooked in the osteopathy profession, as is specific understanding regarding the complexities of trauma-informed touch. It is suggested that formal education and supervision be established to provide osteopaths with greater knowledge, skills and confidence regarding trauma-informed touch, the negative consequences of an inadequate response to sexual trauma, and the likely positive effects of an adequate response on patient recovery. In terms of the third theme in Chapter 5, the findings substantiate a thorough comprehension of, and attempt to mitigate, the power differential that exists within the therapeutic relationship between healthcare practitioner and patient, and the significance of this power imbalance for those who have experienced sexual violence. However, the phenomenon of power dynamics could well be included in future education programmes to ensure that osteopaths are formally and consistently equipped to

manage this complex aspect of therapeutic care with patients who have been sexually abused, as well as with all patients.

Chapter 6 focused on the theme of professional resilience in relation to patient experience of sexual violence. Results indicate that osteopaths have adequate strategies, such as the maintenance of professional boundaries, self-reflective practice, regular supervision, informal peer support and organised peer groups, to mitigate the risks of vicarious traumatisation, compassion fatigue and burnout when managing and treating sexually traumatised patients. Again, however, much of this knowledge is acquired in an ad hoc fashion or as a result of negative clinical experience. This finding calls for a more formal and consistent approach to the education and supervision of osteopaths in the area of professional resilience and the management of sexual trauma.

In conclusion, this research thesis supports the contention found in the current literature that primary healthcare practitioners, including osteopaths, do and will continue to encounter victims of sexual violence in the context of clinical practice, and that in some cases this history will be impacting on patient health. This thesis also supports the premise found in the literature that primary healthcare workers, including osteopaths, are not always adequately prepared to manage the encounters that they will have with sexually traumatised patients during the course of their careers. The investigation shows that New Zealand osteopaths seem to acquire knowledge in this important area of practice through self-guided education, peer exchange and individual clinical experience, which is sometimes negative, rather than through formal training and supervision. The participants in this project were self-selected due to their interest in, and motivation to educate themselves regarding, the phenomenon of sexual violence amongst their patients. This may explain the favourable attitudes and considerable level of knowledge, skill and confidence that they brought to this area of practice, even while all had experienced an initial period of professional insecurity and self-doubt. It is suggested that the broader cohort of practising osteopaths will have a weaker comprehension of the topic overall, and be less equipped to adequately manage and treat sexually traumatised patients within their scope of practice, and to maintain their professional resilience in this regard. Recently graduated practitioners are likely to find themselves even less prepared to respond adequately to such clinical circumstances. The thesis argues that the 'ad-hoc' approach, whereby osteopaths are required to rely on informal means to equip themselves to manage and treat patients who have been sexually violated, is inadequate and has led to a situation in which New

Zealand osteopaths are insufficiently trained and supervised to effectively work with such patients.

The thesis therefore recommends that the New Zealand osteopathy community consider professional training, at the student level and beyond, regarding the management and treatment of patients who have experienced sexual violence. The thematic threads identified in this preliminary inquiry could be utilised in such programmes, as they are based on empirical research and supported by expert literature. An education programme might therefore include a focus on the illness experience of sexual violence and the complex range of attitudinal responses that may be experienced in the face of sexual abuse disclosure, somatic illness including the mind-body link between psychological and physiological ill health, the clinical relevance of sexual trauma, scope of practice, the therapeutic management of disclosure and sexually abused patients, trauma-informed care and trauma-informed touch, the damaging consequences of a negative response to the experience of sexual violence and the positive effects of an adequate response on patient recovery, power dynamics in the therapeutic relationship between healthcare practitioner and patient, and professional resilience in relation to sexual trauma.

The larger intention of this research thesis is to benefit the New Zealand osteopathy profession by contributing to the improvement of osteopathic healthcare services for patients who have suffered sexual violence. Further studies are recommended in this regard, both quantitative and qualitative, to build on this preliminary inquiry, to engage the wider community of New Zealand osteopaths and to assist in ascertaining further gaps in knowledge, skills, attitudes and confidence regarding the osteopathic management and treatment of patients who have experienced sexual violence. Overall, it is hoped that the findings of this thesis will amplify awareness of this important area of practice in the osteopathy community, as well as contribute to current discussions regarding best healthcare practice in the field of sexual trauma. It is also hoped that the recommendations offered for improved education and supervision will see osteopathy practitioners in New Zealand formally prepared and more consistently able to adequately manage the complexities of sexual trauma in their patients, and therefore make a more profound overall contribution to their recovery.

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Appendices

Appendix A: Literature Search – Key Terms, Words and Descriptors

Key Terms	Key Words	Key Descriptors
Sexual violence	Osteopath	Attitudes
Sexual trauma	New Zealand osteopath	Interventions
Sexual violation	Manual Therapist	Referral
Sexual abuse	Chiropractor	Management
Sexual assault	Physiotherapist	Care
Sexual crime	Health practitioner	Reporting
Victim of sexual violence	Health personal	Detection
Sexual experience	Primary care	Perceptions
Rape	Health professional	Intentions to disclose
	Multidisciplinary	Touch
	Screening	Therapy
	Primary health care	Experience
	Allopathic health care	Therapeutic touch
	Alternative health	Knowledge
	Musculoskeletal Specialist	Skills
	Health	Adequate management
	Disclosure	Confidence
	Vicarious Traumatization	Countertransference
	Compassion Fatigue	Transference
	Burnout	Men
	Mind-Body	Male
	Somatisation	Female
	Illness	Women
		Secret
Limiters		Suppression
After 2004		Hidden
Peer Reviewed Articles		Power

Appendix B: Facebook Post

An invitation to participate in a research project investigating how osteopaths care for patients who have experienced sexual trauma.

Participation involves taking part in a recorded confidential 60 to 90-minute face to face or video interview about your opinions and reflections as an osteopath regarding the management of disclosure, referral and therapeutic touch for patients who have experienced sexual trauma.

The interview data will be used to write up my research thesis for the Master of Osteopath programme at Unitec Institute of Technology.

If you are willing to participate, please read the google document for more information:

https://docs.google.com/document/d/e/2PACX-1vQXlChCnhMTgb8g0JM8g5N1nsTmDUUZ66qFidSm3M8Iw9HNNmBauwPAqs1HEw5ShkhdKjUsYK5vki_5/pub

Feel free to contact me on email <e.michaelanna@gmail.com> or by phone (027 330 6077).

This project has been approved by the Unitec Institute of Technology: **UREC REGISTRATION NUMBER: 2017-1072**

Appendix C: Information Letter

Research Project: A preliminary investigation into the way in which osteopaths working in New Zealand manage disclosure, referral and therapeutic touch when working with patients who have experienced sexual trauma.

Synopsis of the Project

This project aims to investigate the current knowledge, skills, attitudes and confidence of osteopaths working in New Zealand regarding the management of disclosure, referral and therapeutic touch for patients who have experienced sexual trauma. For the purposes of this study, the definition of the term sexual trauma includes all forms of sexual abuse, violence and assault.

What We are Doing

The researcher will interview up to 10 New Zealand practicing osteopaths. The interviews will be digitally recorded and then transcribed using a confidential transcription service. The collected data will be analysed by the researcher and her supervisors, using qualitative methods, for common themes regarding the osteopathic management of disclosure, referral and therapeutic touch for patients who have experienced sexual trauma, and written up as a research thesis as part of a Master of Osteopathy course. The thesis will become part of the Unitec Commons held by the Unitec library. Findings may be published in a peer reviewed academic journal and/or presented at a conference.

What it Will Mean for You

This project focuses on the management of patients who have experienced sexual trauma, including forms of sexual abuse and assault. This is a potentially sensitive subject with emotional ramifications, and we therefore ask you to reflect carefully before deciding to take part.

You will be asked to participate in a face to face or video call interview lasting up to 90 minutes, which will be scheduled at a time and place that is convenient for you. The interview will be semi-structured, allowing plenty of time for you to reflect and explain your views and experiences. The interview will be recorded using digital technology and the researcher may take notes to help keep track of information.

All information provided by you will be kept confidential and your identity will be protected. Pseudonyms will be used to preserve your anonymity within the written thesis.

If you agree to participate, you will be asked to sign a consent form. This does not stop you from changing your mind if you wish to withdraw from the project. However, because of our schedule, any withdrawals must be done within 2 weeks after we have interviewed you.

Your name and any information that may identify you or your organisation will be kept completely confidential. All information collected from you will be stored on a password protected file and only you, the one researcher and her two supervisors will have access to this information.

Please contact me if you would like to participate or need more information about the project.

Esmé Michael-Anna: <e.michaelanna@gmail.com> or 027 330 6077.

If at any time you have concerns about the research project you can contact my principal supervisor, Dr Alexandra Hart, at the Auckland Unitec. Phone 09 815-4321 extension 8919 or email <ahart@unitec.ac.nz>.

UREC REGISTRATION NUMBER: 2017-1072

This study has been approved by the UNITEC Research Ethics Committee from 2017 to 2018. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 8551). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Appendix D: Interview Schedule

At the Beginning of the Interview

- Introduce self, thank them for agreeing to see me and taking the time to complete the interview.
- Set the scene for who is to be present and how to manage any interruptions (eg an infant, phone calls).
- Outline what we will be doing: first we will attend to administrative duties then we will move into the interview phase which will be audio recorded.
- Check that the interviewee has read and understood the participant information sheet, including the sensitive nature of the research and its potential to trigger psychological distress for some people, and has a copy to keep.
- Invite the interviewee to sign 2 consent forms, one for them to keep and one that I will bring back to Unitec to be filed.
- Outline the interview order and general content: “The interview will begin with an open-ended question which you will then be invited to answer. At any time, you are able to pause the interview or ask for comments to be deleted from the interview”.
- Explain to the participant that their details will be kept confidential and explain any pseudonyms or numbering system that I am using. Explain that I may take written notes throughout the interview, so we can follow up on points of interest later on in the interview.
- Explain the sensitive nature of the topic and explain that they can stop the interview at any point.
- Ask if the participant has any questions. Check it is now OK to begin the interview.
- Turn on the recorder and speak the date, the purpose of the interview and who is present - my name and the participant pseudonym.

Interview Questions

- What is your perspective regarding patients who have experienced sexual trauma?
- Have you had any patients mention this topic or tell you about their experiences?
 - If the answer is yes: Please tell me more?
 - Please tell me about any other experiences you have had when managing these patients?
(Including suspected cases or if you wondered about patients)
- Do you approach touch differently with these patients?
 - Please tell me about that?
(I just wondered if you thought differently about touch with these patients?)
- Have you ever had to refer these patients?
 - Where did you refer them? Do you know of other places where you can refer them?
 - If not, then...If you did have to where would you refer them to?
- Can you reflect on how confident you feel in your ability to manage these patients?
- Can you reflect on the attributes/ skills you use in these cases?
(communication, touch, empathy, compassion, therapeutic)
- Can you tell me about any training that you have done in this area?
(as student or registered osteopath)
- Can you tell me about any professional support that is available for you regarding managing these patients?

- Can reflect on the prevalence of this issue amongst your case load and also in the New Zealand context?
 - Can you reflect on the overall relevance of this topic for osteopaths?
- Can you share any other thoughts you have regarding this topic?

Towards the End of the Interview

- Let the participant know we are nearing the end of the interview and invite questions or further comments.
- Close by reminding the participant of withdrawal conditions (participants are able to withdraw anytime within 2 weeks of the interview), whether and how they will get a copy of the interview transcript and how they might respond. Ask if they want reminders of any of these actions.
- Remind the interviewee of my contact details.
- Give the interviewee the 'Post-Interview Handout' (Appendix E) with information regarding the way in which they can access support and discuss any concerns that they may have, including any support that they request for themselves or for their patients.
- Thank the interviewee for their participation in the research project.
- Take all my equipment and go to my car.
- Make immediate notes verbally into the recorder about my impressions, feelings, observations and reflections.
- Make a note of aspects to remember for the next interview.

The Week Post Interview

- Review the recording within a week of the interview.
- Make notes of concepts and topics that do not appear in the literature review but appear in the interview.
- Make notes regarding the improvement of the next interview.
- Follow up on any participant who sought, or indicated that they needed, post-interview support.

Appendix E: Ethics Approval



Dear Esme Michael-Anna,

Your file number for this application: **2017-1072**

Title: **A Preliminary Investigation into How New Zealand Osteopaths Manage Disclosure, Referral and Therapeutic Touch when Working with Patients who have Experienced Sexual Violence**

Your application for ethics approval has been reviewed by the Unitec Research Ethics Committee (UREC) and has been approved for the following period:

Start date: 2 October 2017

Finish date: 2 October 2018

Please note that:

1. The above dates must be referred to on the information AND consent forms given to all participants.
2. You must inform UREC, in advance, of any ethically-relevant deviation in the project. This may require additional approval.

You may now commence your research according to the protocols approved by UREC. We wish you every success with your project.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'N. Adams'.

Nigel Adams
Deputy Chair, UREC

cc: Supervisor Name
Academic Administrator Name

Appendix F: Participant Consent Form

Research Project Title: A Preliminary Investigation into How New Zealand Osteopaths Manage Disclosure, Referral and Therapeutic Touch when Working with Patients who have Experienced Sexual Trauma

I have had the research project explained to me and I have read and understand the information sheet given to me.

I understand that I don't have to be part of this research project should I chose not to participate and may withdraw at any time up to two weeks post-interview.

I understand that everything I say is confidential and none of the information I give will identify me and that the only persons who will know what I have said will be the researcher and her supervisor. I also understand that all the information that I give will be stored securely on a computer at Unitec for a period of 5 years.

I understand that my discussion with the researcher will be taped and transcribed.

I understand that I can see the finished research document.

I have had time to consider everything and I give my consent to be a part of this project.

Participant Name:

Participant Signature: *Date:*

Project Researcher: *Date:*

UREC REGISTRATION NUMBER: 2017-1072

This study has been approved by the UNITEC Research Ethics Committee from 2017 to 2018. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 8551). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Appendix G: List of Sexual Violence Support Services



Support for people who have suffered sexual trauma

If you would like to find out more about this topic or if you experience any distress or upset after this interview, please use the below resources. Please feel free to contact the researcher or her principle supervisor directly should you require any further information.

Esmé Michael-Anna: e.michaelanna@gmail.com or 027 330 6077

Principle supervisor is: Dr Alexandra Hart. Phone: 09 815-4321 ext. 8919 or email: ahart@unitec.ac.nz

Where to get Information

For Support Services:

National Collective of Rape Crisis and Related Groups Aotearoa: <http://www.rapecrisisnz.org.nz/>

Help Foundation: <http://helpauckland.org.nz>

To Report a Sexual Assault:

Contact 111 for a sexual assault that has just happened or contact your local police station to report historical event: <http://www.police.govt.nz/advice/victims/victims-rape-or-sexual-assault>

For Articles, Reports and Statistics:

New Zealand Articles and Reports: <http://helpauckland.org.nz/get-info/download-e-books-reports>

New Zealand Statistics: <https://nzfvc.org.nz/>

Information for Managing Disclosure and Supporting a patient:

<http://helpauckland.org.nz/get-info/normalising-your-reactions>

<http://helpauckland.org.nz/get-info/being-supportive>

Helplines:

New Zealand Wide Helplines:

Lifeline: 0800 543 354

Youthline: 0800 376 633

Rape Crisis: 0800 88 33 00

Depression Helpline: 0800 111 757

Healthline: 0800 611 116

Samaritans: 0800 726 666

Women's Refuge Crisisline: 0800 733 843

Sexuality or Gender Identity Helpline: 0800 688 5463

Regional Helplines for Victims of Sexual Abuse or Assault:

Auckland: The HELP Crisis Team who are available anytime, day or night, for information, support, advocacy or referrals to other agencies on 09 623 1700.

Hamilton: Rape and Sexual Abuse Healing Centre Hamilton on 07 839 4433.

Dargaville: Support of Sexually Abused Dargaville and Districts (SOS) 09 439 6070.

Kerikeri and MidNorth: Mid North Family Support Rape Crisis and Youth Services 09 407 4298.

Whangarei: Whangarei Rape Crisis 09 438 6221

Dunedin: Rape Crisis Dunedin 03 474 1592

Wairarapa: Wairarapa Rape and Sexual Abuse 06 370 8446

West Coast: Rape and Sexual Abuse Support West Coast 0800 274 747 or 03 789 7700

Hawkes Bay: Hawkes Bay Rape Crisis 021-2276622

Tauranga: Ahuru Mowai O Tauranga Moana (Rape Crisis Tauranga) 021-2494433



Full name of author: Esmé Michael-Anna

ORCID number (Optional):

Full title of thesis/dissertation/research project ('the work'):

Osteopathy and Patients who have Experienced Sexual Violence: Management, Treatment and Self-Care

Practice Pathway: Community Development

Degree: Master of Osteopathy

Year of presentation: 2018

Principal Supervisor: Dr Alexandra Hart

Associate Supervisor: Dr Julia Hollis

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Signature of author:

Date: 27 / 11 / 18