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Childhood Abuse Survivors' Experience of Self over the course of Emotion Focused Therapy for Trauma: A Qualitative Analysis

Elisabeth Sylvia Heide Mundorf

CHILDHOOD ABUSE SURVIVORS' EXPERIENCE OF SELF OVER THE COURSE OF EMOTION FOCUSED THERAPY FOR TRAUMA: A QUALITATIVE ANALYSIS

by

Elisabeth Sylvia Heidi Mundorf

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Approved by:

_____

A. Pos, External Examiner
York University

_____

J. Grant
School of Social Work

_____

C. Senn
Department of Psychology

_____

A. Pascual-Leone
Department of Psychology

_____

S. Paivio, Advisor
Department of Psychology

September 6, 2013

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Abstract

This study is a qualitative approach to understanding how childhood abuse survivors experience and describe their sense of self, as well as how this experience of self changes over the course of therapy. Participants of the present study were adult clients engaging in Emotion Focused Therapy for Trauma (EFTT; Paivio & Pascual-Leone, 2010) to address psychological effects of childhood maltreatment. The data source was audio-recorded therapy sessions in which clients discussed their experiences of self. The author identified and selected excerpts from these therapy sessions that contained client statements about their experience of self (e.g., perceptions and feelings about oneself, sense of identity, self in relation to others, self-conscious emotions, changes observed in self). These session excerpts were transcribed and analyzed using a thematic analysis methodology (Braun & Clarke, 2006). Analysis of these session excerpts yielded three major themes addressing the experience of self of childhood abuse survivors: an unclear sense of identity, not participating actively in one's life, and feelings of worthlessness. In terms of the process of change over the course of therapy sessions, analysis of client statements yielded themes relating to shifting blame for the abuse from self to the perpetrator, allowing and expressing emotions, and becoming aware of how positive experiences of self are blocked or disallowed. Near the end of therapy most clients reported changes in their experience of self, including a sense of authenticity and being true to oneself, feeling in control of life choices, and increased self-acceptance. The various themes are described and illustrated with excerpts of client statements. The themes are discussed in relation to current theory and research on the effects of childhood maltreatment, and implications of these findings are explored.

Dedication

To my husband, Ryan.

Acknowledgments

I would like to thank all of the members of my committee for their valuable contributions and discussions at the various stages of this process. To Dr. Alberta Pos, my external examiner, thank-you for your thought-provoking questions regarding the role of emotions in defining the self as well as your thoughts on qualitative methodology and how to build upon the work I have begun with this study. To my committee members, Dr. Jill Grant, Dr. Charlene Senn, and Dr. Antonio Pascual-Leone, your feedback throughout this process has been invaluable. I have appreciated the collegial and collaborative atmosphere at my proposal, progress meeting and defense, and how, despite holding differing viewpoints, you all helped me to synthesize a variety of ways of understanding the phenomenon of childhood abuse trauma and EFTT. I have grown as a researcher and a clinician through this project and through the discussions we have held as a committee. To Dr. Sandra Paivio, my research advisor for both my master's thesis and doctoral dissertation, thank-you for helping me to build confidence in my skills as both a researcher and clinician. I have greatly appreciated your support and encouragement, as well as your ability to stimulate me to think in new ways about my research. Thank-you as well for matching my pace and process as a researcher – you motivated me when I needed a push, and gave me space to reflect when I felt stuck. It has been a pleasure to work with you and I hope to continue collaborating with you in the future.

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CHAPTER ONE

INTRODUCTION

Objective and Rationale for the Present Study

The experience of maltreatment in childhood is unfortunately a common phenomenon with serious negative consequences for its victims. Many individuals who have experienced childhood maltreatment suffer negative effects in adulthood, including psychological disorders, problems with emotional and impulse control, difficulties in interpersonal relationships, and a negative sense of self (see Neumann, Houskamp, Pollock, & Briere, 1996 for a review). In particular, they may feel a sense of worthlessness or inner "badness", confusion about their identity, a sense of powerlessness and inefficacy, or may have difficulty managing emotions and feel "out of control". These areas relate to the individual's experience or perceptions of self, and are the focus for the present study.

Much research has documented the effects of childhood maltreatment on self-development and perceptions of self in adulthood (e.g., Briere, 1992; Herman, 1992) and many models of psychotherapy targeting the long-term psychological effects of childhood maltreatment have demonstrated efficacy in improving self-esteem and negative beliefs about self (Martsolf & Draucker, 2005). Therapy outcome studies generally provide information limited to broadly defined improvements in symptomatology (e.g., depressive symptoms, self-esteem, emotion regulation skills, self-critical thoughts), thus providing limited information about *what* changes in the client's experience of self or *how* self-concept improves. Furthermore this information generally emerges from quantitative self-report measures that reflect researcher assumptions about what ought to change over the course of

therapy. While some models of therapy do propose mechanisms of change that address self-related disturbances, these have not been examined in-depth.

The present study approaches the question of the individual's experience and perceptions of self and how these are linked to childhood maltreatment experiences by using a qualitative research design to examine and analyze statements that were made by clients during therapy sessions. Qualitative research designs emphasize description of phenomena and the generation of working hypotheses about these phenomena, rather than imposition of existing theory on observations (Henwood & Pidgeon, 1992). These approaches provide participants with the opportunity to describe their experiences in their own words, thus producing richer and more complex data than would be available through quantitative methods (Liamputtong & Ezzy, 2005). Through the present study I hope to develop and provide to readers a greater understanding of the lived experience of individuals who have suffered childhood maltreatment, with a particular focus on their experience of self. Furthermore, the present study examines this question through live observation of the client moment-by-moment process of exploring the self in therapy sessions, rather than through retrospective interviews. This provides a unique perspective on the question of the abuse survivor's experience of self, as well as providing a longitudinal examination of the process of change over the course of therapy.

The data for this study are audio-recorded sessions of Emotion-Focused Therapy for Trauma (EFTT; Paivio & Pascual-Leone, 2010), which is an evidence-based psychotherapy approach for addressing the psychological effects of physical, sexual, and/or emotional childhood maltreatment. Therapy sessions in which there was an explicit focus on clients' experience of self were transcribed and client statements were interpreted using a thematic

analysis methodology (Braun & Clarke, 2006). The goal of this study was to produce a description of both the client's inner experience of self as it is explored in therapy, and of the client's process of developing a healthier, more adaptive self-concept, qualitatively-rich information that can inform both current theories of change and clinical practice.

Research Questions

The following research questions provided the framework and focus for the present study. As this is a qualitative study, these questions do not represent hypotheses to be tested, nor were they meant to be answered explicitly by participants, but rather these were used to guide my approach to selecting and coding data, such that themes relevant to these questions would be identified in the analysis.

1. How do adult survivors of childhood abuse experience and describe their sense of self?
2. What changes occur in clients' experience of self over the course of therapy, and how do these changes come about?

Researcher Stance and Assumptions

Epistemological Considerations in Qualitative Research

Positivist and post-positivist perspectives on the nature of knowledge and research findings, which are commonly adopted in quantitative research studies, assume the existence of one true reality, which can be grasped only by being fully objective. Research studies under these paradigms seek to limit researcher bias and assumptions, by emphasizing objectivity, reliability of observations, and systematic testing of theories (Gergen & Davis, 1985). By contrast, a social constructionist perspective, often adopted in qualitative research, suggests that knowledge is not absolute and research findings not "objective", but that

scientific findings and statements about “truth” or “what is known” are embedded within a historical and societal context which influences the nature of what we define as truth or knowledge (Gergen & Davis, 1985). C. Kitzinger (1995) draws a distinction between “strong” and “weak” social constructionism; the former calling into question the categories of knowledge that are taken for granted among researchers. For example, areas of study in psychology (e.g., “the self”, “emotions”, “mental illness”, “abuse”) as well as the methods of study (e.g., “scientific inquiry”) are themselves identified as social constructions or linguistic conventions we have adopted to make sense of the world, and do not represent any absolute or external truth. By contrast, “weak” social constructionism assumes the objective existence of phenomena under study but suggests that one’s social, historical, and political context influences the manner in which a particular phenomenon is understood. The present study is in line with this latter perspective.

Under this perspective the assumption is made that there is not only one “correct” interpretation of data. Rather, the interpretation and findings of qualitative studies are considered to reflect one particular way of understanding a phenomenon, and contribute to a broader conversation among researchers about the implications of this phenomenon (Auerbach & Silverstein, 2003). Within this paradigm, participants and researchers may co-construct meanings and interpretations, and researcher subjectivity is considered to be an essential part of the research (Morrow, 2007). Rennie (2012) comments that since qualitative research involves interpretation of human experience, the validity of results can be acknowledged in part by the way findings are grounded in evidence and how they resonate with consumers of the research. Furthermore, Rennie suggests that the researcher’s reflexive disclosure of his or her perspective and how this influences interpretations will aid in the

reader's understanding of the findings. Some pioneering qualitative research paradigms have suggested attempting to "bracket" one's prior knowledge of a phenomenon in order to limit the influence of researcher preconceptions on the data (e.g., Glaser & Strauss, 1967), for example by conducting a literature review only after data collection and analysis has taken place. However, other qualitative researchers suggest that researcher bias is unavoidable and that a prior literature review may be important to provide a conceptual structure to the study (Elliott & Timulak, 2005) and to introduce the researcher to a variety of ways of understanding the phenomenon under study (Morrow, 2005) – this is the perspective taken in the present study. Rather than "bracketing" prior knowledge, researchers are encouraged to acknowledge and critically evaluate their role in the process of creating meaning from the data. This includes using language that acknowledges the researcher's role as a co-creator of meaning (i.e., use of first person), as well as explicitly reflecting on the research topic, design, analysis, and personal experiences throughout the research process (Morrow, 2007).

Furthermore, qualitative research emphasizes the importance of recognizing the power differential between the researcher and the participants of the study, whose statements will be subject to the researcher's analyses and interpretations. Qualitative designs highlight the value of representing reality from the perspective of participants and accessing their lived experience, and thus are less likely to make unwarranted assumptions about the experience of research subjects (Ezzy, 2002). This consideration is particularly important when examining the experiences of a vulnerable population, as in the present study. Kitzinger and Wilkinson (1996) highlight the importance of recognizing the researcher's position of power and domination in relation to a population of research subjects who have been oppressed or victimized. They suggest that researchers critically examine their own assumptions and

biases and carefully consider how to think or speak about a group to which they do not belong, without disempowering these individuals.

Researcher as Instrument

I provide here a brief summary of my background and interest in this project, in order to allow readers to contextualize the study design, findings, and interpretations as they have emerged from my perspective. I am a 31-year-old, heterosexual, married Caucasian woman, raised in an upper-middle class, intact family. I have not personally experienced childhood maltreatment or intimate relationship abuse in adulthood. Thus, I approach this project from the stance of an outsider, naïve to the experience of being subjected to long-term abuse by a trusted person. My interest in this area emerges from my chosen profession as a psychologist and my desire to study an area that will be directly relevant and applicable to my day-to-day work engaging in psychotherapy with clients. My involvement with individuals who have experienced childhood maltreatment has been primarily through a researcher and/or therapist role. I had previously conducted a project examining trauma narratives written by survivors of childhood abuse, and was emotionally impacted by the vivid descriptions and metaphoric language clients used to express how abuse experiences have affected them. I felt drawn to continue exploring the experiences of these individuals as told through their own words; thus emerged my interest in conducting a qualitative study. My stance in working with therapy clients and in seeking to understand the experiences of the clients in the present study is rooted in an experiential/humanistic therapy framework; I favour these therapies for their emphasis on the client's lived experience rather than therapist expertise. Given my clinical training and research focus on the individual client's perspective, it has been a new challenge for me to consider the phenomenon of childhood maltreatment from a broader stance,

considering the various environmental, social, and political forces that serve to perpetuate childhood maltreatment. I have attempted to raise these issues in the current project, where appropriate.

Theoretical, Historical, and Cultural Positioning of the Present Study

Within the present study, it should be acknowledged that attachment theory (Bowlby, 1988) is the primary theoretical model adopted for understanding the effects of childhood maltreatment, and is an important influence on the treatment principles in EFTT. Abundant research evidence exists in support of attachment theory and it has been recognized as a useful way to conceptualize the dynamics of childhood maltreatment (as detailed in the upcoming literature review). However, it is important to recognize the implications of this theory and how it may be influenced by current sociocultural values (Bolen, 2002). For example, because attachment theory emphasizes family relationships, this may obscure the influence of important societal factors that contribute to the phenomenon of childhood maltreatment. Additionally, the focus on familial relationships (particularly the mother-child relationship) has the potential to perpetuate political or societal prejudices that place the locus of blame within the family and therefore influence the systemic response to the issue of childhood maltreatment (Bolen, 2002). Olafson (2002) also raises the critique that a focus on attachment relationships and a caregiver's "failure" to protect a child from abuse by a perpetrator risks ignoring the impact of abuse within intimate relationships –for example, a mother who is subject to violence or threats by her partner may be afraid or unable to protect her child from maltreatment, or have difficulty providing a supportive response to the child who discloses abuse (see also D'Cruz, 2004). Furthermore, attachment theory is based in an assumption of determinism – that what occurs within the early years of life creates the

foundation for later development (Andrews, 2002), and does not sufficiently acknowledge resiliency or self-righting tendencies of the abused child (Contratto, 2002).

The model of therapy used in the present study should also be acknowledged. Emotion Focused Therapy for Trauma (EFTT: Paivio & Pascual-Leone, 2010) is based in experiential/humanistic theory, which places value in the client's subjective internal experience as a source of valuable information about what is psychologically healthy for that individual. Experiential therapies consider clients to be the experts of their own experience, and are thus compatible with a qualitative research design that uses client-generated statements as the primary data source. Accordingly, the coding scheme that emerges from this study will reflect the assumption that client statements in therapy are important and accurate sources of information to learn about how the experience of self changes over the course of therapy. A feminist critique of humanistic personality theories and therapies suggests that in their focus on the immediacy of individual experience, humanistic approaches exclude a consideration of external influences or structures that affect an individual's circumstances. Whereas an individual may experience internal change and move towards self-actualization, he or she may still face external (e.g., economic, legal, interpersonal) obstacles, particularly if he or she is a member of an oppressed group (Lerman, 1992).

Thirdly, the concept of "child abuse" or "child maltreatment" should be briefly explored. One of the earliest discussions of psychological effects of childhood maltreatment came from Freud's 1896 paper "The Aetiology of Hysteria" (as cited in Masson, 1984), which suggested that childhood sexual abuse was a precursor to the development of symptoms of hysteria, a position that came to be known as the seduction theory. It has been

suggested by some scholars that Freud later reversed his position in order to avoid professional ostracism, stating that his patients' reports of childhood sexual abuse were merely fantasies (see Masson, 1984). Only in the last several decades has the phenomenon of childhood abuse been widely recognized as a social problem and it has been discussed and portrayed in media from various perspectives (see Beckett, 1996). For example, some scholars and community groups have strongly questioned the veracity of recovered memories of childhood abuse (see Loftus & Ketcham, 1994), whereas other perspectives highlight the role of a patriarchal power structure in society's collective denial of the pervasiveness of childhood maltreatment (e.g., Rush, 1996).

The present study is conducted within a clinical psychology framework and thus takes as its primary focus the negative psychological effects of maltreatment on the individual. I have attempted to acknowledge the assumptions inherent in this perspective. In particular, a focus on the traumatic aspect of childhood maltreatment and the negative psychological effects that often emerge may fail to recognize the role of resilience or to examine the absence of psychological consequences after trauma (Levett, 1995). It has been suggested that emphasizing the effects of childhood maltreatment as "traumatizing" or "damaging a child's innocence" can in fact be disempowering as it places those who have experienced maltreatment in the role of being a passive and vulnerable victim, reinforces the view of children as helpless and silent thus ignoring their own resources and resiliency, and stigmatizes children who have been exposed to sexual acts as "damaged goods" (J. Kitzinger, 1997; Scott, 2001). Finally, a focus on the psychological effects individualizes the issue of childhood maltreatment and fails to acknowledge this phenomenon as a systemic

concern (Levett, 1995). Where possible, and within the limits of my awareness of broader issues, I have attempted to acknowledge and address these limitations in this study.

Finally, I will acknowledge that the present study is conducted from a Western cultural perspective, which generally considers "the self" to be an internal mental experience that is separate from the external world, and which places value in independence, autonomy, and a developmental process of increasing separation from others. This perspective is at odds with relational or collectivist understandings of self that focus more on interdependency and mutual growth in relationships, and risks devaluing or pathologizing groups that emphasize interdependence, caregiving, or self-sacrifice (see Jobson, 2009; Jordan, 1997). Theoretical perspectives on "the self" from a variety of traditions in Western psychological understanding will be described in the literature review.

Outline of the Literature Review

The following literature review begins with definitions of self and descriptions of healthy self-development as presented by three major theories of functioning in clinical psychology. Following this is a review of the negative psychological effects of childhood maltreatment and explanation of sources of disturbance, particularly effects of maltreatment on perceptions and functions of the self. Finally, the therapy model used with participants of the present study, Emotion Focused Therapy for Trauma (EFTT; Paivio & Pascual-Leone, 2010), will be described. The methodology for the current study will be presented in chapter three.

CHAPTER TWO

LITERATURE REVIEW

Theories of Self and Self-Development

Definitions of "Self"

The self is thought to be a psychological construct that organizes an individual's experiences into a sense of individuality, unity, and continuity (Cole & Putnam, 1992). A review of references to 'self' in current psychological and social science literature (M. Leary, 2004) reveals five uses for the term self. Two of these refer to the self as a synonym for "person" or "personality", whereas the other three convey more nuanced conceptualizations. Specifically, self can be classified as a subject, the "I" of the person's self-experience, which captures capacities for self-awareness, and a sense of continuity and coherence within one's identity (Leary, 2004). Secondly, the self can represent an object, the "me" to which individuals refer when they observe or evaluate themselves. The me-self is implicated in self-evaluation, self-conscious affects (e.g., pride, shame or guilt), and the sense of self-worth (Harter, 1999). Thirdly, the self can refer to the "do-er", or the agent of the person's actions (M. Leary, 2004). The following sections will review briefly theoretical perspectives on self-development and self-structure that are prominent in the clinical psychology literature, with a focus on theories that are relevant to emotion focused therapy for trauma (EFTT), which is the context for the present study.

Psychodynamic Views of Self

Early psychoanalytic theories viewed the self as synonymous with the "ego", one of Freud's structures of the mind, thus the ego or self was considered to be a unitary entity whose structure remained constant after early development. The ego is defined as a

superordinate regulatory system that controls the degree to which mental content emerges into consciousness (Cooper, 1993). Traditional psychoanalytic theories viewed adaptive self-functioning as the ego maintaining authority over the individual's id impulses and drives, and emphasized autonomy and independence as central to psychological health (Muran, 2001).

Later object-relations and attachment variations of psychoanalytic theory have defined the self in relation to others and maintained that the self develops in the context of early life experiences with parents or caregivers. These early experiences are encoded in memory as internal representations of self and others or "object relations" that continue to influence perceptions of self and others. Winnicott (1969), for example, described that an infant's sense of self emerges through a balance of contact and differentiation with its mother or primary caregiver. A "good enough" mother or other primary caregiver is available and responsive to the infant's needs, and the caregiver's occasional failure to meet the infant's precise needs allows the infant to learn to separate from the mother, thus fostering the developing self (Muran, 2001). Winnicott also made a distinction between one's "true self" and "false self". The child's "true self" represents the source of authenticity and emerges in the spontaneous expression of the child's needs and impulses. However, in situations in which the child learns that he or she may be rejected or punished for expressing authentic feelings and needs, a "false self" develops as a defense that allows him or her to be socially accepted (Cooper, 1993). Healthy self-development inevitably involves the development of a "false self" in order to cope with environmental demands. However, when there are repeated parental failures to respond to the infant's authentic feelings and needs, the true self remains completely hidden, leading to later psychological disturbance (Muran, 2001). Criticisms of

Winnicott's object relations theory suggest that it raises the risk of "mother-blaming" while overlooking the role of the father in the child's development (Caplan, 1985), and that it assumes that mothers as primary caregivers is "natural", rather than a culturally-constructed gender role (Formaini, 2005).

Kohut's (1977) self-psychology theory also emphasizes reliance on others ("self-objects") to provide a basis for self-development. From this perspective, caregivers satisfy two central needs of the young child: the need to receive recognition and admiration ("mirroring"), and the need for connectedness with an idealized parental figure ("idealizing"). By empathically responding to the child's experiences (mirroring), the caregiver fosters a healthy sense of self-worth and efficacy, and by serving as an idealized parental figure, the caregiver implicitly teaches the child about relatedness with others. Over time, these functions become incorporated into the child's self-structure (Muran, 2001). Both object relations and self psychology theories focus on the role of mothering in forming the child's development, and have been critiqued for assuming the existence of an innate "maternal instinct", pathologizing women who do not adapt well enough to their infant's needs, and holding mothers responsible for their children's later psychopathology. These theories also fail to acknowledge other socio-cultural influences on the mother-child relationship (Okun, 1992).

Interpersonal dynamic theories consider the self to be the product of internalized interpersonal interactions. Early interactions with caregivers result in mental representations of self in interaction with others, and the associated emotions, expectancies, and interpersonal behaviours that are based on these early experiences become repetitive, self-confirming patterns that lead to a stable sense of self across time (Henry, 2001). A child's

early experiences with others are translated into mental representations of self through three mechanisms: (1) identification, in which the child imitates significant others; (2) internalization, in which abstract representations of other people serve as a basis for future interpersonal interactions; and (3) introjection, in which the child comes to treat him or herself as he or she has been treated by others (Henry). An operational framework (Structural Analysis of Social Behaviour, or SASB; Benjamin, 1974) has been developed to observe and classify interpersonal behaviours along the dimensions of affiliation and autonomy (see also T. Leary's interpersonal circumplex; 1957). The SASB is used to classify interpersonal interaction (e.g., controlling vs. autonomy-granting; hostile vs. affiliative), and also to classify actions by the self toward the self (i.e., self-acceptance, self-criticism; self-control).

Attachment theory, which emerged simultaneously with interpersonally oriented psychotherapeutic traditions, also describes the development of the sense of self within the context of relationships with caregivers (Bowlby, 1988). Bowlby posits that the two basic and normative activities of infancy are attachment seeking and exploration. The drive to establish intimate emotional bonds with others reduces the risk of harm and promotes survival. When attachment relationships are secure, individuals feel safe enough to explore their environment, which promotes a sense of autonomy and mastery. Over an individual's lifetime, attachment figures continue to provide a source of comfort and safety in times of distress. Secure attachment throughout life allows individuals to balance their need for safety and security with autonomous functioning.

Attachment theory further suggests that "internal working models" or mental representations of self and caregivers develop in the first few years of life. These working models are activated later in life and influence interpersonal relations. A child's view of his

or her parents develops from their day-to-day interactions, and the child's view of self develops from the daily messages that parents communicate about his or her worth, lovability, competence, and so on. These messages are internalized by the child and become part of his or her working model of self, subsequently influencing how the child feels about him- or herself across a variety of situations (Bowlby, 1988). In this manner, attachment relationships are considered central to the child's developing sense of competence, value, and self-worth.

Feminist Views of Self

Feminist views also consider the relational context to be central to defining the self. These theories challenge the commonly-accepted notion of self as inherently oriented towards autonomy and separateness (Jordan, 1997; Suyemoto, 2002). The developmental goals of self-sufficiency and self-control are identified as representing a Western and andro-centric view of self, and feminist theories highlight how assuming these characteristics to be end-points of development inherently devalues characteristics more commonly associated with women or non-Western cultures, such as self-sacrifice, interest in others, or caregiving (Jordan & Hartling, 2002). By contrast, feminist views consider the self to be oriented towards relationships. Relational-cultural theory suggests that the self be viewed as one who attends to and responds to others, and that internal representations consist of the self in active interchange with other people (Miller, 1991). Healthy development is thought to occur when both people are growing and changing within their relationship (Jordan & Hartling, 2002). This represents a shift towards a mutual rather than individualist model of development. As an example, Brown and Gilligan (1992) in their discussion of girls' development, emphasize their orientation to relationships and the conflict they face in silencing their own voice in

order to remain in relationship with others. Thus, feminist views challenge traditional notions of self as oriented towards autonomy, separation, and individuation.

Cognitive-Behavioural Views of Self

In contrast to theories that propose that the self has internal drives or motivational forces (e.g., toward relatedness or autonomy), the cognitive-behavioural tradition views the self as a collection of the individual's past experiences, which provides the basis for future decisions and behaviours. Specifically, social learning theory (Rotter, 1954) proposes that a construct of "self" is useful in helping predict future behaviour because the individual's previous experiences can influence new experiences. Thus, the person's attitudes and perceptions of him- or herself (what other theories might call the "self-concept") are a relevant psychological construct.

Other cognitive theories expand the role of mental representations of self. These are considered to be a direct, static reflection of past experiences, which not only guide future behaviour, but also provide the individual with a sense of self-coherence. Information-processing theories understand the self as an individual's mental representations of his or her own personality, attributes, and beliefs. Thus, the self is viewed as a "knowledge structure," a mental concept stored in memory, in the same way as mental representations of other people, objects, and the world are created and stored (Strauman & Higgins, 1993). Cognitive theories also have introduced the concept of "self-schema" – that is, a network of information about one's past experiences, personal characteristics, and possible future behaviours. The self-schema guides current perceptions and interpretations of life events, providing the individual with a basis for responding to and making judgments about the

environment, and for processing new information in the context of his or her existing view of self (Segal, 1988).

While some cognitive theories focus on the content of what is known about the self, others include a consideration of the individual's subjective perceptions of self. For example, theories of self-discrepancy and cognitive dissonance suggest that people are motivated to ensure that their self-concept corresponds to a desired end-state. Individuals have a mental representation of their "actual self" (the attributes they believe they possess), their "ideal self" (hopes, wishes, aspirations for themselves), and their "ought self" (representing their sense of duty, obligations, and responsibilities) (Higgins, 1987). It is suggested that people experience emotional distress when discrepancies arise between their "actual" and "ideal" self; or when they experience discrepancies between their self-concept and their thoughts, beliefs, or social feedback about the self (see Strauman & Higgins, 1993). By contrast, healthy functioning occurs when there is consistency across these different representations of self.

Constructivist Views of Self

Constructivist views call into question how we understand knowledge and concepts such as "the self". A social constructionist perspective, (see Gergen, 1985), would challenge the notion of an objective "self" or "mind" that can be observed or understood, and views the concept of "self" as a communally constructed shared understanding, shaped by social and historical conventions. Other constructivist perspectives assume the existence of a real "self" but suggest that it cannot be known or grasped "objectively". In contrast to cognitive views that assume an objective external truth about the "self", which exists independently of people's observations of it, the constructivist perspective emphasizes the characteristics of

the observer and how these frame our understanding (Guidano, 1995). Constructivist perspectives consider how our social and cultural frames impose a structure on our understanding of self (Wentworth & Wentworth, 1997).

Generally speaking, constructivist frameworks view humans as active agents who create meaning for their experiences in a way that promotes internal coherence (Neimeyer, 1993). An early constructivist view of self, Kelly's Personal Construct Theory (1955), suggested that individuals actively collect and integrate information from past experience into "personal constructs" or theories that help them to interpret and understand the world. Personal constructs are developed through social interactions and the individual testing hypotheses about life events; these constructs ultimately form the basis for self-evaluation. One constructivist theory proposes that the self is composed of a dynamic multiplicity of "selves" (Hermans, 1996). In this view, there is not one unitary, centralized self, but rather, a complex combination of multiple aspects of self or "voices" that interact with each other, each holding different perspectives and values. Some of these "voices" are those of significant others in the past whose positions have become incorporated into the self. Although individuals typically have one "dominant" voice that they consider their "usual self", other less dominant positions of the self may emerge in different situations. Hermans (1996) further suggests that through the process of self-reflection, less dominant positions can be explored and become more salient aspects of self.

Experiential/Humanistic Views of Self

Experiential and humanistic perspectives view the self as a process or experience rather than a structure or mental representation. Experiential theories of self and psychological health are philosophically rooted in the phenomenological tradition, which

emphasizes the personal meaning of an individual's experience as central to understanding them. Experiential therapies thus consider individuals to be experts of their own experience. They draw from dialectical constructivist views of self, in which the self is understood to be a synthesis of both conceptual/explanation-oriented and automatic emotional/experiential parts (Greenberg & J. Pascual-Leone, 2001).

Humanistic and experiential therapies traditionally have viewed people as having an inborn "actualizing tendency," that is, a fundamental motivation or drive toward growth and self-development (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, Rice & Elliott, 1993). From the perspective of client-centered therapy (Rogers, 1951), this actualizing tendency leads individuals toward greater autonomy and an increasing ability to make decisions based on their own values rather than those of society (Bohart, 2003). The Gestalt perspective (Perls, Hefferline, & Goodman, 1965) suggests that individuals possess a self-regulatory mechanism in which they are motivated to interact with the surrounding environment in order to satisfy "organismic" needs. From both perspectives, this actualizing or growth tendency is dependent on the individual's awareness of his or her inner experience and needs; people are best able to develop and make decisions for themselves when they are fully aware of their personal experiences. Thus, developing and maintaining awareness of internal subjective experience is considered to be a key aspect of psychological health. Gendlin (1968) introduced the construct of "experiencing" to describe the process of attending to and verbally symbolizing one's bodily felt sense or gut-level reaction to the environment, along with its personal significance (Klein, Mathieu-Coughlan, & Kiesler, 1986). Gendlin suggested that this is a process of constructing meaning for life experiences.

As with constructivist views, the self from an experiential/humanistic framework is not considered to be a static structure. Rather, it is viewed as a fluid process that reflects the experience of the person in any given moment. Rogers (1963) suggested that healthy psychological functioning includes the ability to live in the present moment, without imposing rigidity or structure on experience. The self is considered to be continually in flux, with an intrinsic self-organizing capacity, and the ability to flexibly resolve the individuals' existing needs in the present environment. The self and personality are considered to emerge from the person's experience, rather than the individual modifying his or her perceptions of experience to fit a preconceived self-structure. Furthermore, Rogers proposes that an individual's capacity for self-acceptance is based on others' perceptions of him or her. When significant others impose conditions of worth (i.e., communicate that they are worthwhile only when they conform to specific standards or values), people learn to conform rigidly to expectations, rather than valuing their inner experience. By contrast, in environments that provide acceptance, unconditional positive regard, and understanding, individuals are better able to consider and accept all aspects of self and integrate these into an organized and coherent system (Rogers, 1947). Providing this type of environment is thus the key focus of client-centred and humanistic therapies.

Emotion focused therapy. Current emotion-focused therapy theory (EFT; Greenberg & Paivio, 1997; Greenberg, Rice, & Elliott, 1993) is grounded in the experiential tradition and integrates elements of information-processing, constructivist, attachment, and emotion theories. First, EFT emphasizes the role of emotion (in addition to experiencing) in allowing individuals to construct meaning for life experiences. According to emotion theory (e.g., Damasio, 1999; Fridja, 1986; Izard, 2002; Ledoux, 1996), emotions are associated with

a complex network of information that includes cognitive, affective, somatic, motivational, perceptual, behavioural, and relational information as well as an associated action tendency. This multi-modal network of information is encoded in memory as an emotion scheme and is the basis for constructing meaning from experience (Paivio & Pascual-Leone, 2010). Furthermore, particular discrete emotions are adaptive sources of information about an individual's needs and goals, and are associated with specific action tendencies that promote survival and adaptation to the environment (Ledoux, 1996; Greenberg et al., 1993). For example, anger promotes self-protection and assertiveness, and sadness promotes grieving losses and self-soothing (Paivio & Pascual-Leone, 2010). Exploring a particular emotional state activates the entire emotion scheme (e.g., associated feelings, needs, desires, somatic experience, thoughts, perceptions, and memories), permitting exploration of the meaning associated with this information. Particularly important emotion schemes are those that concern the self and self in relation to others.

EFT theory suggests that an individual's sense of self is constructed around one or more dominant affective meaning systems, or self-organizations, that are activated as part of specific emotion schemes. Drawing on constructivist views of self (Hermans, 1996), EFT theory views the self as a dynamic system, composed of multiple self-aspects or "voices" that are continually evolving, rather than a single, static, "executive" self (Elliott & Greenberg, 1997). One self-organization may be more dominant than others at particular times or situations but other self-organizations are available to be integrated into current experience (Paivio & Pascual-Leone, 2010). For example, individuals exposed to childhood abuse may have a dominant self-organization centred on vulnerability, inferiority, or worthlessness, but be able also to access less dominant self-organizations (e.g., self as

confident and valuable). From this perspective, psychological health occurs when the different aspects of self are brought into contact with one another and integrated, such that a coherent sense of self emerges in any given situation (Greenberg & Elliott, 1997). For example, an individual with a core self-organization as worthless and bad may be able to access healthy resources (e.g., feeling anger at maltreatment, recognizing unmet needs for caring and acceptance) that activate an alternative sense of self (e.g., self as valuable and deserving of care) and thus challenges the dominant self-organization.

Furthermore, emotion focused therapy adapted for trauma experiences (EFTT) draws on attachment theory (Bowlby, 1988) that posits early, affectively charged experiences with attachment figures as the basis for developing core self-organizations. These self-organizations consist of feelings, images, memories, needs, beliefs, and expectations about self and others that were formed in attachment relationships that can become re-activated in current situations (Paivio & Pascual-Leone, 2010). The focus of the EFTT treatment approach is on resolving issues with abusive or neglectful others by accessing and modifying core negative self-organizations that were formed in the context of these relationships.

Most theoretical models view early experiences with attachment figures as central to the development of self. Childhood maltreatment experiences would thus be expected to negatively impact the developing self. The following section of the literature review will describe the effects of early childhood maltreatment experiences on self-perceptions.

Childhood Maltreatment

Definitions and Prevalence of Childhood Maltreatment

Childhood maltreatment can be defined as an unwanted experience in childhood that is perpetrated by an adult or older person, causing physical and/or psychological harm.

Prevalence estimates indicate that a considerable segment of the population has experienced some form of childhood maltreatment, although these vary somewhat across studies, due to methodological differences in data collection, choice of sample, types of questions, and definitions of ‘abuse’ and ‘child’ (Goldman & Padayachi, 2000). The most frequently reported and studied types of maltreatment are sexual and physical abuse.

Childhood sexual abuse describes unwanted sexual activities in which there is a large age or maturational difference between the child and perpetrator, a relationship of authority or care-giving, or the use of force, coercion or trickery to carry out the activities (Banyard, Williams, & Siegel, 2001; Finkelhor, 1994). Sexual activities may or may not include physical contact, and range from non-contact exhibition or verbal harassment and propositions, to non-penetrative fondling and sexual kissing, to activities involving penetration (Finkelhor, 1994). The prevalence of sexual abuse is generally higher among females than males, but with variability across samples. A large community study in the United States indicated rates of sexual abuse at 32% for women and 14% for men, (Briere & Elliott, 2003). A representative population sample conducted in Québec reported a prevalence rate of 22% for women and 10% for men (Hébert, Tourigny, Cyr, McDuff, & Joly, 2009). Within the United Kingdom, a community sample of young adults had a prevalence rate of 10% (May-Chahal & Cawson, 2005). International estimates of the prevalence of childhood sexual abuse average 12.7% across studies; with a rate of 18% for women and 7.6% for men (see Stoltenborgh, Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011 for a meta-analysis). It should be noted that prevalence estimates that rely on retrospective reports have the risk of underestimating child sexual abuse rates, given the

evidence for adult survivors of child sexual abuse who have no recollection of the abuse incident(s) (see Williams, 1994).

Childhood physical abuse involves a non-accidental injury to a child resulting from an act of physical violence or excessive punishment on the part of an adult, and resulting in demonstrable harm or endangerment to the child. (Malinosky-Rummell & Hansen, 1993). Prevalence rates for physical abuse in community samples in the United States have been reported at 19% (Scher, Forde, McQuaid, & Stein, 2004), with similar exposure to physical abuse across genders (20% for women, 22% for men; Briere & Elliott, 2003). In Ontario, the prevalence for men has been found to be slightly higher (31%) than for women (21%; MacMillan et al., 1997). A community study of young adults in the United Kingdom indicated that 7% had experienced severe physical abuse (May-Chahal & Cawson, 2005).

Childhood emotional or psychological maltreatment is less easily observed and documented than physical or sexual maltreatment, and thus its prevalence is more difficult to estimate. Some researchers have suggested that emotional abuse is a core aspect of other forms of maltreatment (physical, sexual), and that it may well be the most prevalent form of maltreatment, but is also the most hidden, under-reported, and least studied (Barnet, Miller-Perrin, & Perrin, 2005). Emotional maltreatment is often detected in the context of other forms of abuse; an estimated 29% of reported and substantiated cases of child maltreatment in Canada involved either emotional abuse or emotional neglect, reported either alone or along with other forms of maltreatment (Chamberland, Fallon, Black, & Trocmé, 2011). Emotional maltreatment can be defined as acts of commission or omission that communicate to the child that he or she is unwanted or unworthy of attention and affection, and which negate the child's developmental and social needs, self-worth, and self-esteem (Hart,

Brassard, Binggeli, & Davidson, 2002; Iwaniec, Larkin, & Higgins, 2006). Guidelines published by the American Professional Society on the Abuse of Children (1995) identify six types of emotional maltreatment: hostile rejection or degradation; exploiting or corrupting a child for one's own needs; terrorizing, for example, by threatening the child or the child's loved one; ignoring or withholding affection and emotional responsiveness; isolating the child from sources of support or socialization; and neglecting the child's mental health, medical or educational needs. Additional examples of emotional maltreatment include physical control causing distress (but not physical injury); inappropriate stimulation of a child's aggression and/or sexuality; showing marked dislike of the child; and permitting a child to witness domestic violence between his or her parents (May-Chahal & Cawson, 2005; Barnett, Manly, & Cicchetti, 1993). Emotional abuse reflects behaviours that demean or humiliate children, while emotional neglect refers to failing to meet the child's emotional needs (e.g., unresponsiveness to children's appeals for attention and care) (Bernstein et al., 1994; Hildyard & Wolfe, 2002). A community sample in the United States reported a rate of emotional abuse of 12% and emotional neglect at 5% (Scher et al., 2004), while a rate of 6% was found within a community sample of young adults in the United Kingdom (May-Chahal & Cawson, 2005).

Psychological Outcomes of Childhood Maltreatment

A history of childhood maltreatment has been associated with a wide range of psychological problems. Thus, the prevalence of a history of childhood maltreatment is particularly high in clinical samples. Fifty to sixty percent of psychiatric inpatients and 40 to 60% of outpatients report histories of childhood physical or sexual abuse (Herman, 1992). Prevalence rates as high as 90% have been reported among specific diagnostic groups

(Pilkington & Kremer, 1995). A history of childhood abuse is also common within incarcerated populations (e.g., Johnson, Ross, Taylor, Williams, Carvajal, & Peters, 2006; Warren, Hurt, Loper, Bale, Friend, & Chauhan, 2002).

Traumatic events, by definition, are unexpected, extraordinary situations that exceed an individual's ability to meet situational demands. They disrupt the person's frame of reference and sense of what to expect from the world, and may cast doubt on previously held beliefs and assumptions (Crossley, 2000a). Individuals often develop psychological reactions to traumatic events, including symptoms of post-traumatic stress disorder (PTSD). These include persistent re-experiencing of the traumatic event (e.g., nightmares, flashbacks), physiological reactivity to cues that resemble the traumatic event, persistent avoidance of trauma-related stimuli, diminished responsiveness (e.g., feelings of detachment, loss of interest, restricted emotions), increased arousal and hyper-vigilance, and negative alterations in cognitions and mood (American Psychiatric Association, 2013).

Complex or Type II trauma refers to a more intricate constellation of disturbances resulting from exposure to traumatic stressors that are prolonged or repetitive, involve harm or abandonment by caregivers, and occur at developmentally-vulnerable life stages (e.g., childhood or adolescence) (Ford & Courtois, 2009). A proposed diagnostic category capturing the disturbances of early-onset, prolonged interpersonal traumatic exposure has been empirically supported (DESNOS, or Disorders of Extreme Stress, Not Otherwise Specified; Scoboria, Ford, Lin, & Frisman, 2008). Symptoms of DESNOS or complex trauma include: alterations in affect regulation (e.g., difficulty modulating anger, self-destructive and suicidal behaviours); alterations in consciousness (e.g., memory gaps, amnesia and dissociation); somatization; maladaptive perceptions of self (e.g., chronic guilt,

shame, ineffectiveness); alterations in perceptions of the perpetrator (e.g., preoccupation with or idealization of the perpetrator); alterations in relationships with others (e.g., withdrawal, distrust, revictimization); and alterations in systems of meaning (e.g., hopelessness, loss of previous beliefs) (Herman, 1992; Scoboria et al., 2008). A field trial of individuals exposed to prolonged interpersonal trauma at an early age showed evidence of this constellation of disturbances, with more severe symptoms among those who experienced trauma at a younger age and for a longer duration (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazolla, 2005). Furthermore, research on the long-term effects of childhood maltreatment has demonstrated a variety of psychological effects that are consistent with the DESNOS designation, including depression, anxiety, PTSD, physical symptoms, self-harm or suicidal behaviour, substance abuse, dissociation, and negative perceptions of self, as well as disturbed sexual functioning (sexual abuse) and interpersonal violence (physical abuse) (Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia, 1992; Malinosky-Rummell & Hansen, 1993; Neumann, Houskamp, Pollock, & Briere, 1996; Spertus, Yehuda, Wong, Halligan, & Semeretis, 2003). Research evidence further demonstrates that greater psychological disturbance is associated with earlier age of onset, a greater number of abuse incidents, multiple perpetrators, greater emotional distress at the time of the abuse, the use of force or threat of harm, penetration in sexual abuse, and multiple forms (physical, sexual, emotional) of abuse (Beitchman et al., 1992; Briere & Elliott, 2003; Malinosky-Rummell & Hansen, 1993). DESNOS was included in the appendix of the DSM-IV-TR (American Psychiatric Association, 2000), but it was not considered a distinct diagnosis in the DSM-V (American Psychiatric Association, 2013), as field trials have indicated that the majority (92%) of

individuals meeting criteria for DESNOS also meet criteria for PTSD (Friedman, Resick, Bryant, & Brewin, 2011).

Effects of Childhood Maltreatment on Self-Development

Among the many long-term psychological outcomes of childhood abuse, the effects on the sense of self and on interpersonal relationships are undoubtedly among the most significant. Most theoretical perspectives agree that the sense of self is related to (and develops from) relationships with significant others. The following section highlights evidence for self-related disturbances resulting from childhood maltreatment, including negative effects on self-worth, self-awareness, a personal sense of agency or control, and self-regulation.

Self-worth, shame, and self-blame. The concept of self-worth or self-esteem refers to people's conceptualizations of, or beliefs about themselves, and implies an evaluative or affective reaction to oneself (Leary, 2004). Numerous studies have shown a link between experiences of childhood maltreatment and low self-esteem. One prospective, longitudinal study examined a community sample of children over three years. Maltreated and non-maltreated children were matched based on age, gender, ethnicity, and family economic status. Results showed that exposure to physical abuse or sexual abuse predicted lower self-esteem scores, as did early onset and more frequent maltreatment (Bolger, Patterson, Kupersmidt, 1998). Another longitudinal study examined children between the ages of six and eleven across several years. Results demonstrated that children experiencing physical abuse had lower initial levels of self-esteem, and that experiencing emotional maltreatment predicted slower growth of self-esteem over time (Kim & Cicchetti, 2006). A richer understanding of the effects of emotional abuse emerges from a phenomenological study of

eleven young adults who described the impact of psychological maltreatment by their mothers. Participants in this study reported frequently feeling unwanted or ignored, and believed that they were not good enough to earn their mother's approval, acceptance, or love. The resulting sense of loneliness and isolation led to sometimes-frantic attempts to prove their worth to perpetrators of the abuse. Participants also indicated that their feelings of shame and low self-worth were linked to perceived belittlement and maltreatment in their current romantic relationships, and reported engaging in self-destructive, avoidant, and aggressive behaviours. They reported feeling intense self-doubt and disempowerment, and having great difficulty making decisions about their life (DeRobertis, 2004). A review of studies examining the effects of childhood neglect demonstrates that neglected children tend to have difficulties with social, emotional, and cognitive development, are more socially withdrawn, and often have negative perceptions of self (Hildyard & Wolfe, 2002). Thus, quantitative studies and reports from survivors of childhood maltreatment both demonstrate the substantial negative impact of maltreatment on self-esteem and a sense of self-worth.

Feelings of shame or shame-proneness in adulthood have been associated with a history of childhood abuse. Shame implies a negative evaluation of a central aspect of self (Paivio & Pascual-Leone, 2010; Tangney, 1999). One study demonstrated that maternal physical abuse was associated with feelings of shame and anger among their preschool children (Bennett, Sullivan, & Lewis, 2005). In addition, young adults who reported being exposed to emotional abuse were more likely to report more shame and guilt (among women), and hostility and anger (among men) (Hoglund & Nicholas, 1995). A study among bulimic women found that a history of sexual abuse was associated with greater internalized

shame (Murray & Waller, 2002). These results suggest that various types of childhood maltreatment are associated with feelings of shame.

Furthermore, individuals exposed to childhood maltreatment are more likely to blame themselves for negative events. A review of qualitative and quantitative studies examining the effects of childhood abuse on cognitive styles in adulthood (Gibb, 2002) suggests that a history of childhood emotional maltreatment is associated with the tendency to make internal, global, and stable attributions for negative life events, that is, to attribute these negative events to one's own doing (i.e., self-blame), a cognitive style that is associated with depression.

Self-awareness and identity. Clinician observation and anecdotal evidence suggests that a common consequence of childhood abuse is an unclear self-identity and poor self-awareness, as well as associated problems establishing interpersonal boundaries and feelings of personal emptiness (e.g., see Briere, 1992). There also is empirical evidence to suggest that survivors of childhood abuse experience disruptions in identity or self-awareness. For example, one of the major features and diagnostic criteria for borderline personality disorder (BPD) is "identity disturbance" or an unstable sense of self (American Psychiatric Association, 2013). Borderline personality disorder has been widely associated with a history of childhood abuse (Herman, Perry, & Van der Kolk, 1989; Ogata, Silk, Goodrich, Lohr, Westen, & Hill, 1990; Westen, Ludolph, Misle, Ruffins, & Block, 1990; Zanarini, Williams, Lewis, & Reich, 1997), and childhood sexual and physical abuse have been identified as etiological factors in the development of BPD (along with family environment and family history of psychopathology) (Bradley, Jenei, & Westen, 2005). Some research has suggested that for a subset of individuals who have experienced sexual abuse in early childhood, the

diagnosis of borderline personality disorder may be subsumed within the construct of complex PTSD, given the considerable overlap in symptoms that exists between these two diagnostic categories (McLean & Gallop, 2003). Becker (2000) suggests that BPD may be considered a form of complex PTSD that has been integrated into the personality structure, and that the diagnosis of complex PTSD has the advantage of being non-blaming and situationally-focused, rather than identifying the root of problems as existing within the individual.

A recent study examined the nature of identity disturbance in patients diagnosed with borderline personality disorder as well as the association of identity disturbance with a history of sexual abuse (Wilkinson-Ryan & Westen, 2000). In their development of a scale addressing identity disturbance, the authors identified one of four factors as “painful incoherence”, which referred to distress about having an incoherent sense of identity and was found to be highly correlated with a history of sexual abuse. This concept captured a feeling of not knowing oneself, feeling empty inside, feeling “unreal”, having a “false self”, fears of losing one’s identity, and lacking a sense of continuity over time (Wilkinson-Ryan & Westen, 2000).

A dissertation study (Buggs, 1997) examined the experience of “emptiness” in adults who had and had not been abused during early childhood, and identified two factors: a sense of yearning or hunger, and a sense of emotional numbness. Results demonstrated a significant difference in “emptiness” scores between those who had been abused and those who had not, and further demonstrated that a history of emotional abuse was a predictor of the experience of emptiness.

Finally, a clearer sense of identity and increased self-awareness has been linked to the process of recovery from childhood abuse. A qualitative study of female survivors of childhood abuse who underwent therapy examined themes related to the recovery process in interviews with these clients (Phillips & Daniluk, 2004). Many of the survivors talked about feeling "different", "alone" and "invisible" prior to beginning the process of recovery, and described a sense of incongruence between their inner feelings and how others perceived them. At later stages in the recovery process, they reported feeling more visible, more connected with others, and more congruence between their inner feelings and external persona. A second, related theme described their changing sense of identity. Many of the survivors described feeling "engulfed" in the pain of the abuse, and being unable to discover who they were outside of that experience. Many reported that taking on the identity of "survivor" (rather than "victim") was an important early stage of recovery and that as they continued to heal over time, they were able to allow other aspects of their identity to emerge (Phillips & Daniluk, 2004).

Sense of agency. Some research has also examined links between childhood abuse and constructs related to personal agency or control, such as a sense of empowerment, self-efficacy, locus of control, and learned helplessness. One qualitative study examined themes of power and powerlessness in stories told by twenty women who were either abused in childhood or who had not experienced childhood abuse (Liem, O'Toole, & James, 1992). Those who had been abused told more stories with the theme of "need for power", were more likely to describe blocks to achieving power goals in their stories, and included more references to powerlessness, as compared to the stories of women who had not been abused.

Another study with female undergraduate students examined the links between childhood abuse, adult sexual victimization, locus of control, and current PTSD symptoms (Bolstad & Zinbarg, 1997). Those who had experienced multiple experiences of childhood sexual abuse reported a lower generalized perception of control than those who had only experienced one incident of childhood sexual abuse. This study thus supported the idea that repeated experience with uncontrollable, unpredictable events would lead to expectations of future uncontrollability (see Foa, Zinbarg, & Rothbaum, 1992). A similar construct was examined in a study examining attribution style (i.e., learned helplessness) in relation to a history of childhood abuse and PTSD symptoms among Vietnam War veterans (McKeever, McWhirter, & Huff, 2006). A helpless attribution style was associated with both a history of childhood abuse and current PTSD symptoms, and PTSD symptom severity increased as the degree of learned helplessness increased. This suggests that early exposure to uncontrollable environments is associated with enduring helpless attributions. A recent study with male and female undergraduate students examined associations between self-schemas (i.e., internal representations of self), childhood experiences, and current symptoms (Wright, Crawford, & Castillo, 2009). Self-schemas of vulnerability to harm were found to mediate the relationship between childhood emotional neglect or emotional abuse and current symptoms of anxiety and depression.

In addition to research on powerlessness, helplessness, and vulnerability to harm, some studies have examined constructs of self-efficacy and empowerment. For example, Banyard and Laplant (2002) found that a history of childhood maltreatment was related to lower levels of intrapersonal empowerment, which encompasses a person’s perceived sense of control, self-efficacy, desire for control in his/her life, and perceptions of his/her own

abilities. Finally, a recent study of undergraduate students examined the association of childhood abuse and neglect with aspects of vulnerability and resilience to depression (Soffer, Gilboa-Schechtman, & Shahar, 2008). Depression is commonly linked to negative evaluations of self (e.g., as vulnerable or powerless). Notably, in this study lower self-efficacy was associated with a history of emotional neglect, but not emotional abuse, which suggests that the lack of positive parent-child interactions (rather than the presence of negative interactions) might prevent the child from developing positive beliefs about their self and abilities.

Self-regulation. The concept of self-regulation includes both emotion regulation and behaviour or impulse control. A healthy capacity for emotion regulation is considered to include three features: experiencing the full range of emotions, modulation of emotional experience, and appropriate displays of emotion (Gross, 1999). Individuals who have limited emotion regulation capacities may either over-control or under-regulate their emotional states, or may engage in maladaptive strategies for coping with distress. Under-regulation of emotional states may result in the individual experiencing overwhelming emotions (e.g., chronic depression or anxiety), having difficulty handling aggression or self-destructive impulses, and feeling over-aroused (Van Dijke, 2008). This may result in maladaptive behaviours that are considered to be attempts at self-regulation, such as aggression against others, eating disorders, substance abuse, and self-harming behaviours (Van der Kolk & Fisler, 1994). By contrast, emotional over-control is an alternate strategy for coping with high levels of internal distress (Paivio & Laurent, 2001). This describes individuals who avoid their emotions as a means of protecting themselves from being overwhelmed. This may include feeling “numb”, “blank” or “empty”; suppressing feelings, having difficulty

identifying or describing emotions (i.e., alexithymia), as well as symptoms such as somatization or dissociation (Van Dijke, 2008).

A history of childhood abuse has been associated with under-regulation and over-control of emotion, and both are features of the trauma response and symptoms of PTSD. Most prominently, the DSM-IV field trial for complex PTSD demonstrated an association between early interpersonal trauma and effects on psychological functioning, which include problems with affect dysregulation, aggression against the self and others, dissociative symptoms and somatization (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazolla, 2005). These symptoms correspond to strategies to cope with emotional under-regulation, or to examples of emotional over-control (described above).

Sources of Disturbance

There are three interrelated sources of disturbance that contribute to the effects of childhood abuse trauma on functions of the self (Courtois & Ford, 2009; Paivio & Pascual-Leone, 2010). These include: exposure to trauma, negative experiences with attachment figures, and reliance on avoidance as a coping strategy. The following sections will describe the mechanisms for these sources of disturbance of the sense of self.

Exposure to trauma. Exposure to repeated traumatic experiences can have a profound impact on an individual's capacity to regulate emotional reactions. Traumatic experiences, by definition, are events that involve actual or threatened death or serious injury, or a threat to the physical integrity of self, and to which the individual reacts with intense fear, helplessness, or horror (American Psychiatric Association, 2013). In the case of traumatic childhood abuse, the constant threat of danger evokes overwhelming emotions (e.g., of fear and terror) that exceed the child's abilities to manage his or her reactions. This

may result in affect regulation difficulties, such as emotional over-control, under-regulation of affect, or the use of maladaptive coping strategies to manage emotional distress (see van der Kolk & Fisler, 1994).

Secondly, exposure to trauma can minimize the individual's personal sense of control or agency in their life. Traumatic events are situations in which individuals are unable to stop or prevent the incident from happening, thus repeated instances of trauma may result in a profound sense of powerlessness. In the case of ongoing or repeated childhood abuse, this can result in the adoption of maladaptive beliefs about the self and the world. For example, the victim may develop perceptions of the self as weak and vulnerable, others as unreliable and untrustworthy, and the world as a dangerous place (Briere & Runtz, 1993). This experience or perception of self as weak and powerless may be compounded by a behavioural coping strategy adopted by many abused children to escape or avoid further punishment. Engaging in "compulsive compliance", that is, excessive vigilance and compliance with the abuser's demands, may be more likely to maintain the child's safety in the short-term by appeasing the abuser, but ultimately prevents the child from learning to act in accordance with his or her own needs and desires (Iwaniec, Larkin, & Higgins, 2006).

Furthermore, children who experience repeated maltreatment are likely to have limited awareness of their own feelings and needs. Children growing up with abusive family members may be exposed to unpredictable, arbitrary punishment and inconsistent rules, and may develop a state of constant alertness to warning signs of attack. They may become closely attuned to the abuser's mood states and subtle changes in facial expression, voice, and body language, which may serve as cues for abuse, a strategy that has been labelled "other-directedness" (Briere, 1992; Herman, 1992). This tendency has been empirically

supported; physically abused children have been shown to over-attend to angry facial expressions, and to disengage more slowly from these images when they serve as invalid cues of danger (Pollak & Tolley-Schell, 2003). While adaptive in serving to anticipate or avoid abuse, this sustained focus on external cues to danger and safety draws attention away from the developmental task of building self-awareness.

There are other reasons why exposure to trauma may result in limited self-awareness. The overwhelming fear experienced during the traumatic event may result in memory gaps that interfere with the individual's ability to fully remember or understand what happened to him or her; this is commonly observed in individuals with PTSD. A recent literature review has examined the features of autobiographical memories for traumatic events (Brewin, 2007). Some evidence exists that abuse survivors are highly accurate in recalling traumatic events, and that the quality and vividness of these memories remains consistent over time. By contrast, other studies have shown that memories for traumatic events are more fragmented, scattered, and incoherent than non-traumatic memories, and that they are more likely to be disorganized or contain gaps. Greater memory gaps for trauma- or abuse-related events have been associated with specific characteristics of the abuse, such as greater duration, severity, use of force, multiple perpetrators, greater distress at the time of the abuse, abuse by a family member, and early-onset trauma (Brewin, 2007; Briere & Conte, 1993; Edwards, Fivush, Anda, Felitti, & Nordenberg, 2001; Van der Kolk & Fisler 1995).

Physiological evidence supports the view that memory gaps result from traumatic events. Neurobiological evidence suggests that trauma may cause structural changes in the brain, such as a reduction in hippocampal volume. This may subsequently affect the ability to process and encode experiences later in life, whether or not they are traumatic (see

Edwards et al., 2001). In support of this theory, some evidence suggests that survivors of childhood abuse have more general memory gaps than non-abused individuals, even for non-traumatic events. Specifically, in a study of 450 adult subjects from a clinical population who reported histories of childhood sexual abuse, 59% of participants reported that there had been a period of time in which they could not recall their first experience of being abused (Briere & Conte, 1993). In a nonclinical population, a history of physical or sexual abuse in childhood was associated with a greater rate of amnesia for childhood memories, as compared with individuals who had no abuse history (Edwards et al., 2001). A study of 129 women with documented histories of childhood sexual abuse demonstrated that over one third (38%) had no memory of the documented incident when interviewed seventeen years later (Williams, 1994). As well, a study of the retention and quality of traumatic and non-traumatic memories among incest survivors, rape survivors, and non-abused women, demonstrated that both the traumatic and non-traumatic memories of incest survivors were more fragmentary than those of the other two groups (Fisler, Vardi & Van der Kolk, 1994).

There are several possible explanations for memory gaps for traumatic events. The first is that overwhelming emotion and heightened physiological arousal affects the degree to which details of the event are encoded, thus interfering with the organization, accuracy, and coherence of trauma memories. For example, the possibility of danger may focus the individual's attention toward threat-relevant information as compared to neutral or threat-irrelevant information (Foa, Molnar, & Cashman, 1995). Traumatic memories have been described as having prominent perceptual features and being associated with strong emotions (see Brewin, 2007), which suggests that the emotionally salient and threat-relevant details may be those that persist in memory.

It has also been suggested that memory gaps for traumatic events may occur because individuals dissociate during the traumatic event, as a means of coping with or avoiding the overwhelming emotions that result (Putnam, 1997; Van der Kolk, 1996). Dissociation can refer to a range of experiences, including the sensory and emotional fragmentation of an experience, depersonalization or derealisation during a traumatic event, ongoing depersonalization or "spacing out" in daily life, and confining the traumatic memories within distinct personalities (Van der Kolk & Fisler, 1995). In the case of dissociation during trauma, the sensory and emotional aspects of the experience are not integrated into a whole, but are stored in memory as isolated fragments. Over the course of repeated or chronic trauma, the individual may develop a dissociative style, resulting in a series of fragmented or disorganized memories (Putnam, 1997; Van der Kolk, 1996).

Another theory suggests that emotional and sensory aspects of the traumatic event are encoded separately from the narrative or linguistic representations of the memory (see Brewin, 1989; LeDoux, 1996). Fragmentation or separation of the linguistic from the sensory aspects of traumatic memories may make it difficult for the individual to integrate their experience and be able to tell the story of it. For example, Van der Kolk & Fisler (1995) interviewed 46 subjects regarding their perceptions of traumatic and significant but non-traumatic memories. Several of the participants who had been abused as children had difficulty describing a complete narrative of their traumatic experiences. All participants described that they initially remembered traumatic experiences in somatosensory "flashbacks", and only over time did they come to develop a narrative that explained what had happened to them.

Research by Pennebaker and colleagues suggests that language is important in the understanding and assimilation of upsetting events, and that those who fail to express their feelings and thoughts will be unable to fully process the event (Pennebaker & Stone, 2004). The act of accessing emotions and images and converting them to words is considered to change the way the person organizes and thinks about trauma. Thus, memory gaps or the inability to coherently describe significant or traumatic events can have an important effect on an individual's sense of self-awareness and self-coherence. Some have suggested that individuals who are unable to develop a personal narrative that integrates their traumatic experiences are more likely to experience a fragmented sense of self (Dimaggio & Semerari, 2001). Other researchers have proposed that individuals who have a lack of childhood memories may not feel anchored by a continuous sense of self in time (Edwards et al., 2001). Feminist theorists have suggested that being able to tell one's story gives power and memory to events, and thus the silencing of one's story of trauma results in a sense of lost "voice" or reality (see Belenky, Clinchy, Goldberger & Tarule, 1986). In a qualitative study interviewing female survivors of childhood abuse about their sense of self (Fivush, 2004) many women described having a dissociated self-concept, in which their mind felt "split off" from their body, or their abuse memories "split off" from other personal memories. The author suggested that those who were unable to integrate their traumatic experiences into a coherent self-understanding were more likely to experience a fragmented sense of self.

Furthermore, trauma, by definition, is considered to challenge individuals' expectations or perceptions of the world. However, in the case of childhood abuse, traumatic experiences disrupt the stability of life events while children are still *developing* their fundamental assumptions and beliefs about the self and the world. This results in a disruption

of the development of a sense of continuity and meaning for personal experiences (Reviere & Bakeman, 2001) and thus further impacts the capacity for self-awareness and a coherent view of self.

Negative experiences with attachment figures. Childhood abuse frequently occurs in the context of early attachment relationships, with the abuse perpetrated by a parent, stepparent, or other trusted adult in the child's life. A study of randomly sampled cases of child abuse or neglect reported to Ontario Children's Aid Societies found that in 48% of cases the child's mother was the alleged perpetrator of abuse or neglect, and the father or stepfather was the alleged perpetrator in 43% of cases (Trocmé, McPhee, & Kwok, 1995). The following section will consider the implications of negative experiences with attachment figures as an important source of disturbance from the perspective of attachment theory.

Attachment theory (Bowlby, 1988) suggests that a person's sense of self develops in childhood through interactions with his or her primary caregivers. The child develops "internal working models" (i.e., mental representations) of him- or herself, as well as working models of his or her parents, based on their day-to-day interactions. These models become enduring cognitive structures that capture not only the child's experience of his or her parents but also the image or perceptions of self that were communicated to him or her (Bowlby, 1988). Thus, if caregivers communicate love and acceptance to the child, and validate his or her emotions and experience, the child will develop a sense of self as worthwhile and acceptable, and a sense of others as loving and trustworthy (Briere & Scott, 2006). By contrast, children who are abused are likely to experience a family environment of instability and limited emotional support (Friedrich, Beilke & Urquiza, 1987; Horwitz, Widom, McLaughlin, & White, 2001). The child's feelings and needs for security,

autonomy, and love are often ignored, invalidated or violated, leading to an internal model of self as powerless, worthless, or bad, and models of others as unreliable, unsupportive, or dangerous (Herman, 1992).

There is much support for attachment theory. For example, the importance of attachment figures in self-development was demonstrated by a longitudinal study of mother-child relationship quality (Kim & Cicchetti, 2004). This study demonstrated that for both maltreated and non-maltreated children, those who reported greater insecurity with their mother exhibited lower self-esteem; findings that suggest that having attachment figures that provide emotional security may be central to the development of self-worth. Another study suggested that abuse occurring in attachment relationships may be significantly more detrimental to later psychological adjustment than abuse occurring outside the family (Roche, Runtz, & Hunter, 1999). Specifically, women who were sexually abused in childhood by a family member rated themselves lower on dimensions assessing a positive view of self, and rated themselves higher on a negative view of self, as compared to non-abused women and women abused by non-family members. These findings suggest that attachment relationships may be a mediator for the effect of childhood sexual abuse on one's view of self and psychological adjustment.

Growing up with an abusive family member leads children to frequently experience feelings of fear in response to danger, and shame in response to criticism and blaming. Paivio and Pascual-Leone (2010) suggest that when early development is embedded in constant fear and anticipation of danger, with inconsistent availability of protection and support, the child develops a sense of self as vulnerable or insecure. This core "self-organization" may be activated later in life, resulting in feeling powerless, helpless, or

having low self-confidence across situations. Similarly, when shame is the primary emotional experience in childhood, the core sense of self or self-organization that develops is one of worthlessness and inner "badness" (Paivio & Pascual-Leone, 2010). This sense of self is thought to develop through repeated instances of rejection by attachment figures, and may be associated with explicit or implicit beliefs that one is somehow to blame for the abuse. Complex trauma in the context of attachment relationships often results in *both* experiences of insecurity and helplessness, as well as worthlessness and inferiority, resulting in a core "weak/bad" sense of self (Alexander, 1992; Greenberg & Safran, 1987; Herman, 1992; Paivio & Pascual-Leone, 2010).

It is also important to consider the implications of early interpersonal trauma when, in many cases, the child is simultaneously threatened by and dependent on the abuser for survival. Thus, the child is faced with the paradoxical scenario in which his or her only source of comfort and safety (however inconsistent) also is a source of feelings of fear and shame. Studies have found, for example, that maltreatment in infancy is associated with an insecure-disorganized attachment pattern. This suggests that infants who cannot escape their caregivers' maltreatment, nor approach them for comfort, become unable to establish a consistent behavioural coping strategy to manage their emotional state (Carlson, Cicchetti, Barnett, & Braunwald, 1989) Similarly, Mollon (2001) has suggested that dissociative states during traumatic events allow the child an escape from the external world in which the child has nowhere to run and no one to turn to. Psychodynamic theories suggest that an abused child may develop psychological adaptations that serve to preserve the attachment to his or her parents or primary caregivers. Specifically, the child rejects the notion that his or her parents are deliberately harming him or her, as a means of preserving some sense of hope or

meaning. Experiences of abuse are minimized, rationalized, or excluded from conscious awareness, as in the case of extreme dissociative states (Herman, 1992). Alternatively, the child may form self-deprecating conclusions (i.e., “I am bad”, “this punishment is deserved”) that allow the child to preserve both the attachment to his or her parents (“they are doing this for my own good”) as well as a sense of control and hope that the abuse may end (i.e., “if only I can be good enough”) (Andrews, 1998; Briere, 1992; Herman, 1992). The paradoxical scenario and the associated need to preserve the attachment relationship may thus result in an inner sense of self as bad and responsible for the abuse. The victim may also feel guilty or responsible for the abuse as a result of direct messages of blame from the abuser and the negative connotations (e.g., badness, shame, or guilt) that are communicated to the child and become incorporated into his or her self-image (Finkelhor & Browne, 1985). For example, perpetrators of physical abuse may justify their actions by telling the victim it is deserved punishment for wrongdoing (Briere, 1992). These direct messages are often compounded by societal messages of victim blaming (e.g., “why didn’t you just say no?”, “what did you do to provoke it?”) (Briere, 1992; Finkelhor & Browne, 1985).

In addition to providing the basis for internal representations of self, attachment figures are thought to fulfil crucial developmental functions in a child’s life. Specifically, attachment figures provide a physical and emotional safe haven for the child, by providing support and comfort and alleviating distress. Furthermore, they provide a secure base from which children can explore and learn about the world (Mikulincer, Shaver, & Pereg, 2003). The role of attachment figures in providing a safe haven is essential in the development of the child’s self-regulatory capacities. Caregivers implicitly teach infants and children to regulate their emotions by recognizing and responding to their cries of distress. When the

young child's arousal level exceeds his or her capacity to manage emotion, the responsive caregiver is available to soothe and comfort the child and prevent emotion from becoming an overwhelming experience (Sroufe, 1996). Emotion is thus initially regulated through the parent-child dyad, which teaches the child that others are available to respond when they are emotionally aroused, that emotional arousal is rarely overwhelming or disorganizing, and that, when emotions do become overwhelming, re-stabilization occurs quickly (Sroufe, 1996). Thus, children whose caregivers have engaged in dyadic affect regulation develop sufficient capacities for emotional self-regulation and self-soothing in adulthood. For individuals whose parents or caregivers were inconsistently available, or who failed to acknowledge or respond to the child's distress, the capacity to self-regulate emotional arousal is likely to be impaired.

There is empirical support for a link between childhood maltreatment in attachment relationships and self-regulation difficulties. For example, a number of studies have found that early relational trauma is associated with deficits in the function and structure of the right hemisphere of the brain, which typically forms extensive connections with the emotional processing areas of the brain (i.e., limbic system) (see Schore, 2002 for a review). Another study found that experiences of childhood abuse and neglect were associated with self-destructive behaviours in adulthood, such as self-harm and suicide attempts (Van der Kolk, Perry, & Herman, 1991) – behaviours that exemplify self-regulation difficulties. The sample in that study included individuals who had experienced physical and sexual abuse as well as prolonged separations from their primary caregivers, physical or emotional neglect, or who could not remember feeling special or loved by anyone as children.

Parental responsiveness to their child's feelings and associated needs also helps the child develop a capacity for self-awareness and self-understanding. Parents who value their children's emotions and "coach" their children to talk about them, help them to recognize and understand their feelings. In turn, these children develop a better capacity to self-soothe (calm themselves when upset), as compared with children whose feelings were ignored or dismissed (Katz, Wilson, & Gottman, 1999). Children whose parents did not identify and validate their emotions may develop a limited capacity for recognizing, identifying, and communicating their internal emotional state. The term alexithymia refers to disturbances in the ability to identify and communicate one's emotions (Taylor, Bagby, & Parker, 1997). Alexithymia has been associated both with PTSD and past experiences of childhood abuse and neglect (McLean, Toner, Jackson, Desrocher, & Stuckless, 2006; Paivio & McCulloch, 2003; Zlotnick, Mattia & Zimmerman, 2001).

Furthermore, children who are abused may learn to ignore or reject aspects of their experience that are not accepted or acceptable to their caregiver as a means of preserving attachment. Winnicott's object relations theory (1969) suggests that in response to an environment that does not accept and respond to the child's spontaneous expression of needs, the child develops a "false self". This is considered to be an aspect of identity that embodies socially expected or desired feelings and behaviours, in contrast to the "true self" which embodies the child's authentic feelings and needs. Although all individuals develop a false self to some degree, under extreme conditions of criticism, rejection, and disapproval, the false self becomes predominant and the true self remains hidden in order to protect the child from further punishment (Winnicott). Others have suggested that abused or neglected children may acknowledge some of their emotions but deny or dissociate from others that

have never been acknowledged or validated, in order to maintain connection with their caregivers (Lombardi & Lapidos, 1990). While these strategies may be an adaptive means of preserving some form of attachment to the caregiver and avoiding further harm, they are likely to disrupt the development of the child's self-awareness and understanding of his or her inner experience.

A related function of attachment figures is to provide a "secure base" for the child from which he or she can explore the environment (Bowlby, 1988; Mikulincer et al., 2003). Availability of this "secure base" results in development of a sense of mastery and self-confidence. Attachment theory suggests that when a child feels secure he or she is more likely to explore the environment away from his or her attachment figure, and to seek proximity when feeling anxious, tired, or unwell. If children are confident in the caregiver's availability and responsiveness to them when needed, as they grow older, they explore for longer periods and farther from their attachment figure (Bowlby, 1988). Cicchetti (1989) suggests that the availability of a secure base and the subsequent possibility for exploratory behaviour forms the basis for developing a sense of autonomy and mastery over one's environment. With confidence that support will be available when needed, individuals can take more risks and engage in more autonomous behaviours (Mikulincer et al., 2003). By contrast, when this sense of security is not provided by attachment figures, resources must first be devoted to maintaining safety and/or confronting distress, and therefore not to exploration and developing autonomy. Thus, maltreated children may not develop the sense of agency that allows them to confidently explore and master their environment (Harter, 1999). Furthermore, when confronted with repeated experiences of limited control and power, such as in the case of physical or sexual abuse, the child's will, desires, and sense of

efficacy are blocked, resulting in the sense that they have no ability to control their own lives (Finkelhor & Browne, 1985).

Reliance on avoidance. The third source of disturbance associated with child abuse trauma is avoidance of trauma-related memories, thoughts, feelings, and stimuli. The following section will review various forms of avoidance, their association to childhood abuse, and possible explanations for why these avoidance strategies lead to disturbances of the self. First, the DSM-5 criteria for posttraumatic stress disorder includes symptoms reflecting effortful cognitive and behavioural avoidance of trauma reminders (e.g., thoughts, feelings, and environmental stimuli), as well as "emotional numbing" (e.g., detachment, diminished interest in activities, and restricted range of affect) (American Psychiatric Association, 2013). These two aspects were previously combined under the same cluster of symptoms, but research has suggested that behavioural or cognitive avoidance and emotional numbing are two distinct features of PTSD (Foa, Riggs, & Gershuny, 1995).

Some cognitive theorists have suggested that emotional numbing arises as a means of coping with overwhelming emotions and hyperarousal symptoms that occur in PTSD (see Horowitz, 1986). That is, when a trauma victim experiences frequent arousal in response to threat-related stimuli, his or her cognitive resources are directed to responding to or coping with the possibility of threat. This leaves fewer cognitive resources available for processing other stimuli, and thus emotional responses are reduced (see Litz & Gray, 2002). Some empirical evidence supports this view. For example, hyperarousal symptoms predicted symptoms of emotional numbing among Vietnam War veterans (see Litz, Schlenger, Weathers, Cadell, Fairbank, & LaVange, 1997) and female sexual assault survivors (Tull & Roemer, 2003).

The concept of “experiential avoidance” refers to an unwillingness of individuals to remain in contact with their inner experiences (such as bodily sensations, emotions, thoughts, and memories) and taking steps to avoid, escape from, or alter either the inner experience or the environmental context that elicits it (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Experiential avoidance has been associated with psychological problems, including depressive symptoms, greater PTSD symptom severity, substance abuse, and greater psychological distress (see Rosenthal, Hall, Palm, Batten, & Follette, 2005).

A history of childhood physical, sexual, and emotional abuse has been associated with experiential avoidance (Gratz, Bornovalova, Delany-Brumsey, Nick, & Lejuez, 2007), and experiential avoidance has been shown to mediate the relationship between traumatic events (including childhood abuse) and psychological distress (Marx & Sloan, 2002; Plumb, Orsillo, & Luterek, 2004; Rosenthal et al., 2005). Findings from these studies suggest that the tendency to avoid internal experience contributes to the development and/or maintenance of trauma-related symptoms. The following section will examine the specific impact of experiential avoidance and emotional numbing on disturbances of the self, that is, self-regulation, self-awareness, a sense of agency, and self-worth.

Many disturbances of self-regulation can be understood as attempts to avoid internal experience. Some experts suggest that there may be a subgroup of individuals who are motivated to not think about negative experiences, and who attempt to reduce or inhibit trauma memories as a means of avoidance or to control negative affect (Goodman, Quas, & Ogle, 2009; Williams, Barnhofer, Crane, Hermans, Raes, Watkins, & Dalgleish, 2007). For example, Polusny and Follette (1995) propose that dissociation allows trauma survivors a means of coping with overwhelming emotion, and chronic use of psychoactive substances

can reduce or modify emotional responses. Individuals also can focus attention away from internal experience and onto bodily, physical sensations, as in the case of binge eating and somatization. Similarly, Polusny and Follette suggest that deliberate self-harm allows individuals to focus on physical pain as compared to emotional pain, or alternatively, to emerge from a dissociative state in which they felt “dead” or “numb”. These avoidance strategies can be negatively reinforcing because they reduce or suppress the intense negative thoughts and feelings associated with childhood abuse experiences. Thus, although experiential avoidance reduces psychological distress in the short-term, it can contribute to the long-term negative outcomes associated with childhood abuse (Polusny & Follette, 1995). For example, Chapman, Gratz, and Brown (2006) reviewed the literature and found that individuals who engaged in deliberate self-harm had greater experiential avoidance tendencies. Furthermore, when examining self-reported reasons for deliberate self-harm, the primary motivations reflected desires to avoid, eliminate, or escape distressing thoughts, feelings, and memories.

Avoidance of trauma-related stimuli also may contribute to disturbances and limitations in the area of self-awareness. Avoidance of one’s subjective internal experience restricts an individual’s access to their own sense of history and thus their understanding of their own response tendencies (see Safran & Greenberg, 1988; Greenberg, 1994). Reliance on avoidance as a coping strategy also affects autobiographical memory, which serves an important function in developing and maintaining a coherent sense of self. The way an individual remembers and constructs his or her memories of the past is considered central to constructing an understanding of the self over time (Fivush & Nelson, 2004).

Autobiographical memories also are thought to play an important role in creating a stable self-system (Conway & Pleydell-Pearce, 2000).

One difficulty with autobiographical memory is over-generalized memories, that is, the tendency to recall general categories of events (e.g., “summer vacations”) rather than specific incidents or episodes (Williams, Barnhofer, Crane, Hermans, Raes, Watkins, & Dalgleish, 2007). A history of traumatic experiences (Williams et al., 2007), and specifically a history of childhood sexual or physical abuse (Kuyken & Brewin, 1995) have been associated with over-generalized autobiographical memories. Conway and Pleydell-Pearce (2000) suggest that recalling general descriptions of events frequently occurs among child abuse survivors because it produces less emotional arousal than the recollection of specific episodic memories. Thus over-generalized autobiographical memories also function to regulate emotion.

Finally, experiential avoidance also can exacerbate damage to self-worth and a sense of agency that occurs in the context of childhood abuse. There is a general consensus across theoretical orientations that avoidance of feelings and memories related to trauma prevents the individual from accessing new, more adaptive information that is central to their recovery (see Paivio & Pascual-Leone, 2010). Foa and Riggs (1995) suggest that emotional numbing and experiential avoidance interfere with successful emotional processing of traumatic experiences and thus with recovery from abuse. This postulate is the basis for all exposure-based therapies. Accordingly, two elements are necessary for emotional processing to occur. First, the trauma memory structure and associated thoughts and feelings must be activated so that it is available for modification through exposure to new information. Secondly, new information is introduced that is incompatible with components of the existing memory

structure and this allows for modification and new meaning to emerge (Foa & Kozak, 1986). For example, individuals who access trauma-related memories may learn that they can tolerate these memories, may recall that they tried to resist the abuse, or may access anger at the abuser, which counteracts feelings of self-blame. Emotional numbing and experiential avoidance prevent the activation of trauma-related memories and thus preclude their modification toward a more adaptive emotional response. Thus, maladaptive feelings and beliefs about the self (e.g., self as worthless or powerless, feelings of shame, guilt, and self-blame) would not be available for modification to more adaptive perspectives and self-experience.

Treatment for the Negative Effects of Childhood Maltreatment

The following section will describe a general treatment model for self-related disturbances related to childhood maltreatment and briefly outline other treatment approaches for trauma. Emotion focused therapy for trauma (EFTT), which is the therapy model used in the present study, will be described in-depth.

The “gold standard” for trauma therapy (Herman, 1992) proposes a three-phase structure to therapy: (1) establishing safety and security, and forming the therapeutic alliance, (2) trauma processing, and (3) reconnection and reintegration with ordinary life (see also Ford, Courtois, Steele, Van der Hart, & Nijenhuis, 2005 for an updated description of this integrative therapy approach). The first phase, establishment of safety and security, occurs through the development of a collaborative therapeutic relationship as well as through interventions designed to increase the client’s sense of safety and control. Therapist and client agree to work together on the client’s recovery goals, and the therapist takes a supportive stance that helps empower the client and strengthen his or her sense of control in

therapy. Other interventions in this first phase are introduced to help counter feelings of helplessness and loss of control, for example, informing and educating the client about his or her diagnosis and symptoms, and emotion regulation techniques. In addition, therapist and client attend to the client's safety and security in his or her immediate environment, by addressing self-destructive behaviours, discussing self-protective or safety plans if needed, emphasizing self-care, and mobilizing social support. Once a sense of safety has been established both within the therapeutic relationship and in the survivor's life, other therapeutic tasks can be pursued (Herman, 1992; Ford et al., 2005).

The second phase of therapy focuses on remembering the traumatic event or events and mourning the associated losses. In this phase, clients are encouraged to tell the story of the traumatic event in depth. As a means of promoting self-empowerment, the choice of what, when, and how to disclose remains with the client, while the therapist acts as a witness and provides guidance and support. The therapist remains attuned to the client's emotional response and arousal levels while disclosing, in order to help the client confront the traumatic memories in a manner that is safe and tolerable. Thus, the therapist strives to find a balance between reducing avoidance of trauma memories (which interferes with recovery) and avoiding re-traumatization that can occur when trauma memories are approached more quickly than the client can handle (Herman, 1992; Ford et al., 2005). Disclosing detailed information about traumatic experiences allows client and therapist to gradually reconstruct the story into an organized, detailed, and coherent account. The client can then begin to articulate the meaning of the trauma and how it has affected his or her view of self, others, and the world. Finally, accessing and exploring trauma memories can lead to mourning the

associated losses (e.g., cherished aspects of self, relationships with others). Grieving these losses is considered to be an important part of recovery from trauma (Herman, 1992).

Finally, the third phase of therapy emphasizes reconnection to everyday life. The client's task in this phase is to develop a new sense of self; to become more the person he or she wants to be. Therapy focuses in particular on the development of desire and initiative. This means replacing the "victim" identity with that of a survivor, and strengthening values, hopes, and dreams in order to identify goals for the future. This also means developing a renewed capacity for interpersonal relatedness, including relationships with partners and children. Some clients may choose to engage in social action as a means of affirming their emerging sense of empowerment (Herman, 1992; Ford et al., 2005).

Other therapy models that address the effects of trauma and abuse typically include interventions that are consistent with these phases, and add components specific to their proposed mechanisms of change. Cognitive-behavioural therapies are generally short-term approaches that focus on the acquisition of adaptive thinking patterns and coping skills. Specific skills for tolerating and/or reducing the intensity of emotions may be taught along with psycho-education about trauma and the trauma response (Jackson, Nissenson, & Cloitre, 2009). Cognitive restructuring involves teaching clients to identify maladaptive thought processes (e.g., "I should have done something to stop him"), develop more adaptive alternative thoughts (e.g., "I was just a child, I was powerless"), and re-evaluate beliefs about themselves, the trauma, and the world (Marks, Lovell, Norshirvani, Livanou, & Thrasher, 1998). Dialectical behaviour therapy (DBT; Linehan, 1993) focuses on improving client self-regulation by reducing self-destructive and dysfunctional behaviours that are associated with dysregulated emotions. Other cognitive-behavioural models introduce some form of

exposure to memories of abuse, and the associated thoughts, feelings, and needs. The purpose of exposure is to access trauma-relevant information that can then be explored and processed in order for new meaning to be constructed (Foa, Rothbaum, Riggs, & Murdock, 1991).

Narrative therapies are based on the assumption that people make meaning of their lives by constructing stories of their life events, which link together into a narrative (Combs & Freedman, 1994). For individuals who have had many negative experiences with attachment figures early in life, their dominant self-narratives are likely to be negative and problem-focused. Narrative therapy interventions help clients examine their life story from a different perspective, develop alternative narratives with different meanings, and consider how one event (e.g., a trauma) connects to previous life events or to their hopes and expectations for the future (Combs & Freedman, 1994). These interventions help to foster greater self-awareness, personal agency, and self-empowerment.

Psychodynamic therapies for the effects of trauma seek to increase the client's understanding of his or her unconscious processes (e.g., motives and defenses) and maladaptive interpersonal patterns, within the context of the therapeutic relationship (Kudler, Blank, & Krupnick, 2000). Most psychodynamically oriented therapies explicitly focus on the therapeutic relationship as a mechanism of change. In contrast to previous interpersonal experiences of rejection, abandonment, or threat, the client encounters a "corrective emotional experience" with the therapist (Alexander and French, 1947), in which therapist expressions of support, nurturance, and caring begin to compensate for the client's unmet attachment needs. Thus, therapy implicitly addresses disturbances of self that are understood

to develop within the context of attachment relationships (i.e., sense of self-worth and capacity for self-regulation).

Emotion Focused Therapy for Trauma

Emotion focused therapy for trauma (EFTT; Paivio & Pascual-Leone, 2010) is an integrative, evidence-based approach for resolving child abuse trauma that is based in current experiential therapy theory and research (Greenberg & Paivio, 1997; Paivio & Greenberg, 1995; Paivio & Nieuwenhuis, 2001; Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010). EFTT integrates recent emotion theory and research (e.g., Damasio, 1999; Fridja, 1986) and shares features with other well-established approaches, described above. The therapy structure consists of four phases, which recur over the course of therapy. These are: (1) building the alliance, (2) strengthening the client's sense of self by reducing fear and shame, (3) resolving interpersonal issues with past abusive or neglectful others, and (4) termination and consolidating changes. Two key mechanisms of change are considered central to the resolution of trauma issues: the therapeutic relationship and emotional processing of traumatic experiences.

The therapeutic relationship in EFTT. The therapeutic relationship in EFTT has two functions. First, it provides a corrective interpersonal experience for clients who have been exposed to abuse in intimate relationships, and therefore helps to correct early attachment injuries. Secondly, the therapeutic relationship provides a safe environment in which the client can explore painful trauma memories and the associated emotional experience (Greenberg & Paivio, 1997; Paivio & Pascual-Leone, 2010). Therapists rely primarily on empathic responding to client feelings and need in order to communicate compassion, understanding, and non-judgmental acceptance of the client. They draw

attention to, and validate the client's internal experience, affirm their sense of vulnerability when disclosing painful material, and provide reassurance and soothing when clients are distressed (Paivio & Pascual-Leone, 2010). This helps to counter past experiences in which the client felt shame and fear in close relationships, and helps the client to develop a secure attachment bond with the therapist (Greenberg & Paivio, 1997). In later phases of therapy, the client is encouraged to explore traumatic experiences, particularly their perceptions of and feelings toward specific abusive and neglectful others, experiences that typically are emotionally painful and distressing. A safe and supportive therapeutic environment increases the likelihood that clients will disclose emotionally difficult material, thus making it available for exploration and modification. Furthermore, the collaborative nature of the therapeutic work ensures that clients explore these memories at a pace they can handle and that maximizes their sense of control over the process of therapy. This can be a new interpersonal experience for individuals who have previously felt powerless in relationships (Paivio & Patterson, 1999).

Furthermore, the therapeutic relationship is the primary vehicle for enhancing client emotion regulation capacity. According to Paivio and Laurent (2001), therapist empathic responding to client feelings and needs can both reduce or intensify client emotional experience, and enhance awareness and understanding of emotional experience. Empathic responses reduce intense emotional arousal by communicating understanding, acceptance, and support for frightening or painful emotions, as well as modelling soothing responses. These responses are gradually internalized by the client, strengthening their own capacity for self-soothing and self-acceptance. Furthermore, this teaches clients that they can rely on others to help manage their emotions, making it more likely that they will seek social support

in the future. In addition to reducing arousal and distress, empathic responding addresses emotional over-control. Evocative words and phrases that reflect client experience can intensify avoided or over-controlled emotional experience and heighten arousal, thus making trauma memories available for exploration and change. Finally, therapist empathic responses increase client awareness and understanding of emotional experience by focusing attention on emotional experience, accurately labelling feelings, and helping clients to articulate the meaning of their experiences. Increased awareness, in turn, contributes to emotion management capacities. Thus, the therapist empathic responsiveness helps to increase client self-worth, self-awareness, and self-regulation capacities, as well as their sense of control and empowerment. Process-outcome research has supported the contribution of the therapeutic alliance as a mechanism of change. In a study of 33 individuals undergoing EFTT, the strength of the alliance was associated with pre-post increases in self-esteem and greater resolution of abuse issues, independent of other interventions (Paivio, Hall, Holowaty, Jellis, & Tran, 2001).

Emotional processing of trauma memories. Emotional processing of trauma memories is considered the second key mechanism of change in EFTT (Paivio & Pascual-Leone, 2010). The concept of emotional processing was first introduced in cognitive-behavioural therapies to describe the process by which trauma-related memories and associated feelings (primarily fear) are activated (for example, by telling the story of the event), and then modified by introducing information that is incompatible with fear (e.g. remaining safe and unharmed while retelling the story). New cognitive and affective information can then be integrated into the memory structure and thus reduce the fear response (Foa & Kozak, 1986). In EFTT, emotional processing is thought to occur when

clients explore feelings associated with traumatic experiences with specific abusive and neglectful others, and are able to express previously inhibited adaptive emotions (e.g., anger at violation, sadness at loss) as well as associated meanings and needs. A unique feature of EFTT is its focus on resolving issues with specific perpetrators, usually attachment figures. Moreover, this process is based on an empirically-verified model that identified steps in the process of successful "unfinished business" resolution (Greenberg & Foerster, 1996). The process begins with client expression of painful unresolved feelings and unmet needs concerning abusive and neglectful others. Confronting trauma feelings and memories typically activates feelings of fear, guilt, and shame and modifying these maladaptive feelings is the focus of the second phase of therapy. This is partly accomplished by accessing the information (needs and goals) thought to be associated with adaptive emotions (Greenberg & Paivio, 1997). For example, anger at the violation that occurred promotes assertiveness, self-empowerment, interpersonal boundary definition, and holding perpetrators (rather than self) accountable for harm, while sadness at loss allows the client to grieve, accept the loss, and access self-soothing resources (Paivio et al., 2010). Process-analyses have indicated that clients who are successful at resolving past interpersonal issues are those who intensely express adaptive emotion (anger and sadness), express a sense of entitlement to having their needs met, and experience a shift in their view of self and in their view of the abusive or neglectful other (Greenberg & Foerster, 1996). The client shifts from a stance of powerlessness, victimization, and self-blame to perceiving him or herself as worthwhile and absolved of blame, and is able to hold the other accountable for the abuse. This is often accompanied by a sense of empowerment and optimism about the future (Greenberg & Malcolm, 2002). Thus, as they process trauma-related emotions through to completion,

clients move from undifferentiated distress and maladaptive emotions (such as fear and shame), toward more adaptive emotions (such as anger and sadness) and a more positive self-evaluation (A. Pascual-Leone & Greenberg, 2007). The goal of emotional processing in EFTT is to expand the depth, range, and meaning of the client's emotions in order to transform emotional experience and construct a new view of self, others, and traumatic events.

Emotional processing is facilitated through interventions that promote re-experiencing of traumatic experiences with significant others. For example, memory work helps the client access and explore a recent or distal situation in which a core maladaptive sense of self (e.g., as powerless or worthless) was activated, or was developed. The memory is explored in detail in order to access internal reactions, perceptions, feelings and beliefs that are part of this core self-organization (e.g., sense of panic, feeling powerless, desire to escape, suppressed anger). Through this detailed exploration, the client can begin to access new information including alternate healthy resources (e.g., self-soothing, anger, grief), and thereby begin to view the event from a new perspective (Paivio & Pascual-Leone, 2010). Imaginal confrontation (IC) is a Gestalt-derived intervention used to access and explore trauma material (Greenberg, Rice, & Elliott, 1993). Clients are asked to imagine an abusive or neglectful other in an empty chair, attend to their internal experience, and express current thoughts and feelings about the abuse directly to the imagined other. Empathic exploration (EE) is an alternative re-experiencing procedure designed for clients who are unwilling or unable to engage in the imaginal confrontation procedure, likely due to the highly evocative nature of the task. Rather than engaging in dialogue with the imagined abusive or neglectful other, the client is encouraged to vividly imagine abusive/neglectful others and traumatic

events in their “mind’s eye” and express their thoughts and feelings to the therapist. Both versions of EFTT are based on the same empirically verified model of resolution (Greenberg & Foerster, 1996) and employ the same intervention principles. Both maintain a focus on reprocessing traumatic experiences with significant others by accessing core feelings and needs, making trauma feelings and memories available for further exploration and change.

Results of a recent randomized clinical trial showed that EFTT with the IC procedure and EFTT with the EE procedure were equally effective. Clients in both IC (n = 20) and EE (n = 26) conditions reported statistically and clinically significant improvements compared to baseline assessments on multiple outcome dimensions, including resolution of trauma, interpersonal problems, traumatic stress symptoms, anxiety, depression, and self-esteem; and treatment gains were maintained at 6 and 18 months post-termination (Paivio et al., 2010). Further research comparing treatment to a control group would be beneficial to support these findings. Furthermore, emotional engagement with trauma material during the IC and EE procedures contributed to treatment outcome thus providing evidence for emotional processing as a mechanism of change (Paivio, Hall, Holowaty, Jellis, & Tran, 2001; Chagigiorgis, 2009).

While the focus of EFTT is on resolving traumatic experiences with abusive or neglectful others, interventions importantly address disturbances of self. In particular, phase two of EFTT (Paivio & Pascual-Leone, 2010) explicitly focuses on reducing self-related disturbances that are blocks to resolving relational trauma and attachment injuries. Interventions within this phase of therapy focus on exploring and reducing experiential avoidance, thus increasing self-awareness and the capacity for self-regulation, as well as negative self-evaluations, thus increasing agency and self-worth. Avoidance and self-

criticism can be addressed using two-chair interventions in which the client engages in a dialogue between the oppressing or harsh, critical part of the self, and the more authentic, vulnerable part of the self that feels squashed and criticized. Processes during these interventions have been clearly specified (Elliott, Watson, Goldman, & Greenberg, 2004; Paivio & Pascual-Leone, 2010) and have been shown to be helpful in reducing self-criticism in depression (Whelton, 2000). However, to date, there is no research on the process of change in self-related disturbances over the course of EFTT; the present study will address this question.

CHAPTER THREE

METHODS

Research Design and Overview of the Present Study

The current project used Thematic Analysis (Braun & Clarke, 2006) as the theoretical and methodological approach to data analysis. This is a qualitative method that holds similarities to other commonly used qualitative approaches (e.g., grounded theory, phenomenology), but which boasts more flexibility in its application. Thematic analysis is not tied to one particular epistemological position, and does not require researchers to subscribe to specific theoretical underpinnings of the methodology, but does require that researchers make explicit their theoretical positions, values, and assumptions. On the whole it is a method that offers an accessible and flexible form of analysis, allowing researchers to search across a data set to find repeated patterns of meaning (Braun & Clarke). A more detailed description of the methodology of thematic analysis is provided in the "Analysis and Interpretation Strategy" section.

The present study used archival data that was originally collected for a process-outcome study evaluating two forms of Emotion Focused Therapy for Trauma (EFTT; Paivio et al., 2010). Participants were therapy clients who agreed to the use of video- and audiotapes of their therapy sessions for research purposes; these were the source of data for the present study. I selected a subset of audiotapes relevant to the research questions for in-depth transcription and analysis.

Participants

Participant Recruitment

Therapy clients for the original study (Paivio et al., 2010) were recruited through newspaper and radio ads and features, referrals, and posters offering free psychotherapy in exchange for participation in a research study. Telephone screening and selection interviews to assess suitability for EFTT were conducted by trained graduate students in clinical psychology. The telephone screening consisted of a standardized script that assessed criteria for exclusion from the study (described below). Those who met the initial screening criteria participated in a 90-minute semi-structured selection interview which assessed mental health, interpersonal and abuse history, current symptoms, level of functioning, and compatibility with the therapy model.

Participant Inclusion and Exclusion Criteria

Participants were included in the original study based on commonly accepted criteria for short-term, insight-oriented, trauma-focused therapy (Wiser & Arnow, 2001). These criteria are: the capacity to form a therapeutic relationship, which was assessed through the interviewer's clinical judgment and the participant's history of interpersonal relationships; the capacity to focus on an issue related to the past trauma; and the capacity to regulate emotional experience. Participants were excluded from the research if they were under eighteen years of age, currently undergoing another type of psychotherapy, had no conscious recollection of the abuse experience, or if they had concurrent problems that are considered to be incompatible with the treatment approach or that would take precedence over a focus on trauma issues (e.g., involved in a current crisis requiring immediate attention, engaging in

aggressive or self-harm behaviour, substance abuse, or ongoing involvement with a person acting violently towards them).

All participants selected for the study provided written, informed consent agreeing to the use of their completed questionnaires as well as audio- and videotapes of their therapy sessions for research purposes. Participants were treated in accordance with ethical principles for research with human subjects, and were given the opportunity to withdraw their consent at any time during or after the study.

Participant Characteristics

The present study includes a sub-selection of participants from the larger process-outcome study (Paivio et al., 2010); selection of this group of participants is described in the "Selection of Data" section. Transcripts of sessions from 22 therapy clients were used in the analysis, of whom ten (45%) were male and twelve (55%) were female. Participants ranged in age from 21 to 71 years old, with a mean age of 47.8 years. The majority of participants specified a Western European heritage (50%), or identified as Caucasian (27%), four as fully or partly First Nations ("Native Canadian";18%), and one participant left this item blank (5%). Most participants were married or living common-law (45%), while 23% were single, and 32% were divorced or separated. The majority of participants had an undergraduate university education (46%); 38% had a high-school education, and 18% had a graduate university education. Sixty-eight percent of participants were employed full time, 5% employed part-time, and 27% not working (retired, unemployed, or disability). Annual household income ranged across clients as well (14% under $20,000 per year; 36% between $20,000 and $39,000; 18% between $40,000 and $59,000; 32% at $60,000 or more). Most clients reported multiple types of childhood maltreatment but when asked to identify a

primary focus for therapy, sexual abuse was the most frequently identified (50%), followed by emotional abuse (27%), physical abuse (18%), and neglect (5%) as the treatment focus. The majority of clients identified either father (55%) or mother (36%) as the primary perpetrator of abuse. Clients were assigned to therapists based on scheduling compatibility, and were assigned either to one of two treatment conditions: EFTT with imaginal confrontation (IC; 55 %), or EFTT with empathic exploration (EE; 45 %). Random assignment to treatment condition took place after session three, before the introduction of the IC or EE intervention in session four. A summary of demographic characteristics for each client in the present study is provided in Appendix A.

Therapy

EFTT is a semi-structured, manualized treatment (Paivio et al., 2001; Paivio & Pascual-Leone, 2010) generally consisting of 16 to 20 weekly one-hour sessions. The exact length of therapy is collaboratively determined based on individual client needs. The first three sessions are devoted to cultivating a secure attachment bond between client and therapist, establishing a safe environment, and collaborating on the goals of therapy. Beginning in the fourth session, the client is encouraged to begin exploring specific memories of the abuse, either through the imaginal confrontation (IC) or empathic exploration (EE) intervention. This second phase of therapy focuses on evoking primary emotions, directing attention to the client's inner experience, while exploring and reducing negative feelings, such as fear, avoidance, shame, and self-blame. The third phase of therapy focuses on resolving past interpersonal issues and accessing adaptive emotions of anger and sadness, and exploring their associated meanings. The final phase of EFTT involves integration of therapy experiences and termination.

The larger process-outcome study included twelve therapists (7 women and 5 men) - one masters and six doctoral level students in clinical psychology, and five post-doctoral psychologists, ranging in age from 25 to 57 years. All therapists had previous clinical experience with this client group, and participated in an intensive 14-week training course, as well as weekly individual and group supervision throughout the course of treatment. Therapists conducted both the IC and EE forms of therapy, with assignments to equal numbers of clients in both treatment conditions. Nine of these twelve therapists were represented among the twenty-two clients selected for the current study.

Selection of Data

Selection of Participants in the Present Study

The concept of purposive sampling in qualitative research consists of selecting a sample of participants whose experiences most closely map onto the research question, in order to provide the richest, most enlightening information about the phenomenon under study. The primary focus of EFTT is resolving unresolved issues with abusive or neglectful others; thus there was variability among clients in terms of the degree to which active therapeutic work addressed disturbances to the sense of self. Because the focus of the present study is to examine changes in experience of self during EFTT, a sub-selection of clients was selected whose course of therapy included significant time examining and exploring self-related experience. This included descriptions and perceptions of self, questions around identity, discussion of thoughts and feelings towards the self (e.g., self-loathing, pride in self), how clients believed others perceived them, and how they understood their maltreatment experiences to have affected their identity and self-development.

As part of the original study, therapists wrote clinical notes after each session, outlining the content of the work (e.g., “feels angry at herself”), the interventions used (e.g., “two-chair intervention with younger self”), general statements about the work (e.g., “shifts in self esteem”), and any significant exploration of emotional experience on the part of the client. In order to select participants for the present study, I examined all available therapist notes, documenting those sessions in which the therapist indicated that self-related issues were addressed and explored. It is important to note that relying on therapist notes for selection of the participants adds an additional element of variability in the data selection method. There were twelve therapists in the original study, and while all were trained in the same model of therapy for this study, they may have emphasized different topics within their work with clients and in their documentation of sessions (i.e., more or less emphasis on exploring memories of childhood abuse, imaginal confrontation exercises, or exploration of relationships versus identity). Thus, therapists are not equally represented among the participants selected for this study.

Since one of my research questions focused on the process of change over the course of therapy, I chose to exclude cases in which the client did not complete therapy, as well as cases in which more than five session notes or five audiotapes were unavailable for analysis (i.e., not stored with the clinical files available to me). This decision was made in order to ensure that those cases that were selected would give me a full perspective of that particular client’s process of exploration of self-related issues. The consequence of this decision is that I have not included the perspective of clients who for a variety of reasons may have terminated therapy early (e.g., discomfort with the therapy model, unwillingness to explore trauma-related material, other life events incompatible with continuing therapy). It is

possible that these individuals would have had different perspectives on their experience of self from those included in the study.

Twenty cases were excluded on this basis, with forty remaining for analysis. After summarizing therapist notes, I identified each session as having a *self-focus* (i.e., the therapist and client explore self-related issues for the majority of the session); *self-content* (i.e., the therapist and client explore self-related issues at length, but spend at least half of the session exploring other issues, such as memories of abuse or interpersonal issues); or neither. I then categorized clients into four groups:

Group A. Clients had at least three sessions with a *self-focus*, as well as multiple sessions with *self-content.* In addition, these cases subjectively appeared to me to have the most information relevant to my research question (eight cases).

Group B. Clients had at least one *self-focused* session, and several *self-content* sessions. Subjectively speaking, self-work appeared to be an important issue but was not elaborated upon to the same degree as clients in group A (seventeen cases).

Group C. Clients had no *self-focused* sessions, but three or more *self-content* sessions (ten cases).

Group D. Clients had fewer than three *self-content* sessions. Self-related work did not appear to be an important issue for exploration (five cases).

With the aim of engaging in purposive sampling (i.e., selecting those cases that would provide me with the most information relevant to my research questions), I chose to select all the cases from group A, and a subset of cases from groups B. Morrow (2005) suggests that researchers seek adequate disconfirming evidence (or potentially disconfirming data) while in the setting, as a means to counter the natural tendency to seek confirmation of

emerging findings. Thus, I chose to include some clients for whom self-related issues was not the primary focus of their therapy, considering that perhaps the experience of these clients would differ in some important way from those who focused more on self-related content in their therapy sessions. Consequently, a subset of clients from group C was also included. I chose to exclude clients from group D, as there would be limited self-related material to transcribe. In addition to the eight clients in group A, I initially selected six clients randomly from the pool of groups B and C, attempting to select clients working with a variety of therapists. After transcribing these, I selected an additional six clients with the goal of representing a variety of demographic factors (i.e., types of abuse, relationship to the abuser, client ethnicity, content of the self-related work).

Guidelines for qualitative research suggest that data should be continually collected and analyzed until "theoretical saturation" is reached; that is, when data from additional participants no longer contributes new information to the existing themes or codes that have been developed (Lincoln & Guba, 1985). The question of sample size is not absolute and can be addressed by examining the purpose of the inquiry, what will have credibility, and what can be done with available time and resources (Patton, 2002). After transcribing sessions from twenty cases, I reviewed therapist notes again, and chose to add two additional clients in which the content of their self-related work (as described in therapist notes) appeared to reflect themes that were not yet discussed in other cases. It should be noted that my determination of "theoretical saturation" was based on the content described in therapist clinical notes rather than on the content of in-session statements; this was due to the extensive time required to transcribe therapy sessions and my need to attend to my limitations of resources and time. The present study comprises a total of 22 cases: 8 from

group A, 10 from group B, 4 from group C. Each case had between four and fifteen sessions for transcription. A total of 173 sessions were reviewed and selections from these were transcribed. Appendix A indicates which sessions were transcribed for each client.

Selection of Therapy Segments for Transcription and Analysis

After selecting the sample of clients and the relevant sessions for analysis, I determined which segments of the sessions were pertinent to the research questions, and transcribed these. This comprised the first data reduction step (McLellan, MacQueen & Niedig, 2003). As the present study examines the verbal content of therapy sessions (but not nonverbal behaviours or gestures), audio recordings of sessions were the data source. The raw data was transferred from audiocassette to .mp3 or .m4a digital files using a cassette player connected to a personal computer, using *Audio Hijack Pro* computer software (Rogue Amoeba, 2003).

I listened to each selected session in full, making note of markers in the session when self-related work began and ended. These segments were then transcribed and analyzed. Markers for the beginning and end of segments were established and documented as I engaged in transcription. Markers for the beginning of self-related work (beginning transcription) included:

a. Any reference to "self" (e.g., self-esteem, self-blame, myself) in which the client elaborates on the topic;
b. References to self in relation to others:
    i. how clients perceive their interpersonal relationships **(**e.g., had to work for others' love, prove she was worthy),

ii. self-perceptions in relation to others (e.g., vulnerable, needy, has nothing to offer others),

iii. how others perceive them (e.g., fear of being seen as crazy/sick, afraid people will notice his flaws, believes others think he is stupid/inferior),

iv. how others have treated the client (e.g., feeling trapped, used, rejected, treated as if she was unimportant, ignored, felt invisible to mom),

v. identified needs in relation to others (e.g., need for autonomy, needed to be told she was okay and worthwhile, deserved love and respect, protection);

c. Self-conscious emotions (e.g., pride, guilt, shame, self-blame, self-doubt and confusion, self-satisfaction and acceptance) or reflection on inner experience (e.g., wanting to get in touch with her own emotions, questioning/examining own reactions);

d. Existential concerns (e.g., wonders why she was put on earth, purpose in life, why she deserved abuse);

e. Reference to restricting or blocking part of self (e.g., ambivalence at allowing herself to feel, “depersonalization”, feeling emotionally numb);

f. Reference to multiple parts of self (e.g., self-critical split, discussion of conflicting feelings);

g. Discussion of changes observed in self (e.g., assertiveness at work, increased ability to make own decisions, dealing with impulsive and self-damaging behaviours, feeling stronger).

Markers for the end of self-related work (ending transcription) included:

a. A clear change of topic (e.g., shifts to a focus on relationships, or on memories of abuse);
b. Client gives an extended example that diverges from focus on self-related process (note: if the example was later connected to self-related work, then a summary of the example was recorded and verbatim transcription was resumed when the client returned to direct discussion of the self-related process);
c. Client is inaudible (if only the therapist was inaudible, then transcription was continued as long as client statements were audible & intelligible);
d. Therapist introduced self-related content but client did not elaborate or discuss this (e.g., client says "yeah" but then changes topic).

Ultimately, this resulted in a series of segments for each client that reflects therapeutic work on issues of self-experience. In order keep track of the chronological order in which the therapeutic work occurred, each segment was identified by the client number, session number, and if there were multiple relevant segments within one session, by the segment number.

Data Transcription

I transcribed the data, from .mp3 or .m4a digital files into word-processed documents, using *Express Scribe* software (NCH Software, 2013), which allows the digital audio file to be played, paused, and rewound using computer keystrokes. A significant number of audio files were processed using the software's *"background noise reduction"* and *"high pass filter"* functions. These functions increased the clarity of the therapist and client voices in the audio file and allowed for more accurate transcription. It should be noted

that some of the content of therapy sessions was inaudible during transcription, occasionally due to soft-spoken participants and therapists. In my self-reflective journal I questioned whether some of the content that was discussed in low-volume voices may have been particularly relevant to the research question (e.g., when speaking of shameful or self-conscious emotions, participants were more likely to speak quietly). Thus, it is possible that some significant aspects of participants' self-experience were not transcribed or analyzed.

Transcription procedures followed conventions outlined by McLellan, MacQueen, and Niedig (2003). Client and therapist statements were transcribed verbatim, including nonverbal sounds (e.g., laughter, sighs), filler words (e.g., "um", "mhm", "yeah"), mispronounced words, repeated phrases, and pauses. Although client statements were the focus of analysis, therapist statements were also transcribed and coded in order to establish context for the client statements. Furthermore a consistent format was adopted for the formatting and labelling of each transcript, as well as indicating speakers within the transcript (McLellan et al., 2003).

Analysis and Interpretation Strategy

Once transcription was completed, thematic analysis of the transcripts was conducted, using the method suggested in Braun and Clarke's (2006) guide to thematic analysis. This analysis and interpretation strategy includes six phases.

Generating Initial Codes

Phase one consisted of familiarizing myself with the data, by reading transcripts several times and documenting initial impressions, ideas and preliminary codes that came to mind. Phase two involved generating initial codes, each code reflecting a basic idea or element within the raw data, based as much as possible on participants' actual wording

(Braun & Clarke, 2006). This low-level coding was completed using *TAMS Analyzer* software (Weinstein, 2002). Using this software, I read through all the transcripts and created low-level codes, linking each code to a specific data extract (i.e., a client statement or series of statements). This software allowed me to link one low-level code to multiple data extracts that reflected similar content, as well as to view all the data extracts linked to one code. Across all transcripts, I generated 914 separate low-level codes (see Appendix B – List of Low Level Codes). I reviewed all the data extracts for each code and created a hand-written index card that included a summary of the content of the data extracts linked to that code, as well as several verbatim examples of data extracts. In some instances multiple meanings were uncovered for one code; all of these were indicated on the summary index card.

Identifying Themes

Phase three consisted of searching for themes that reflected associations among several codes. In order to do this, I reviewed all 914 index cards and hand-sorted them into broad themes. I then reviewed the broad themes, and further hand-sorted the index cards into more specific categories within the broad themes. Phase four consisted of reviewing themes, by combining, breaking down, or rejecting initial themes that were generated in phase three. The validity of each theme was considered in terms of its ability to reflect the codes within its framework (i.e., do all the coded data extracts fit this theme?) as well as in terms of its relation to the entire data set (i.e., does the thematic map reflect the meanings of the data set as a whole?) (Braun & Clarke, 2006). I reviewed the data extracts within each specific category and broad theme, and in doing so, occasionally re-sorted a low-level code into a different category or theme, based on the content of the data extracts within that low-level code. Some codes were split into two low-level codes if they represented multiple meanings

under different broad themes. For example, the initial low-level code “shell” referred to a self-protective mechanism (“I hid under my shell”) and was categorized under the broad theme of “Interpersonal Interactions”, but in a different data extract referred to the client’s sense of identity (“I am a shell of a person”) and was categorized under the broad theme “Something Missing”. As I worked through the process of sorting and re-sorting themes, I began generating a visual thematic map of the data that allowed me to summarize the connections between data extracts, categories, and broad themes. My initial thematic map (see Appendix C) was generated by drawing connections across themes and categories based on data extracts that were connected to multiple themes.

Creating a Narrative

Phase five of the thematic analysis process (Braun & Clarke, 2006) consisted of naming themes such that they accurately reflected the ‘essence’ of the data within them, then organizing data extracts into a coherent account. Phase six consisted of writing the report, which included telling the ‘story’ of the data, including evidence of themes (data extracts), while making an argument that related to the research question. Although these are identified as two separate phases within the thematic analysis process, Braun and Clarke emphasize that the analysis process is not necessarily linear, but rather that researchers may find themselves moving back and forth throughout phases. Furthermore, they assert that writing is an integral part of the analysis rather than something that occurs after analysis is complete. This is compatible with my experience of the analysis process. Although I began writing the report based on the initial themes I had identified in my preliminary thematic map (Appendix C), I found that writing a narrative description of each theme and the sub-categories within them allowed me to generate a different understanding of how themes are connected, and to

re-evaluate my understanding of the data. I also made the decision to remove two major themes from my preliminary thematic map ("Interpersonal Interactions" and "Feeling my Feelings") as these were not directly relevant to the research questions, and instead I integrated some of the relevant data extracts from these preliminary themes into the revised thematic map. After generating an initial draft of the written report, I again reviewed the transcripts, to "check" my understanding of the themes with the raw data, to seek out disconfirming examples (Morrow, 2005), and to determine how frequently themes were discussed across clients. The reader is referred to Braun and Clarke's (2006) guide for a more detailed explanation of the phases of thematic analysis.

Standards of Trustworthiness in Qualitative Research

Elliott, Fischer, and Rennie (1999) have initiated a conversation among qualitative researchers about guidelines to evaluate the trustworthiness of qualitative studies. They present principles that may be used as criteria to review and to promote greater quality control of qualitative research studies, while not inappropriately subjecting them to the standards commonly used in quantitative research. In conducting the present study I have attempted to address the guidelines raised by Elliott and colleagues. Specifically, I have reflected on, and made explicit my personal background and theoretical approach to the project (what Elliott and colleagues call "owning one's perspective"). Throughout the course of this project, I have kept a self-reflective journal to note my personal reactions to the data, emerging interpretations, and decisions about transcription, coding, and analysis of themes (Morrow, 2005). I have attempted to "situate the sample" of the project (Elliott et al., 1999) by describing the research participants and their life circumstances in enough detail to allow readers to recognize to which populations the study findings might be relevant.

In terms of providing a credibility check of the data and interpretations, I engaged in an extensive final review of the data (transcripts) after identification of the themes in order to determine the "fit" of the themes to the overall data set. This also included specifically reading the transcripts for examples that were discrepant from the identified themes. I also presented preliminary findings to groups of colleagues (clinical psychologists) and my research advisor, who has extensive experience as both a researcher and therapist with emotion-focused therapy for childhood abuse trauma. The Results section (chapter four) includes detailed extracts of data to clearly illustrate the themes developed, so that readers may draw their own conclusions about the fit of the data to the interpretations I have presented, or may consider possible alternative meanings and interpretations of the data. Finally, I have attempted to present findings of the study in a coherent manner, by describing the hierarchical relationships among themes through a narrative description of the data, along with preliminary and final thematic maps to illustrate the evolution of the themes throughout the analysis process.

CHAPTER FOUR

RESULTS

Through the process of transcribing, re-reading, and interpreting client statements regarding their perceptions and experiences of self, I have classified and organized my understanding of the client experience into several broad themes and sub-themes. These findings will be presented in three sections. First, I will present themes related to clients' experience of self, including their understanding of how childhood maltreatment has influenced their experience of self in the present. Second, I will present client statements that describe the process of change in experience of self throughout the course of therapy. This section does not include therapist interventions and is not intended to describe how the therapy "works" or the theory of the therapeutic approach, but rather is intended to reflect the types of shifts that occur in self-experience as described through client statements. Finally, I will describe themes relating to the "new" views of self expressed by clients in the later stages of therapy. These findings have been summarized visually in a thematic map (see Appendix D).

The findings I report here are grounded in data extracts, that is, quotations of transcribed client statements. I have not included therapist statements in these data extracts but will provide the context for the client statements through description, as necessary, to enhance readability. The statements presented here have also occasionally been condensed in order to more clearly and unambiguously demonstrate the theme they reflect. Ellipses (...) are integrated into quotations to reflect where additional material (including therapist statements) has been removed from the extract to enhance readability. These omitted

statements can be made available upon request. Each data extract is followed by a reference, for example, [a-1] represents client a, session 1.

Part One: Experience of Self in the Context of Childhood Maltreatment

I have created three major themes to describe clients' experience of self as well as their understanding of the impact of childhood maltreatment on self. These themes are: (1) an unclear self-identity, (2) the experience of not fully participating in life, and (3) feelings of worthlessness. I will describe and illustrate each of these major themes, along with their associated sub-themes, in turn. Data extracts for these themes were drawn from all stages of therapy (early, middle, late).

Theme One: Unclear Self-Identity

The theme "Unclear Self-Identity" captures an experience of confusion regarding one's identity, along with efforts or struggles to define oneself or to live in accordance with what participants describe as their "true self". Within this theme, I have identified four sub-themes, each describing a different aspect of unclear self-identity. These are: (a) questioning one's identity and purpose, (b) something missing inside self, (c) self-doubt, and (d) split self.

Questioning one's identity and purpose. The first sub-theme describes the experience of questioning both one's identity and one's purpose in life. These clients express a confusion about how to define themselves, how to answer their own question, "who am I?"

> *But uh I never had any self-confidence really … And being myself wasn't enough because really, I guess really, who was myself?* [n-11]

> *My feelings get so mixed up at times. There's so many things in me that happen, dynamically, that there's times when I'm not even sure myself what I am, who I am.* [j-7]

Some clients attempt to establish a clearer self-identity by defining themselves through external cues, such as their roles and relationships. While this provides a basis for their identity, they also express dissatisfaction with this means of defining oneself.

> *It's hard to define who I am and what I'm doing, you know. I've always defined myself in terms of other people … you know and now since the other people in my life are changing … but I'm separating from them, who am I? There's that fear … of being lost, I guess of being lost … Because I don't know how to be except that, except. I don't know how to be when I'm not somebody's mother, somebody's daughter, somebody's sister … I don't know how to be without all the references.* [s-19]

> *It's kinda pathetic actually … that I define myself in terms of other people. That I don't have any own self, like a person in my own right. But if everybody disappeared I'd be nobody … I know I sense myself. I know I have these feelings and thoughts that make me myself. But I don't have a sense of myself.* [s-19]

> *It's only a job … it's all I talk about … it consumes me. When I come home from work all I think about is what I didn't do at work, what I gotta do tomorrow, and that consumes me … I associate myself as a person with my job, and he says you know I'm a wife, I'm a mother, I'm a daughter, but I don't think about that, it's just my job. Cause when I lost my job I was devastated … cause I associate working with being someone.* [u-7]

Other clients question their purpose or direction in life as a way of defining identity.

> *I don't know. For the longest time I thought well it's just to be a mom … I couldn't find my purpose in life and then I had my daughter and I thought, this is it, to be a mom, to be a wife, to have a family … and then we divorced and then I just felt like that was really the only thing I had and that was taken away from me and now I have to figure out who I am all over again.* [q-3]

> *Well I become um, I'd sort of lose my direction of where I was and what I was doing. And I'd feel insecure and I'd feel like, what am I doing, like I was lost emotionally … And now I don't have a direction itself, where I'm going to be, where I'm sort of headed in a sense ... I sort of lost myself in a sense.* [o-13]

> *It would mean, it would be kinda losing myself. Um and that for me that would be to plunge wholeheartedly into work. Not become a workaholic, at least I don't think so.*

> *but it's kinda hard, giving me, surrendering myself to what I think or believe is the path of what I'm supposed to be doing. Kinda like a mission in life. Um, scared of doing that. Cause it'd be surrender my whole, seems like it's just not part of what I'm scared of um (inaudible) … seeing that path as directed by my father not by myself. Trying to sort out why I'm doing this or why I want to do this.* [l-5]

"Who am I?" and "why am I here?" appear to be prominent questions in the minds of these clients, as part of an ongoing search to define their identity and purpose in life.

Something missing inside self. The second sub-theme reflects the experience of having an emptiness or void within oneself. Clients describe feeling the absence of something non-tangible, yet core to their identity.

> *I just am not happy inside. Something's missing. I don't know what's missing … I feel kinda ashamed, stiff because why don't I get to be happy like everyone else? … Like putting on an act all the time and surviving … I don't see the point in it … I'm surviving, I'm just alive … when I'm eighty I'll still feel this way. I'll still have this void.* [u-7]

> *I wanna be in touch with me, you know. I see other people, they seem to have some kind of reality about them, some kind of substance … and they can tell you I like this, I don't like this … yeah they seem to be real, you know, there's something to them. Like I always feel my life doesn't.* [s-19]

> *Something happened to me, some, it was like something was taken out of me, it was like my personality left, my soul left, during that time and that's when I, I don't know I became totally different. And in what way different I can't really say. But it's like I lost my spontaneity, that was one of the things. But you know being really and like I wanted to say just now, I lost the love for myself.* [i-15]

These speakers are grappling with what it is inside of them that is missing, what "substance" other people seem to have. While these excerpts focus on the "void" inside of them, another client speaks of trying to "fill up" this emptiness. In the following excerpts, the metaphor of a "light" or "spark" is introduced as a counterpoint to emptiness.

> *Cause that's what they say, you feeling empty inside you should give and it will fill you up. And then okay well what should I, so I'm looking for things to volunteer and*

> *have no idea. Nothing really lights me up … doesn't light me up, doesn't spark me into … it doesn't … give me drive.* [q-8]

> *Cause if I go through, follow my spark and if my spark goes out, then what? Then I'll have nothing in me, there'll be no more spark, there'll be no spirit, there'll be nothing left inside, then nothing will keep me alive.* [q-9]

Another variation on the theme of "something missing" is the experience of being unreal or un-human. Clients compare themselves to inanimate objects with no life, no vitality.

> *I feel like I'm just like a piece of dirt on the ground. A piece of dirt. You know I feel like I'm not really, I'm just on this earth but for no reason, like it's a waste … like what's the point of me being here. I really don't understand … yeah it's like I feel like I'm just an ornament sitting on a table. Like a lifeless thing there's no life to it, you know? An inanimate object.* [u-8]

> *I know the feeling; I've been walking around part of the walking dead, for like living, you know walking dead for six years … You think you're there for your kids but you're really not, you're just a skeleton of a person … you gotta live for your kids, be a vibrant person again.* [q-9]

> *Don't even feel real. Sort of pretending to be real my whole life because I just don't know how to feel. Pretend that I know how to feel because I see other people do it. Not ever because you ever showed me or held me … going to let myself be real again … (inaudible) don't know how but I need, I need to think about what my needs are, my desires are, my hopes are. I never had any of them. I don't even know what they could be … I don't know how I've been.* [e-10]

In these excerpts clients experience themselves as missing an essential aspect of their humanity – they see themselves as non-human, not fully alive ("walking dead") or fully "real". The sub-theme of "something missing" is closely related to the earlier subtheme of "questioning one's identity and purpose" – we see how some of these clients feel "useless", question "what's the point", or "pretend". In addition, they express a desire to begin exploring their purpose in life ("you gotta live for your kids") and their identity ("what my

needs are, my desires are"). Another variation on the sub-theme of "something missing" is the experience of feeling emotionally stunted or less than fully-grown.

> *Sometimes I think that I stopped at like 8 or 9, emotional. My emotional development stopped. And I'm stuck there sometimes emotionally … physically I developed and I grew up but emotionally I didn't … that's a lot of years that I missed of emotional development … I didn't learn a lot of important survival skills … emotionally I'm a kid; a child would behave like that.* [u-8]

> *I wondered when you see me walk in, do you have thoughts like this poor old guy, he appears like he's not really grown up.* [i-2]

> *I was 22 or 23 but emotionally maybe sixteen, seventeen.* [o-7]

These excerpts highlight the speakers' experience as having "missed" an essential part of their lives and development.

Self-doubt. The third sub-theme describing unclear self-identity relates to the experience of not knowing or not trusting one's inner experience. One client speaks of not being able to identify his emotions as an important aspect of self-doubt.

> *Part of the problem is I'm confused about it. I'm confused whether it's anger … it's gone. And it's hard for me to put into words because I don't know that feeling … See when I tell you that, an emotion I feel right now, as I say the emotion I feel, there's no burn in my belly, by the same (inaudible) there's no warmth in my heart, whereas it's just the same feeling.* [t-2]

> *I've made myself numb so much to those feelings that I don't know what they are or how to deal with them, or how to pull one up … Number of times you asked me, how did I feel? I didn't feel anything. And that's one of the things I'm concerned about. Um, is that I don't know what it is; I just don't have an emotion.* [t-8]

Other clients question whether the feelings they have are the "right" ones, whether they are feeling what they are "supposed to" feel. The third excerpt in particular draws a link between knowing and understanding one's feelings and knowing one's "real" self.

> *Well I feel kinda numb, you know … don't know how I'm supposed to feel. If I don't feel what I feel. What am I supposed to feel? … So tell me what to feel. I can't feel sad, I can't feel what it is, I don't feel. But I need to know what am I supposed to feel, what should I be feeling?* [s-14]

> *And that's why I asked the question. Is it, is this is this, should I feel pain, should I feel angry, should I feel hurt? What would the rest, what would the norm do, what would the rest of the world do? ... And I'm sitting there going, well what do you mean, not hurtful isn't. What would a normal person feel? I mean I know what I would feel, I feel angry. And maybe that isn't normal. Maybe that is something that nobody else would feel.* [j-16]

> *But it's confusing cause I don't know my, I don't know which feelings are the right ones, which is the real [me]*. [u-15]

Finally, even if they are able to recognize and identify their feelings, some clients speak of not trusting their inner experience, their "gut feeling."

> *You know your intuition how it's supposed to work? Well mine still does but I don't trust it. That's the biggest damage I think that's done to me as a child. Throughout all these abuse it was this, that I learned not to trust myself because I couldn't trust them, so now I don't trust me … but my intuition's actually very good. If I had listened a lot of times I wouldn't have gotten myself into these things … I wanna trust myself more.* [s-10]

> *I don't have a gut feeling anymore. I feel like I kind of anaesthetized that.* [q-1]

This difficulty trusting one's inner experience is linked to self-questioning and self-doubt.

> *All these years of 'you're no good and you're worthless' and 'should I do this or should I do that', and 'should I feel like this or should I feel like that'. It just twists my mind and makes me feel, like you know, I'd rather be confident and say yes this is the right feeling, go with this. Rather than always second-guessing myself.* [n-13]

Split self. The fourth aspect of unclear self-identity is the experience of a separation or split of one's identity. One manifestation of this "split self" phenomenon is experienced as a separation or disconnection between one's "thinking part" and "feeling part".

> *The feeling part of it wasn't there. It's sort of like I was separating into two different people … I felt like being separated into two different, this is the feeling part and that's the thinking part … No that part was just the straight thinking part … It's like the parts of me are separated. The thinking part, the, you know rational, and the feeling part, over here.* [s-14]

> *Every time that person creeps in it's like a split personality. Generally I'm this aloof and non-emotional person and then when emotions creep in it's almost like I change into another personality, more predominant.* [t-11]

For other clients, the experience of a "split" or separate part of self is more explicit. In these next excerpts, one client speaks about the "child" part of herself who has "flown away".

> *I see her as different. I don't see her as me… like the young version of me. It's just the four year old. And she hasn't changed. She's still the younger one. I guess it feels … there's this whole separate person. It doesn't feel like me. It feels like a person. Like the four year-old … and she's got her own ideas.* [k-15]

> *I need her to be complete. I need to be whole; she's part of me … I want her to be back with me. Once that happens I will be complete … I don't want that split anymore. I wanna feel like I'm connected.* [k-17]

Another client questions his gender identity, wonders what it would be like to be female, and experiences this as two separate versions of his personality.

> *I'm not sure it was me, or something inside of me would be me, so I don't know. I would get the feeling like it was someone else and I have had that feeling, it's almost like a dual personality or something like that.* [d-3]

> *It's very much been something like gingerly walking around inside this new person or having a new; it's not that bad actually. But it is surprisingly you know how it makes me look at myself differently … I look at who I am and what's going on and I think this is pretty good … It's just like I can look back on a long time. Thirty years where there was this personality dislocation. Some kind of a split. You know, a lot of it had to do with being just a little too horrible to remember … and then you get the whole, just shutting it off and trying to get what … the loss of the rest of this personality. And then you get dislocated.* [d-5]

The Connection between Unclear Self-Identity and Maltreatment Experiences

Participants grappling with the question of self-identity have made links to their maltreatment experiences as the source of this identity confusion and self-doubt, which I have organized into two sub-themes: (a) lack of support, and (b) cutting off emotions.

Lack of support. Some clients described a lack of direction and support from caregivers in discovering or defining their self-identity. One client speaks of the lack of a "base" - a secure, safe environment which would act as a foundation for her developing self-identity.

> *Most of the time I don't feel grounded, rooted, I don't feel I've got any kind of basis, I just feel kind of (inaudible) … and whatever the wind comes … I don't have the strength, I don't have that solid type of … I didn't get that. When I thought of home, I didn't think, oh I'm going home, I'm going to be safe and loved there. That didn't happen.* [s-19]

> *I've never had that. I've never felt, oh thank god I'm home, I'm okay … I wasn't protected. Home was a threatening, violent, non-loving place. So where am I building from? Where is this security, this strength, this knowing I'm okay, where is that supposed to come from?* [s-19]

Another participant speaks of her one and only positive memory of childhood as receiving precisely this "base" from her mother.

> *You know, I remember the only thing we maybe would have company over and I was kinda shy around people and my mom would sit on the couch you know, talking to everybody and I would sit on the floor, hugging her leg just to kinda be close to her. That's the only time I felt really kinda comfortable or warm. I felt like oh she's letting me hang on her leg, like look she's letting me hang on her leg. It made me feel, like gave me a base. That's the only thing I can really remember.* [q-3]

Other participants speak more explicitly of a lack of guidance from their caregivers in helping them discover and establish their identities.

> *I'm thinking that's how I disappeared. When people are telling you you're not who you are and you're very little, I didn't even know who I was when I was very little.*

> *People tell you who you are and help you to be who you are. If people tell you you're not important, then you really don't know who you are.* [b-6]

> *When I lived at home type of thing, the bad things were magnified ten times over and then the good things were not even acknowledged or not even talked about. I mean, and no support of what was, of what was my, I guess, role in life.* [o-13]

Cutting off emotions. A second explanation given by clients for their lack of clarity concerning their identity is that they "cut off" what they experience as overwhelming emotions associated with memories of maltreatment.

> *I hope you understand it's hard. How to explain. It is such strong strong emotion for somebody that has (inaudible) because it goes into a whole part of me that basically, is a, that's a whole different part of me. A part that I tried to forget a long time ago.* [j-6]

> *I don't even remember honestly what they were doing, I know things were going on, it's a really vague memory you know cause I was probably about 10. And I think I've developed over the years a really good capacity to not remember any things that hurt. Or things that were scary.* [e-6]

> *Somehow I have to get in touch with those feelings and understand why I detached myself from those. That should be, that's me, and this is the way I, this is my protection … don't know what it's all going to mean to, to bring that. I know right now what I feel when I start to feel emotion, I shut it down, so obviously, I'm filled with the emotions … I know that when it comes in, it scares me, um cause I shut it down. And I don't think I do it for negative reasons in the sense that I don't want the emotion, it's that I don't know what to do with it. It's very strong … it scares me, I don't know what to do. Cause it takes control.* [t-11]

For some clients, this disconnection from their emotional experience appears to be a means of coping. They express fear that if they allow their emotions to be experienced, they will "lose" their sense of self.

> *There's always been a fear of falling apart. If I ever, that if I ever unleash this well of sadness that it'll just overcome me and I'd be … I'd never be able to put humpty dumpty together … and never be able to come back, yeah … yeah. I'll just disappear or whatever, I'll disappear yeah. I'll just be, I won't even be myself.* [s-14]

> *I believe there's so much anger in me, that's why I don't remember things. If I remember, if want the love that she never gave me then I have to bring back the anger … And I don't think I'm afraid of it, so much as I believe if I could throw away the anger I could find me again.* [e-5]

> *Well I guess I, it's I'm afraid of my emotions, like that I'll lose control, those emotions if I cross that line, if I don't do the ordinary thing and then you know, all hell's going to break loose type of thing … I'm afraid of my emotions that they'll go every which way and then I'll be overly confused and um, I won't come back to my normal state of mind type of thing.* [o-6]

At the same time, this "cutting off" of emotional experience is understood as what prevents them from understanding their self-identity. We see in this final excerpt how not allowing oneself to feel one's feelings leads to a sense of being "empty", of not knowing oneself.

> *My life is empty. I made it a shell that protects me instead of having loved ones and family … I don't even know how to let myself feel loved or be, or want, or desire. I wanna feel. I don't feel things right, I don't feel happy when I know I should be happy, I don't let myself get hurt because it's too much. I don't enjoy anything. I don't know where I get pleasure. I do things that should give me pleasure because I think they should give me pleasure … Once the façade comes down it's, you just sit there and you don't even know how to be you anymore. You don't even know who you are.* [e-12]

Theme Two: Not Participating in Life

The second major theme, "Not Participating in Life", captures the experience of not being an active participant in one's choices and actions, feeling not fully present in life experiences, or failing to act in accordance with one's own wishes. I have identified several sub-themes that capture various aspects of this experience: (a) dissociative experiences, (b) lack of agency, (c) not expressing oneself, and (d) self-sabotage.

Dissociative experiences. The first sub-theme under "Not Participating in Life" describes experiences of not being mentally present, or merely "watching" one's life - in

clinical terms, these appear to be in the realm of dissociative experiences. Several clients describe a connection between painful or overwhelming emotions and dissociative experiences in childhood.

> *I don't remember that part. I don't remember anything to that extent. As soon as he started, as soon as I started, that was it. It seemed like that was where I finished, or my mind finished. I just went blank after that… they lose their touch with the … with the feeling or the, the experience.* [j-6]

> *And then at some point I started, that was it, I lost, I went blank. So I don't remember like the things that you were talking about, whether or not he uh eventually uh came. I don't remember that. I was just not there, I don't know if that happened.* [j-6]

> *Didn't feel like I was physically there. Uh I had so many feelings that, like you just described, that were overwhelming me. Loneliness, and not being loved and it's not a good feeling and you feel rejected and you know something's wrong and you just, you know when you feel like you're there you just feel like you're being punished all the time.* [n-3]

These dissociative experiences sometimes continue into the present day. Clients describe the experience of "disappearing" or being "disconnected" when faced with overwhelming emotions in the present.

> *I black out when she says I'm whining … when feeling threatened or abused, I disappear, go away … it's almost like way back when I was abused and here it is happening again and I'm disappearing, I'm not in this moment right now. That's what it's like. I was so afraid of her I just disappear and agree with everything; I disappear with people like that … I have to stop and think about what's happening to me right now and respond instead of disappearing.* [b-5]

> *You know I just still get the flashbacks from, not like an actual blackout (inaudible) but like I'll be sitting there and all of a sudden it's just like you get disconnected from reality… you kinda feel like you're floating in a dream.* [c-4]

Another client uses illustrative language and metaphors to describe dissociative experiences, such as having a "little girl" inside of herself who "flies away", or being under "remote

control". In these excerpts, the therapist asks her to describe the part of her that "comes in and takes over".

> *Yeah. The remote control … Like I can't handle it so if I get lost or I get scared or whatever, you know, the house is burning, she takes over until I can handle it.* [k-15]

> *Like if it's bad, something like I got lost or I can't think, she takes over for a bit and I think okay now you know, stop, breathe. So she kinda maybe, like in that gap of I can't even think straight, you know, lets me still drive … and you're going to have a little break and then you come back into it.* [k-17]

Another example of dissociative phenomena is the experience that one is "watching" one's life occur, rather than experiencing oneself as actively participating in life.

> *It's like you're in a box. Something in a box… it's feeling but it's, it's just (inaudible). … cold … numb, cold … yeah. It's like I'm watching. I'm watching. Not part of it. An observer, I'm observing … I don't participate, whatever … It's not scary because I can't feel anything. It's scary, (inaudible) scary's no good. It's not … nothing. (inaudible) just cold, there's no feeling.* [s-14]

The same speaker continues to describe this experience later in the session.

> *Watching and that was hard. You don't feel physical or emotional… all kinds of things… I didn't have to be afraid because I could numb out … Part of the regret is the time lost too … real loss of you know, 20 years of my life where I wasn't a real participant in it. I felt like … absence … different levels depending how much my presence had to be there.* [s-14]

The speaker describes the experience of life "passing by".

> *Things have passed me by, opportunities or events … for the most part while it was happening there wasn't actually a choice to be not a part of it; I just chose not to be a part of what was going on … I just needed to get by like a substance, self-induced stupor … change in conscious awareness … altered state but self-induced, sort of like a trance but not altered beyond functioning.* [s-14]

We see in these excerpts a mixed reaction to this distance from life; that on the one hand it feels safer to "watch" one's life ("didn't have to be afraid"), and yet at the same time there is

a sense of regret and loss. Furthermore, the parallel drawn with the altered state resulting from substance use reinforces the notion that these dissociative states are a means of coping with overwhelming feelings.

Lack of agency. The second sub-theme under "Not Participating in Life" is the experience of individuals who, although they feel present in their lives, experience themselves as passive participants, having no impact or control over what occurs in their life. For some clients this is expressed as though they are "going through the motions" of life or merely doing what others expect of them.

> *I find myself in situations, in relationships where I'm kinda peripheral; I'm running a pilot … I was like a robot-like person going through the motions every day of getting things because that was the responsibility and the right thing to do, but where was I in all of that?* [s-19]

> *Me, I'm just physical, I'm just a being, you know? I wake up, I go to work, I just don't feel. I don't know, I just don't feel … I feel like I don't really have feelings and I'm like … Cause sometimes I do feel like there's a person in there, but (inaudible) maybe it is that cause I'm not true to myself, you know? I'm not true to myself. I don't even know what that is. I just feel like I'm just doing the moves. Doing what's expected of me. I wake up every morning; I eat, clean. Whoop dee doo. You know? There's no (inaudible) joy. There's no joy.* [u-8]

> *I want to be able to be myself. It's like I'm always planning what I'm going to say next, I feel like I'm a puppet you know sometimes it's like I'm following a little play, I think it should be more, just natural. And you can get more from it.* [u-18]

These excerpts are reminiscent of the earlier discussion of the experience of being less than fully human ("Something missing" sub-theme). The language used ("puppet", "just physical", "robot") implies a lack of humanity, but also introduces the concept of being able to *behave* as a human ("following a little play", "doing the moves"), while at the same time not being an active agent in one's life. Continuing from this, the next excerpts describe the feeling of not consciously or actively making choices in one's actions.

> *I didn't really have a sense of what I wanted, what I didn't want. I was just doing what I was supposed to be doing … where have I been, what's happened to me. How did I? I know how I got here. Cause I have memories of things that I've done to get here, but I don't feel I've been, I was involved in the decision of all of these things you know … No I wasn't choosing a lot of these things. I find myself even today, involved with people and doing things that I have, I've not chosen … it looks like I've made choices but I really haven't. They haven't been conscious choices that I've wanted to make. They've been things that I had no choice about, and choice in the way that, okay I went along with them. But that's all. They're not active choices that I actually wanted to make, you know, there were very few decisions that I actually remember making and feeling good about.* [s-19]

> *I really never made choices. I never made choices until I left my second husband and started hanging out on my own. It was the first time in my life I knew I had the right to make a choice … Yeah. I went along, you know life is not for me, you know just some victim I guess, along for the ride … And so I relied on other people's feelings about me to lead me through my life.* [e-15]

These excerpts again draw us back to the first theme and the reliance on others to define one's identity ("Questioning one's identity and purpose" subtheme). These speakers make choices based on what they believe they are "supposed to" do, and rely on others to decide their actions for them. The first and second themes both demonstrate how clients define their experience of self based on the expectations and perceptions of others, but are distinguished in that the first theme focuses on identity and self-definition while the second emphasizes choices and action.

Another aspect to the sub-theme "lack of agency" is the experience of feeling helpless, powerless, or trapped in one's circumstances.

> *I felt kinda stuck there. Kinda stuck … I felt like I was more like trying to get out, like sometimes I feel like I'm in a bag and I'm trying to work my way out of it. Like I know, I think I've felt like that for so long and that's how kinda like how my life is. And to me it feels like it's almost like there is no way out. And I think that makes me feel depressed.* [v-8]

> *That's like the victim to me feels like that's what I used to be … letting other people's wishes you know based on (inaudible) not knowing, not being in touch with my own body, you know it's a flight or fight adrenaline rush like just shutting it off … being at somebody else's mercy. Your brain says no but being overpowered … it's like wait. The woman saying no and (inaudible) you have to, you know, give into their will. So your brain is saying no but you know, you don't have a choice … It's not a good feeling. Yeah, it's a feeling of being overwhelmed. And being (inaudible) not in control of much.* [k-13]

Other clients experience themselves as having choice and the ability to act freely, but experience a sense of pessimism that their actions will have any positive impact or outcome in their lives. They describe persistently expecting negative outcomes, feeling that "something bad" will inevitably happen.

> *It seems like the whole world is falling down around me. I really feel like I'm just waiting for the next bad thing to happen to me.* [u-2]

> *I think I wonder whether or not people who were sexually abused, whether or not they have this general feeling of disaster where everything's wrong and there's this big problem and everything, you're okay for a little while but then oh god … always expecting the worst things going on … and maybe that's a result of feeling there's something so wrong with your life, especially when it happened so fast you can't do anything about it … we're always expecting the sky to fall, we're always expecting something we can't believe it.* [d-9]

> *It's like I'm afraid that if I wanna live, that if I finally figure out I wanna live I'll probably die of some disease right away. I just feel like I'm dead and I feel like I'm damned and if I ever become happy it's going to be very short-lived.* [q-3]

Not expressing oneself. The third sub-theme under "Not Participating in Life" describes clients' difficulty in expressing their opinions and feelings openly.

> *Like I when I put my ideas across then I don't feel like I'm, I feel like I'm wrong before I even start and I feel sort of um, um, self-centered. Everybody talks about certain things and whatever else, but then when I put my two cents across or whatever, you know I feel self-centered, like it's different, like everybody else is looking at me and I don't feel comfortable.* [o-3]

> *Like I just wish I could, you know, get out of that, and just say whatever I have to say, and then just you know, say my piece and have some peace, you know with myself for saying … saying whatever.* [v-7]

> *There was one conversation going on right in front of me … and I knew something I could've said but for some reason I didn't say it. I wanted to say and put some input into the whole conversation … I just lost self-confidence to say what I wanted to say and then I was stuck in that mode for the rest of the lunch.* [m-5]

The following excerpts explain that the difficulty expressing one's opinion may be due to concern with others' reactions. Specifically, these clients worry that they will "cause problems" or be judged for having a differing opinion than others, and so hold back from expressing their thoughts.

> *I don't want to get into arguments with people, I don't want to get in fights with people, and I don't want to express my viewpoint to people, because I'm afraid that they're going to think, um pass judgment on my viewpoint and pass judgment on me.* [q-8]

> *I can't bring out my actual personality. I'm afraid to do that. Be outspoken and actually what I think and what I feel. With also you know when I do (inaudible) across it, I become emotionally turmoil, oh this is going to cause problems, it's going to cause complications. And so sometimes I'll just you know, agree to, agree to agree type of thing. Even though I disagree.* [o-7]

> *Why can't I just say no? … Because I can't say it so I have to. Then it's imposed on me and I have to do it. And have to struggle to do it. Where a lot of women will say 'No. I can't do it. That's too much.' And I think well, when am I going to figure it out that I can say it? … Not part of my vocabulary.* [k-13]

Another means of avoiding judgment from others is to present a "façade" so that one's true nature will not be seen and negatively evaluated.

> *I've been often called aloof…because um I don't share a lot of anything with anybody… oh I definitely kinda hide from people … if I'm forced in a situation I could play the 'hey what's going on', I can put on a little bit of the salesman stuff. But I can only go so far with it.* [m-5]

> *Guess I had to put up that wall, and that façade, as you're saying. Had to be different things to different people in my mind and that. But mostly to keep standoffish and to be I guess mysterious in a sense, so that they'll think supposedly good of me and not see the bad side of me … boring and incompetent on the job, and um, um, you know, not intelligent enough, not a good personality, and um, you know.* [o-13]

> *I feel like a phony. I feel like a phony. And maybe that's what the song and dance is all about. I'm putting on a show because I don't know how to reach him. I don't know how to be me.* [e-10]

> *I'm trying to pretend. Like I've had a big cover up going for years. So I wouldn't want anyone to expose me or by mistake expose myself for the loser I am when I'm trying to pretend.* [u-6]

Here we see that clients routinely present themselves as something other than their genuine selves ("façade", "salesman", "phony", "cover up") as a means of protection against expected judgment. This concept of a publicly presented façade is related to the previous theme on unclear self-identity.

> *You're so shallow … once the façade comes down, you just sit there and you don't even know how to be you anymore. You don't even know who you are. You're just going through the motions just like always and you just don't know how to be.* [e-12]

Presenting a façade also is related to underlying feelings of worthlessness (covering up the "loser I am", "the bad side of me"), which will be discussed later, as part of the third major theme.

Self-sabotage. The last sub-theme under "Not Participating in Life" captures the experience of individuals who behave and make choices that are contrary to what they really want, or that interfere with them reaching their goals.

> *I've always had that you need to feel 'you don't want to succeed, you're no good, you can't succeed, you're going to fail'. You know, and then I find sometimes I deliberately set myself up … I don't even know I'm doing it.* [n-14]

> *There's that part of me that's always been the rebel and that's where we get into some … just to say look my program is always to be taking it to the brink of success and then backing off. I wanted to satisfy that model you created that I was going to be a fuck up.* [g-11]

> *It's like the worst, the thing that you don't want, you know which I would like to be able to save our marriage and be happy and all that jazz. The thing that you want the most you know, sabotage it or you know, like you don't know what to do to make, to get there.* [k-5]

Self-sabotage appears to occur frequently in interpersonal interactions. Clients speak of wanting social interactions and intimate relationships, but find they hold back from interacting authentically with others out of fear of judgment, rejection, or humiliation. Instead, they engage in self-protective strategies such as withdrawing from social contact, or pushing others away out of fear of being hurt.

> *So protected that I don't let anybody or anything get close. And I do that through just being really cruel. Whether it's subtle or whether it's just obvious … just stay away from me. Thorns, you know, you get close to me I'm going to get hurt, you know?* [l-10]

> *It was almost like a … oh I'll hurt myself and nobody can hurt me as much as I hurt myself … cause I've always been afraid of being hurt. So I've always thought of it with like a protection thing. That you know I'll hurt myself before someone else will hurt me … leaving boyfriends, before they, you know because, before they leave me.* [u-12]

> *I was a person that needed love and somehow when I got love I pushed it away … couldn't accept it … um even when I started feeling love I felt there was something wrong with it, and not right, so I avoided it.* [j-6]

The Connection between Not Participating in Life and Maltreatment Experiences

In seeking to understand why they do not participate in life, why they feel a lack of agency, or why they act in opposition to their true wishes, clients explore links to their childhood maltreatment experiences. Specifically, they describe having had no choice or

control over the abuse that occurred, experiences that taught them they have no choice and no control over what occurs in their life, in general.

> *First of all, a complete and total lack of choice in the matter. It's like a predator having, having his way, her way without you having any choice, preying on you without any, any thought about consequences. So the complete lack of choice in the matter, the helplessness comes up, the helplessness.* [i-3]

> *Always scared I was gonna get hit, scared if I was gonna do the wrong thing or my dad would do something to hurt me … I hate it. I'm living a lie. I think that's where my emotional energy draws in. When I sit there and I feel myself being put back into that position.* [j-14]

> *She would turn everybody in the house on me… my dad would just sit there and he was like one of her pawns … and I would turn to my older brother …and he would just say you're on your own, sorry bro … pretty much I was all on my own … just total helplessness… I was just total emptiness … I don't know what to do, I don't know what to do next. I don't know what to say. It was like someone just pushed you off the edge of the cliff and there's nothing you could do but fall … cause I knew there was nothing at that point I could do or say to change anything.* [m-4]

> *I didn't feel like an individual, like I always felt I was in a prison and he was the prison guard, telling me what to do and how to do it. You know, how to think, how to feel … everything I did was wrong. Like why do anything in a situation, it will just bite me.* [o-12]

Childhood maltreatment experiences also taught these individuals that there was no reason to hope for a positive outcome in life. This calls to mind the clients who spoke of continually expecting negative outcomes or "something bad" to happen ("Lack of agency" sub-theme).

> *I can't imagine what it would've felt like to have my mom be, my parents be supportive. I can't even imagine. I always felt damned … I was feeling damned, I don't have a chance, there's nothing I can do.* [q-3]

> *I was so positive that absolutely nobody cared and I could not even expect for anyone to care about me … No. you know, I didn't know there was such a thing as hope, or such a thing as future. Or such a thing as growing up to be productive or educated or, any, I never knew that I had any options in my life. I just never knew.* [e-5]

> *After what, how many years of being told you're stupid, I mean you start believing you're stupid and you can't do nothing … Everything I do now, I quit, I don't finish. I quit it, I can't do this. I never finished school because I quit. I figured I couldn't do it.* [r-15]

These excerpts highlight that the lack of support from parents, whether by neglect or outright critical messages, communicated to these individuals that they have no chance of being happy, making choices, or having an impact on their life through their own efforts and actions. Finally, participants also speak of being taught that their opinions and ideas were unimportant or wrong, a message that influences their ability to speak up in the present day.

> *You know what, I was never allowed in my life to have an opinion about things. I know we have a right to choices and opinions. But I didn't know that for years and years and years. I just knew that I had to be a good little girl and I better do what people say so if somebody says I'm whining, that means you just shut up, 'just shut up, I don't want to hear about it.' That's what I hear.* [b-6]

> *I don't share all my thoughts with my wife but she shares all hers with me … selective … and that's the way I was with my mother cause she would shoot down most of the things that I thought and wouldn't listen to the rest … I'm selective what I tell anybody. Because when I was younger everything I did was wrong. And after a while I stopped telling them anything and started lying to 'em.* [m-5]

> *What I learned in therapy last year was that I have a theme that I shy away from the people that I care about, because I don't want to share how I feel, cause back in the other day (inaudible). I really felt, I used to be ostracized. (inaudible) used to ostracize me, my parents didn't talk to me. I was taught not to be opinionated, I was taught not to ripple the waters.* [c-5]

Theme Three: Feelings of Worthlessness

The third major theme, "Feelings of Worthlessness", describes the experience of feeling unimportant, inadequate, having no worth. This is expressed through negative evaluations and criticisms of oneself, but also feeling responsible for, or deserving of, the maltreatment that occurred. I have identified three sub-themes that describe these variations

on feelings of worthlessness: (a) defining oneself as “bad”, (b) self-criticism, and (c) self-blame for maltreatment.

Defining self as “bad”. One of the most prominent themes identified in client statements was a negative evaluation of self; viewing oneself as “bad” or “no good” as a person. This was expressed in various ways, for example, seeing oneself as “inferior” or “less than” other people.

> *I would be very embarrassed. I’d feel like I was stupid, I didn’t know what I was doing. I felt the person at the bottom of the whole totem pole. You know I was less than everybody around the situation.* [o-5]

> *There’s the sense, a sense of inferiority that goes right to the core of you. Um, there’s a lack of self-worth.* [i-3]

One client describes how his sense of inferiority is linked to the sexual abuse he experienced.

> *Something that I did went against the, being that I’m, just my whole heterosexual feelings in life. To go through something like that was very hateful and caused me to be, feel like at some point in my life I was (inaudible) it was disgusting … and I’m less of a person.* [j-6]

A variation on “badness” is the perception of self as something “disgusting” to others. Clients used metaphors such as “slime under your feet”, “gum on their shoe”, “pigs”, and believed that others rejected them because of their “disgusting” nature.

> *It was something about me that everybody found ugly and distasteful and they wouldn’t touch me or talk to me.* [e-10]

> *I get stuck with the body that I’m overweight and people make fun of me. I don’t want to feel gross; I don’t feel like a normal person. I feel like somebody who should be at a freak show … they’re not touching you because you’re gross, disgusting.* [c-1]

Other clients identify themselves as “defective”.

> *I feel I’m um, a weird emotional cripple, or um you know, like what’s wrong with that guy.* [o-13]

> *I feel like there's some sort of defect I have.* [c-6]

> *If I don't adapt successfully to you … to your expectations or your demands, that somehow I am deficient.* [g-16]

Another aspect of "badness" is the experience of self as being "useless" or a "waste". These clients experience having no purpose to their lives, feel as though they do not matter in the world. The language used to describe this experience of self includes: being "an empty, useless void", "a big waste", "useless and good for nothing", "wasting space", and "have nothing to offer".

> *I'm just a useless piece of shit and that's exactly how I feel … I really am a useless piece of crap.* [m-11]

> *I'm just on this earth but for no reason, like it's a waste, like what's the point of me being here?* [u-8]

Another common theme is feeling like a burden or a problem to others, whether caregivers in childhood or important others in their present lives.

> *I hated my life so much; I wanted to run away all the time. Cause it was awful. It was just so awful. I felt like germs you know, like just being born, you know the atrocity. The atrocity was that she had to pay by putting up with us. Like it was somehow our fault we were born, like it was somehow our fault that her life was terrible. It was somehow our fault that dad didn't treat her the way she wanted.* [e-6]

> *I knew I was unimportant enough that I could've died and no one cared. No one would care. Just one less mouth to feed. I know I wanted my life to have some value …a by-product of lust and that's it. Just the unfortunate punishment the Lord sent.* [e-14]

> *But why. I don't know why do I feel like such a burden, you know? My my just my existence is a burden. I'm a burden on my husband, a burden on my daughter. A burden on these people because they have to put up with me and they have to see me. That's why it's so much nicer to be alone, you know? And I don't have to worry about being a burden on anybody.* [u-8]

Another variation on "badness" describes the extreme of negative self-worth. This is the experience of feeling of such minute importance and value that one does not exist. The following excerpts describe this experience:

> *It doesn't matter. I feel like I'm nonexistent, I'm nothing. You make me feel like I'm just nothing and I shouldn't be here. You don't even want me. I'm nobody.* [q-10]

> *Ignoring me … I was just almost like a toy for him… there was no importance attached to what I did. You're just doing your own damn thing and I'm just along for the ride. It's like I was a non-entity. Like they needed to hear him. It had nothing to do with me… how would it make me feel? Like a slime ball. Like nothing. A nothing. That nothingness of me, with regard to my father.* [i-11]

> *Nobody was taking care of me. And nobody cared what happened to me. So I kinda see myself as becoming a non-entity in the world. I was just a fixer. I never got to be real.* [e-5]

We see in these excerpts how the experience of utter worthlessness is connected to themes that were discussed earlier. Specifically, the sub-theme of "something missing inside self" explored clients' experiences of feeling unreal or like inanimate objects, which recurs here (i.e., being "like a toy" for his father; never getting "to be real"). These particular excerpts clearly demonstrate connections between unclear self-identity and feelings of worthlessness. In the following excerpt the client speaks of attempting to counter her feelings of "badness" by working at being a good person. Nonetheless, despite her attempts, at her core she continues to feel not valuable, of no worth.

> *I've never been able to accept myself. You know, I've never been able, like I could be a good person and do all the right things and try and be proud of myself and do everything positive, I work really hard at that, but deep underneath all that, I don't have, like it's a show that I have value. Underneath I'm not sure that I can feel that I have value. I'm trying to show that I do. But I need to prove it to myself. But I don't.* [e-16]

Again this demonstrates connections across the major themes, specifically how feelings of worthlessness are connected to holding back from presenting oneself authentically ("not expressing oneself"). This speaker attempts to present the appropriate external façade (i.e., "it's a show"), but at her core she experiences a lack of self-worth.

Self-criticism. The second sub-theme describing "Feelings of Worthlessness" is clients' critical thoughts or statements directed at themselves. Some of the self-critical statements made by clients include: "don't be a wimp," "you don't deserve anything," "you're not cut out for this," "just shut up and listen," "you can't do this, you can't do that, you never did before so why are you thinking to do it again?" and so forth. Within the EFTT treatment model, specific interventions are used to highlight the client's awareness of these self-critical processes, often through a two-chair intervention in which the client is encouraged to speak from the self-critical "part" of self and then respond from the other part of self that experiences or hears the criticism. The following excerpts are in the context of this type of intervention. In these excerpts clients highlight the two sides.

> [speaking from the critical part of self] *It's a weird kind of contempt that I have for you because I feel like I'm telling you the truth. It's not intentional contempt but I realize when I'm doing it how much I like doing it to you … it feels like kicking you around. I know I can do it, you know? And watch you go, oh poor me, the weight of the world. And I know that you experience me as part of the weight upon you.* [l-3]

> *It's like it's funny to him* [the critical part of self] … *he's laughing, it's like well yeah you think you're, you're never going to be nothing … it's like it's mocking, so it's making me feel like he's making fun of me.* [u-14]

Some clients begin to recognize that their bad feelings and negative self-worth are in part generated from their own learned self-critical statements.

> *It's weird because I know I'm competent but there's another part of me that doesn't let me believe that.* [u-6]

> *It was like I'm doing exactly to myself what everybody was doing to me before.* [e-10]

> *And now I'm… I'm the one who's putting me down … I'm being mean to me, I'm hurting me.* [s-10]

> *The vast majority of the criticism's from myself. Criticism in anticipation of criticism that was never gonna come … no one's going to come and criticize my test. But I was making it perfect, criticizing myself so badly, over something that nobody else would even notice* [t-14]

Self-blame for maltreatment. A third aspect of feelings of worthlessness is the tendency to blame oneself for abuse or maltreatment suffered at the hands of others. The following excerpts suggest that some clients blame themselves for causing or bringing on abuse as a means of understanding or giving meaning and context to negative life events.

> *When I was a child and anything like bad happened or like something tragic happened, like in my family or whatever, I always wondered if it was a punishment … I feel like it's, it was meant to happen cause I did something wrong or in a past lifetime, a horrible person.* [f-10]

> *Yeah. The why me feeling, but then I start thinking; you know I kept thinking I must have really been really bad. Because (inaudible) you know all that time I spend (inaudible) really having to pay for whatever I did in a previous life. You know, whatever that was.* [p-13]

In these next excerpts, clients not only believe that they were being punished for wrong-doing, but express a sense of responsibility and blame for "causing" the abuse to happen to them.

> *He punched me in the neck … and I blame myself for that … even though you're wrong you're wrong. I think dad was right; I did the wrong thing. I shouldn't have done that and I blame myself for that.* [j-1]

> *I never really blamed my dad for something like that, like I never really blamed him for this incident. I blame myself, cause I feel like I'm the one who triggered that anger. I'm the one who did it.* [j-1]

> *The beatings certainly I was told I was to blame because I didn't do all the things I was supposed to do and therefore I got punished.* [s-10]

> *I felt like it was my fault … It must have been my fault. I must have been doing something to make someone do that to me.* [b-7]

The language here is particularly interesting. Although clients attribute the actual acts of violence to the perpetrators, they place themselves as the origin or cause of the violence ("make someone do that", "triggered that anger") and thus implicitly absolve the perpetrators of any responsibility for their actions. Even for those clients who have some understanding that they did not cause the abuse to happen, there remains a sense of responsibility for not stopping the abuse, as seen in these next excerpts.

> [speaking to herself] *No. It is her fault. You didn't have to believe it. Didn't have to accept their understanding of who you were, you didn't have to accept that they thought you were a freak. You could've believed in yourself.* [e-5]

> *I don't want forgiveness, cause even at the age of five, I'm sure I was smart enough to know that little boy. I knew there was something wrong, I should've stuck to my instincts. I should've walked away. I shouldn't have let him.* [j-6]

> *I should've been able to tell my mother.* [a-12]

The three sub-themes presented here demonstrate the intertwined ways that clients come to experience themselves as worthless. Defining oneself as bad appears to give clients a means of understanding and justifying the abuse, and results in the tendency to blame oneself for abuse; their "badness" becomes the reason for "deserved" punishment. These feelings of low self-worth are then perpetuated and reinforced by ongoing self-criticism.

The Connection between Feelings of Worthlessness and Maltreatment Experiences

In seeking to understand the source of their feelings of worthlessness, clients explored their childhood maltreatment experiences and identified three causes of their low

self-worth: direct messages from others of their low worth; humiliating or degrading maltreatment; and unmet needs for affection, attention, and protection by caregivers. Each will be described in turn.

Direct messages of worthlessness. For many individuals, abusive parents and caregivers gave them direct messages about their lack of value and worth. These clients eventually believed what their parents said about them or to them.

> *It's a kind of feeling of total I am way beneath this … there is a total lack of worth … That I, that almost everyone I come in contact with is like, is like so much better. And and and you know that ties in totally with with with I think with what my father developed in us, and that is that I can (inaudible) he would talk about the wonderful accomplishments of everyone else and his own children were absolutely incapable of doing anything of note. Doing anything at all … I can't get over it. I cannot get over it. Now I don't know if that totally ties in with with this feeling of absolute worthlessness. Um, but that has something to do with it. The, you know, I, it's like I become nothing in the face of someone else. Like I, I'm not you know, worthy.* [i-10]

Another excerpt demonstrates a client's unquestioning belief in his mother's evaluations of him.

> *I didn't want to even uh bother going on because I guess I'm stupid or filthy or, one time she actually she called me a puke whatever that means I have no idea what that means. Called me all kinds of things and just made me feel terrible. It's even hard for me to talk to her because I still feel I'm changed … Very raw very, I just I couldn't, I didn't even want to go on because I well I feel worthless what's the point. And mom says I'm bad so I must feel bad. I must be that. … Yeah. Cause whatever mom said I believed.* [n-9]

Another client explains that there was no reason not to believe her father's statements because he was her source of information about the world. His statement that she was "good for nothing" meant to her that this must be the truth.

> *I was stupid, good for nothing …'you're good for nothing, you're good for nothing, people aren't going to want you'… It's my dad's voice like I got that … I think it's just because he's your dad, when you're a little girl and he's your dad he's supposed*

> *to protect you and he loves you and you don't know anything else, and he must be telling the truth, like why would he lie? You know? Cause I, and that's I think why I really knew about (inaudible) because why would he lie, I mean he loves me, why would I lie? He must obviously see these awful things in me.* [q-3]

Clients were able to reflect on these messages received from caregivers and recognize these messages as the source of self-criticism they now direct toward themselves.

> *I learned to believe what they told me and so no matter how much I think about it and remove myself from everything, there's still that part of me that says 'it's your fault', it's still part of me.* [s-10]

> *My dad's voice, 'oh I'm such an idiot, oh you're stupid, you're ugly, you're good for nothing, you can't do anything. Whoever's going to want you?' I wanna stop that tape. That tape plays in my head all the time.* [q-1]

A more specific message of low self-worth was communicated to some of the female clients, who were told that as girls and women, they were inherently worth less than men.

> *Mom used to tell us that it was our responsibility. We were women and that's just what happens to women. We're pretty much worthless to society. It's men that matter and we're supposed to serve them.* [e-6]

> *Nobody asked my sister and me if we were okay. It was like they were bad for doing it but it didn't really matter that it happened to us because we were just girls.* [e-6]

> *Just that he just didn't want me. He didn't want me and I was just a pain in the butt and, 'you're a girl. You're nothing. Like you're nothing.'* [q-1]

Degrading treatment. In addition to direct messages of worthlessness, clients learned to see themselves as having low worth or value as a result of how they were treated by their parents and caregivers. These excerpts show that clients consider the source of their feelings of worthlessness to be the humiliation and degradation suffered at the hands of their caregivers.

> *It's really hard to feel worthwhile. To feel like you deserve good things. Because as a child you were certainly treated in such a way you thought you didn't deserve it, you were bad, that you were worthless and that's how they made you feel.* [p-13]

One client described his father's degrading treatment, making him lay in his own urine-soaked bed sheets as a punishment for wetting the bed:

> *He totally humiliated me. He made me feel I was just a worthless person. To do that to me for something that I could not control, just like you think I wanted to lay in my own urine?* [t-8]

Another humiliating treatment was a father berating and belittling his son in front of other people.

> *Sort of like perpetuated his feeling that we were useless, that we didn't know a damn thing, that we were, are you crazy, I just remember the son of a bitch yelling at me, right on the front porch. You know, (inaudible) all to him. And that made him big. When he was down. It's the same thing when he said to his Italian coworker right in front of me, 'no fucking good'. It's the same thing. He destroyed me. The son of a bitch destroyed my insides, my soul.* [i-10]

Similarly to the concept of being "destroyed", other clients speak of feeling "broken" as a result of maltreatment. For example, they speak of the abuse "crippling me", being "scarred", and having a "wounded soul" due to the abuse they suffered.

> *I won't let them break me anymore. And I'm already broken. I don't want to let them have that part of me. There's not much of me left. I'm hanging on, I don't know why. Cause there's nothing to live for.* [e-12]

> *It really damaged my life emotionally. I'd be a different person if things had happened otherwise.* [o-9]

Furthermore, clients develop a sense of self as "separate" or "different" from others as a result of the secrecy about the abuse and feelings of shame for having participated in it.

> *I was on the outside looking in. I didn't belong. Because I had the deep-rooted secret, that I was ashamed.* [a-12]

> *I thought I was the only child in the world who had to go through this. It was a big secret, you know?* [u-11]

> *I was worried all my friends would look at me and somehow know.* [h-12]

Clients have linked the experience of worthlessness ("broken", "destroyed" "different" from others) to their memories of degradation and humiliation at the hands of trusted caregivers.

Unmet attachment needs. Another source of feelings of worthlessness was the experience of unmet needs for affection, acknowledgment, and protection. Clients identified several areas in which their caregivers failed to provide them with basic needs as children, and drew clear links between these missing experiences and their problems as adults. One of the most prominent unmet needs was for love and affection from parents.

> *Wouldn't it be nice to be treated like you're supposed to treat your kids, like love and 'you're beautiful, and you're smart, and you're such a good kid and I love you so much'?* [q-3]

> *But I told him everything I need. I told him I need to be loved and accepted and not made fun of and be treated fairly and … I don't know what else is there, I need a hug, I need a kiss, I need to be loved, I need to be treasured. I need to be valued. I don't know what else I need to say to this person. I don't know what else to tell you.* [q-4]

> *My dad has never once given me a compliment. He's never hugged me, he has never said I love you. Ever. Since I was little. He's never ever once said he loved me. Never hugged me. Never took me anywhere. Never did things with me.* [r-10]

> *And I get the feeling that she didn't really want me. … I try and piece together that maybe she just didn't, she didn't really want me. And that's all they say that you know I basically feel unwanted that I wasn't loved, I, that she didn't want me around … it makes me feel very unwanted and it makes me feel unloved that maybe she just had me because she had to have me, you know and I never really had a mother that was there to help show me love and bring me up.* [n-3]

These excerpts highlight the deep yearning experienced by clients, for love and affection from parents. Those who did not experience or receive love were likely to question their self-worth.

> *Yeah, affection. For sure. Because I know if I got one [a hug] from say an aunt or an uncle it felt, it felt really good. I know I felt, actually I felt important, you know. Um. And never getting it from my parents, I know that really really hurt me and I think it always made me question, you know is there something wrong with me, or what's wrong with me, you know, because they never gave it to me.* [v-15]

> *I just thought that I was doing something terribly wrong to piss my mother off like I was. I'm just useless and good for nothing. And I was just brokenhearted that my mother hated me.* [m-11]

One client described how not receiving love and affection from her family influenced her view of the sexual abuse she experienced.

> *I'm ashamed to say that as bad as that was, it was the first time in my life that any people paid attention to me. And somehow I guess I didn't realize it was bad because they were paying attention to me, they were being nice to me, it was, never happened before.* [e-6]

> *[I liked] the attention and that they were being nice to me. But I don't remember them hurting me particularly. But I know there was great shame when the secret was broken … because I was supposed to know that was bad … like I didn't feel the need to go back and tell somebody they were hurting me cause to me they weren't hurting me. They were showing me the only affection I'd ever seen.* [e-6]

> *I was so starved for any kind of attention that no matter how ugly it might look to the world, it was attention.* [e-6]

Furthermore, this client is held responsible for not knowing "that was bad" and disclosing the abuse. These excerpts communicate that unmet needs for love and affection from attachment figures can lead to the experience of worthlessness. Demonstrations of affection communicate that an individual has value; when these are not received, clients view themselves as unimportant, unworthy.

> *I'm hurt, that's how hurt I am. It doesn't matter. I would tell him anyways, it doesn't matter. I feel like I'm nonexistent, I'm nothing. You make me feel like I'm just nothing and I shouldn't be here. You don't even want me. I'm nobody, I don't know how much more to say, it's pretty basic … you make me feel like I wish I was dead. I wish I were dead all the time. You don't want me, you don't love me. You don't care about me. And like, of course, I mean what more is there to say, somebody doesn't want you.* [q-10]

> *That made me question what's wrong with me, that there's gotta be something wrong with me cause there was no affection, no love. And I just blame it on myself.* [v-15]

A related need is for attention and acknowledgment. When this need was unmet, clients also questioned their self-worth and importance, and were more likely to feel "invisible".

> *I didn't really realize I was invisible until later, you know? … it was just cause I was always … I was just always trying to get his attention and his approval … Feeling like notice me, notice me, instead of feeling invisible, it's more like notice me, notice me.* [q-2]

> *I needed to matter. Somewhere. To someone. Somehow. I needed somebody to tell me I was real.* [e-15]

> *They don't give me compliments on anything I do. Anything I achieve they never say oh you did a good job with that … They never once ever noticed anything I've done. Not once.* [r-7]

> *Ignoring me. Like I was, maybe that's it. I was just almost like a toy for him. It was, it was, there was no importance attached to what I did and I think it had, has maybe something to do with the fact that he never never praised me. Never. It was always about him. And him and him only. It was never about me and him. Or him and me. It was always just him.* [i-11]

Another core need that often was unmet during childhood was for protection, safety, and security. As with love and affection, when this need was unmet, it communicated to these participants that they were unimportant, of no value.

> *The pain comes from just knowing that someone who was supposed to love and protect you was the one who damaged you. Who frightened you. And that he took away my innocence.* [p-9]
>
> *Needed her to hold me and reassure me. Make me feel safe. Instead of you know, 'get out of my way and I'm working and I don't have time,' and you're too busy.* [k-9]
>
> *I wasn't even important enough for you to protect me.* [e-10]
>
> *I would feel bad because my aunt would cover up for him and I would get. He was a big boy; I was just a little girl. Why didn't she stick up for me? I mustn't be worth much.* [b-16]

The excerpts provided here have demonstrated the variety of ways in which these clients have explored and described their experiences of self. The following section will highlight changes in clients' experience of self over the course of therapy, and how clients understand these changes to have emerged.

Part Two: The Process of Change in Experience of Self

Note on the Methodology and Research Process

In order to address the second research question (What changes occur in clients' experience of self over the course of therapy, and how do these changes come about?), I initially planned to re-read therapy transcripts in chronological order for each client, making notes on the prominent themes relating to experience of self, and the order in which they emerged for each client. My hope was to create "meta-themes" that reflected the sequence in which the content themes were expressed by clients. However, in my experience of re-reading the transcripts, I realized that it would be an arduous if not impossible task to keep track of and summarize the sequence of emerging themes for 22 clients (who each had between six and fifteen sessions of material).

One of my realizations was that the process of change for clients was not as linear as I had initially assumed (i.e., moving from one theme, to a new theme, to a final theme, etc.). This assumption was likely a result of my experiences as a therapist and my desire to believe that the process of change for therapy clients can be a clear progression from "unhealthy" to "healthier" self-perceptions. Rather, my observation was that many clients engaged in a more circular process of change, in which there was evidence of shifts in their self-perceptions, and in later sessions, shifts "back" to more maladaptive views of self (the "maladaptive" label being applied through my therapist/clinician lens). I speculate that perhaps some clients spoke more about negative views of self later in therapy as they explored and worked through these feelings more explicitly than in earlier sessions. I also observed that as some clients began exploring more positive views of self, this brought up feelings of shame or embarrassment and a return to previously-held negative views of self (this will be explored in more depth in the following section). Thus, rather than describing the sequence in which themes were identified, the second research question will be addressed based on client statements about their experience of changes in therapy, as well as my general observations of this circular process.

In examining client statements about the process of change, I identified three major themes that illustrate how some of the changes in self-experience came about. The first of these themes is the process of shifting blame or responsibility for the abuse from oneself to the perpetrator of abuse. The second theme is the process of beginning to allow and express emotional experience. The third is an emerging awareness among clients that they hold themselves back from experiencing positive feelings and self-evaluations. I will describe each of these themes in turn, along with associated data extracts.

Theme One: Shifting Blame for Abuse from Self to Perpetrator

One of the primary aspects of change in self is the process of trying to understand a reason for the abuse that occurred. In asking themselves, "why did this happen?" and more specifically, "why did this happen *to me*?" clients are trying to place their life experiences in context, to find or construct meaning, a basis for understanding these events.

> *You know and the things that kill me are the things that I'm still trying to get through this whole thing and trying to understand you know, come up with you know, an answer or reason why it happened. Cause that's my biggest thing, you know, why would it happen to me?* [j-7]

In seeking to answer this question, some clients begin to question the validity of blaming themselves for abuse.

> *It doesn't make sense that it was really my fault. I didn't understand.* [e-5]

> *Why is it my fault? ... I didn't do that to my parents. I never asked them for anything. I never used them. It's not me, why is it my fault? I'm not doing this. I never did this, why is it me?* [s-13]

> *Well maybe it was partially my fault, maybe it wasn't. Because I'd sort of always been told that. That it was always mostly my fault and all my fault. And then but it's still in the back of my mind that it was maybe partially my fault. But I mean um, I was only a kid and I didn't know at the time.* [o-6]

Several clients are able to shift away from viewing themselves as deserving of abuse.

> *I often wasn't a perfect kid … but I wasn't that bad.* [m-4]

> *I knew we were good kids. I couldn't understand why there had to be this when we were good.* [p-13]

> *But I could never believe I was bad. I don't ever ever really honest in my heart ever believe that I was a bad person or a bad child. I worked really hard not to get, not to be bad, and I never had. You know, like mom just didn't like me. Didn't matter what I did for her or how nice I tried to be.* [e-5]

This next excerpt illustrates the search for understanding the abuse. As this speaker reflects upon the importance of this question, she begins to consider the role of the perpetrators of abuse (her parents).

> *Maybe it didn't serve any purpose, but it's hard to think of that cruelty from my parents, having it, you know, because certainly you didn't deserve that. You know? And so you go through life saying 'Why? Why did that have to happen to me', you know … and finding ways to just give it some other reason (inaudible). You could put it down to these people are sick, they're cruel, you can say all these things but, but then you think but, you know, 'Why me, why did it have to be, why, why would they do that to us?' Not just to me but to all of us … Sometimes you hear these things and you just shudder thinking 'How can someone be that cruel?' And you really want I think, as an abused child when you become an adult, you really do search for that reason. You know? You really do try and figure out why it had to happen. What purpose was that? And what purpose did it serve?* [p-13]

In this excerpt, the client identifies her parents' behaviour as "cruel", language that judges their behaviour as negative and unnecessary, and in doing so, implies that she did not deserve this punishment. Similarly, in these next two excerpts, the speakers question how or why the perpetrators would act as they did. The perpetrator's behaviour is no longer seen as warranted, a punishment that was justified. Rather the clients are able to question this cruelty and label it as being beyond understanding.

> *I really don't understand my mother's need to do that. I don't know where that comes from. That need to degrade her children. I don't understand that at all. I mean, I know she had a rough upbringing as a child, but look, like so did I.* [p-13]

> *What was this man thinking? … I was a child of five or six and he hacked this [animal] to death in front of me, to see my pain. To see my pain. I cannot believe that was his motive. But it was. It was his motive. He saw my pain and he got off on that.* [i-2]

Identifying the perpetrator's actions as abnormal, not understandable, and inappropriate, shifts the focus away from self as deserving punishment to holding the

perpetrator accountable for their actions. Part of this shift occurs as clients recognize how young they were, which highlights their experience of vulnerability and helps in recognizing that abuse was not deserved.

> *I remember one, when I think of myself, and I've got pictures of me from a long time ago. But I see this really kinda um, small child, big brown eyes, long blonde hair. And just I look at these pictures and I was so trusting, so long ago and I just (inaudible) why would anyone want to have (inaudible) a child? What, what kind of person would choose to harm a small innocent child?* [p-9]

> *I remember the incident with my uncle first. When he was coming at me … How old was I, how old was he when this happened? So I worked it back mathematically to find that I was probably six. And he was twenty-four. This deliberate act of a man. He wasn't a little boy, my mom told me all my life he was just young, he was just a kid and he was so stupid, and he went to jail for it. So I assumed he was young, a kid when he did that to me too … Cause it was uh, it really struck me hard that he was a grown man when he did that to me. And I know how small a little seven-year-old child is. And I remember from my point of view in memory that I seemed very small. And that his penis was so large. I didn't even know it was a penis, I guess I didn't know what that was. I didn't even know what it was. A big purple thing is what I remember… I'm appalled. I'm appalled. How could anyone do that to a child? It doesn't surprise me I feel worthless.*
> [e-12]

The strong language at the end of the second excerpt – "I'm appalled" – demonstrates the client's anger and outrage at the actions of the perpetrator, along with the realization that she is not at fault, that she did not even understand this to be a sexual act, that the perpetrator is solely responsible. Anger and outrage at the perpetrator's actions were expressed by a number of other clients. We hear in these excerpts a clear declaration that perpetrators violated the rights of those they victimized.

> *Why the fuck did you do that? You took part of my childhood. You had no right to do that.* [h-4]

> *You're a black-hearted, soulless creature. You were the freak, and you wouldn't quit until you made us feel like slime under your feet. Because it made you feel important to belittle me. You ruined my life, you didn't have the right. You didn't have the right.* [e-4]

> *I wanted to ask her why she treated me like I didn't matter. Why didn't she care, why, like all the things, why she did. And when I was finished, both sides of the page I filled up with whys. And then I came to a point where I started feeling like, 'How dare you, how dare you just starve me like I'm a piece of trash, I'm a piece of gum on your feet, how dare you'… I'm angry.* [e-5]

> *Well I mean it was completely wrong. I mean it just didn't even make sense, what he was talking about, he was just whipping his frustrations out on me, I mean maybe he, he had no right to say stuff like that.* [o-12]

For some, this anger and outrage is so strong it includes a desire for revenge.

> *I wanna kill the bastard. I remember thinking I wished he were dead.* [h-12]

> *I remember hating her. Really hating her. Really wanting to hurt her. I remember just really especially hating, feeling hatred towards her. And I cut up her dresses.* [f-5]

> *You know there were times where I did think … 'I hate my parents', or 'I wish they were dead'. You know? But they weren't. So. And then I'd feel guilty for wishing they were dead and then.* [u-11]

> *You know what I wanna do? I wanna grab her by the throat and tell her to shut the fuck up and listen.* [m-4]

The imaginal confrontation intervention used in EFTT directs the client to imagine an abusive or neglectful other in an empty chair and express their thoughts and feelings about the abuse directly to this person. The next excerpts are in the context of this intervention and demonstrate clients' experience that they feel robbed of some core aspect of their self.

> *That day you touched me dad, inappropriately. At the time I didn't realize it, you stole my right to have some pride with myself.* [a-12]

> *I was able to realize by doing therapy the past year - you stole my childhood. You caused me to grow up faster than a child should. I became a man…. you made me*

> *feel (inaudible) than what I was. You made me feel like a useless child. You disrespected my body, my mind, and my soul.* [h-13]

> *Felt like I was the only child in the world who had to go through this… I thought everybody had nice parents except me, I felt shorted a bit, I think. I felt ripped off.* [u-11]

Use of terms such as being "ripped off" or having something "stolen" suggests that these speakers believe they deserved better treatment than they received. These next excerpts demonstrate clients explicitly asserting their rights ("I deserve", "not fair") and identifying that these rights were violated through the abuse they suffered.

> *I was late for supper; I didn't deserve a beating. The consequences were excessive to the behaviour.* [t-8]

> *I deserved better than what I got… deserved to be shown love and you to teach me how to respect myself.* [n-9]

> *As far as dad, he'd produced a son, he's produced an heir, the rest of the kids are just nothing … I'm a girl, but [I am as] good as a boy. Not fair that you like boys better, not fair that he gets all the advantages. It's not fair that he didn't have to do housework or mow the lawn or anything like that. And the only reason he did it was cause he was a golden child cause he's a boy.* [q-1]

There is a shift to holding the perpetrator accountable for their actions, holding them as the responsible party for the abuse that occurred; this is often expressed directly to the perpetrator through the imaginal confrontation intervention.

> *Mom I think this is, you're responsible for making me feel this way. You said a lot of things that just don't seem to add up they're not true. And I feel like I'm the one who's suffering because you said all these negative things to me when I was younger.* [n-8]

> *I didn't do anything wrong … I was innocent; you're the guilty bastard.* [h-4]

> *You know that's the first time I ever realized, hearing you say that, that there was something wrong with her. I never thought it was her. I thought everybody was like*

> *her. And I was the problem. But I don't think so. … Now when you say it, it makes more, it makes more sense that there was something wrong with her. And not all of us. We were innocent, we knew nothing. We didn't know that, any of that. All we, just trying to survive and we're over here, (inaudible) wanting.* [e-14]

> *He should've stopped. Just because it was done to him doesn't make it right to do it to someone else. Doesn't justify that kind of abuse. (inaudible) um. It's just the abuse. I was a good daughter. And I didn't deserve that. I deserved better.* [p-13]

The process of shifting blame occurs as clients question why the abuse happened, recognize themselves as victims who did nothing wrong, and identify the perpetrator's actions as morally wrong. This leads to a new understanding of the abuse, not as a deserved punishment, but as needless and cruel maltreatment, that absolves the clients of responsibility for the abuse. This process allows the clients to re-evaluate their feelings of self-blame, and their perceptions of self as deserving of abuse. They recognize themselves as having rights, realize that these rights were violated, and are able to express anger and outrage at the perpetrator's actions, giving them the opportunity to experience a greater sense of self-worth.

Theme Two: Allowing Emotions

The second process of change I have identified is that of clients allowing themselves to experience and express their emotions, rather than suppressing or ignoring them. In the earlier section on unclear self-identity, excerpts were presented in which clients spoke of "cutting off" their emotions because they were too overwhelming or painful to deal with. Part of the process of change in experience of self (including a clearer sense of identity), is allowing oneself to begin to feel, verbalize, and process these emotions that have been "cut off". In these excerpts clients speak about how they begin to allow their emotions to emerge.

> *Big walls. Big walls. That was my biggest, that was my biggest protection. How do I keep that wall up? Now you're telling me that as an adult, that those walls have to*

> *come tumbling down and what you need to do is kinda look at those, resurface those emotions and try to understand them and focus on them and highlight and try to understand this whole process. And you're saying to me, [C], those emotions have to start coming back up.* [j-14]

> *I'm sort of, I guess, training my emotions that they are honest, and they are my feelings, and it's okay to sort of feel like that, but um. Cause sometimes I was sort of dishonest with my feelings and they should be feeling more so, but then not really … Like true feelings weren't coming out.* [o-12]

> *It's sort of getting in touch with emotions instead of just shutting it down and trying to get it take a look at that, and think that I would like to feel that emotion, you know to just work with it … I mean the way emotions would well up in me. That would scare me because all of a sudden it's just coming and I'm of control. That's what was the scary part.* [t-13]

Part of this process includes accepting one's emotions as they are, recognizing that they exist and that they do not need to be changed, and believing that emotions will not "take over", but can be tolerated.

> *You know how I had to hide my feelings and camouflage them to be acceptable to others? ... But sometimes it was just to bury them cause no feeling was acceptable … Well I'm not doing that anymore, I'm letting myself feel … Now I'm giving myself the freedom to feel what I feel because it's okay.* [s-2]

> *You worry about to what extent you should feel. Cause you don't want it to take over your body … just go with it. Just let it wash over you and you'll get by it, you really will. Something else will come along. You'll get through this … to be able to feel sad and not worry it's going to become this boulder and it's crushing you. It's not going to take control of you.* [p-9]

> *Yeah actually I'm feeling it in my stomach and um … my stomach like the muscles are, I can feel that something is happening. Letting it out verbally is very difficult. Like that. The guard you know, what's going on if I find that that little girl deserves love, is the rage going to come?* [e-5]

Once an emotion has been acknowledged and accepted, the process of expressing or describing that emotion occurs. Clients here reflect on the difficulty they experience in verbalizing their inner experience.

> *I've been feeling it that way for a while now. I feel that it doesn't hold true anymore. But I haven't been able to put it to words or feel my way through it.* [e-12]

> *I'm letting myself feel … but I'm confused with them. I have the feelings it's just the expression of them that's the problem.* [s-2]

> *This is a lot of work to push it through, to sit here and actually feel I need to talk about, that I'm actually talking about my emotions, it definitely is a struggle.* [j-14]

> *I would touch the abuse, touch and go and just leave it you know, where with this it's more coming back to focus on it, and always getting it back to this issue we talk about you know, and that was a big difference was actually bringing it back to the focus and taking care of how you feel about this or you know, having me express I think. We had a session (inaudible) was expressing, verbalizing how it felt emotionally about (inaudible) and having me say it, (inaudible) that was probably the most difficult session.* [p-15]

For these clients, there appears to be an emerging awareness of their inner experience, but difficulty identifying or describing this experience in emotional terms. Rather clients begin by expressing their bodily experience of emotion (i.e., "something is happening", "push it through", "feel my way through it") as they challenge themselves to find words to describe their experience. Despite the initial difficulty in verbalizing their emotions, clients express feeling a sense of relief in doing so.

> *I'm concentrating on more on trying to find the word instead of just crying. Like I know crying's you know, good too … before it's just, I'm crying I'm not saying anything … yeah I noticed, I was actually concentrating on trying I think, I'm thinking of the words. Before I would just, you know, I would kind of just give up. So I noticed that. And I really noticed how much of a relief that was.* [v-19]

> *I think for me what's happened in these eight sessions, you know (inaudible) um, being able to feel that pain, like it sounds strange but, you know, you intellectualize it*

> *so you can deal with it, but to be more open, emotionally, that's been good for me, really good for me, to acknowledge what's been this pain.* [p-9]

> *I feel somewhat better. A little bit more at ease. Sometime I, during the session sometimes I started to, I could feel myself starting to move around and starting to get a little tense because I knew we were hitting on some things that were really pushing me and I just try and focus myself on, and I'm glad that you did keep trying to focus on that because it just made me aware of the fact that I was trying to move away from it. I'm looking at different realms. I could understand this and really really wanted to understand it so I appreciate you pushing me.* [j-6]

> *I cried on the way home. It was a good upsetting, like it opens you up. But kinda sad too. That also tells me that something's touched inside of me.* [u-12]

In allowing themselves to experience their emotions, clients begin to recognize that their emotions are valid and acceptable, and that verbalizing and exploring them provides a sense of relief, understanding, and the experience of acknowledging their pain.

Theme Three: Awareness of Blocking Positive Experiences of Self

Data excerpts addressing the process of change in self suggest that this change involves a non-linear progression. Some clients begin to experience a more positive view of self, but then consciously revert back to the negative sense of self they have held for years. This third theme represents the process of emerging awareness among clients, of the ways in which they prevent themselves from experiencing positive changes in self. I identified three areas in which this process of blocking positive experiences of self was apparent. Clients consciously stop or hold themselves back from: (a) feeling or expressing happiness or positive emotion, (b) making choices and taking action in life, and (c) expressing confidence or a positive evaluation of self.

Interrupting positive feelings. Clients speak of interrupting their experience and expression of happiness or positive emotion.

> *Looking at the negative side of life, and that there's no positive things, I sometimes even, I can feel it pulling me back from trying to be happy. Sort of having a clear emotional thought of some situation and to be fully happy and then express myself, as I say it's like a rubber band it just pulls me right back. And, but I'm not supposed to be thinking like that, I'm not supposed to be happy, I'm not supposed to be looking at the good things in life and the positive things that should happen, that could happen.* [o-14]

> *It scares me, I don't know. I told you before, I'm so afraid, I don't know. I can't even imagine that. Even just saying that, I feel lighter, just saying oh my gosh, just being, just being a confident person, oh I can't even. … if I can, I can just tap into it for a second, yeah, yeah. It's like wow I could, and then I'm thinking, and then I hold back right away. … You know? I don't know why. It's uncomfortable over there. It's comfortable over here in the sallows of your soul.* [q-2]

> *I kinda feel like I'm in trouble now too. I feel like I'm going to be in trouble for this after I leave. Isn't that weird? (inaudible) like I'm going to get in trouble for something that I … I feel like I just all of a sudden felt ashamed that I was bragging or … show off … bad girl … it is because I feel like a bad girl now just from telling you how happy I was. I feel kinda bad now … yeah. I feel bad now … just feels yucky. In trouble. I'm going to be reprimanded.* [u-16]

Self-imposed barriers to action. A second aspect of blocking positive self-experience occurs in relation to taking action or asking for one's needs to be met by others. In these next excerpts the speakers express hesitation in acting on their wishes.

> *Stick your neck out… well it's not even answering questions, it's asking them … Because once you, once I realize what I want and what I need, then I gotta, the next question is well, what are you going to do about it? How are you going to respond to it? You gotta take responsibility. Cause I need to.* [l-7]

> *I have the power to make the decision to change my life. I have to get the guts.* [q-9]

> *It's a crutch; it's a crutch type of thing. It is and as I say it's gonna have to, you know, take some work at it to get up to that point of … to know what I want and to go after it and then do it. Why take a chance? … I'm good to take chances in other areas, other than personally, like for business and otherwise and that, but for personal, personality and growth area and that, I'm not as much for.* [o-16]

In addition to fear of taking action, clients speak of having difficulty expressing their needs and desires to others.

> *And I'm afraid to ask for something from somebody, you know emotionally or friendship-wise, or otherwise. And then um, I guess sort of fear rejection. Rejection cause I, that's why I never ask for stuff like that.* [o-9]

> *I need you to listen. … I need you to listen. … That's right. I need you to listen when I say something … Like I don't understand why it has to be such a big thing for me to be able to say that … Why is that so hard? You know it's almost kinda ridiculous. When I hear myself I think you know, why do I have such a hard time asking … It should be a simple thing. For anybody else it would be … Well because I see people ask for what they want. And I don't have a problem with that. I think it's wonderful. But why can't I do that? ... Oh I'm not going to get it. I'm not worthy, I'm not smart enough, I'm a loser. Why would they want to do that? … I'm not worth it. How can anybody else think I'm worth it when I don't think I'm worth it? You know you get what you ask for right. You don't ask for nothing you'll get nothing.* [k-9]

> *But why, sometimes I wonder why … why do I govern my life around somebody else, how they feel? You know? … what they want. What about what I want? (inaudible) … what about what I want? But it's not her fault because most of the time I always don't know what I want. Or I'm afraid to ask for what I want. I don't make my wishes known so it's not anybody's fault. And I realize that about myself.* [k-9]

In the last two excerpts, the same client speaks of her difficulty in expressing or asking for what she wants from her mother. She expresses that this difficulty is linked to unclear identity (not knowing what she wants), and from feelings of worthlessness (believing she does not deserve it). In the first excerpt, the client hesitates to express his wishes because he expects a negative outcome (related to "Lack of agency" subtheme). Thus the three major themes relating to participants' experience of self may function as barriers to taking action in one's life.

Difficulty experiencing positive evaluations of self. Clients also describe having difficulty viewing themselves positively, taking pride in their achievements, and accepting

praise from others. When positive evaluations or compliments are awarded by others, clients speak of their awareness that they cannot allow themselves to believe or accept these compliments.

> *You're just saying that to make me feel better, just being nice … I push it away … I can't handle that, you saying something nice about me.* [q-10]

> *I get compliments and I cry … because I don't know how to take it. I've never had compliments … it's just why are you complimenting me? What did I do to get a compliment?* [r-10]

> *They did call me after and congratulate me and said 'I'm happy for you' and I deserved it. That was hard for me to hear. It was almost like 'yeah yeah yeah yeah. Whatever. You're just saying that, you're just saying that'. You know? In my head I'm thinking 'yeah yeah yeah, you're just saying that'. That was hard for me to, to … when it's really so much inside of me but when people acknowledge it, which is what I want, I'm like 'no no no'.* [u-9]

This discomfort with positive evaluation is even more apparent when clients speak positively about themselves. In these excerpts, clients express an awareness of how they disallow or block experiences of confidence and pride.

> *I can't even be proud of myself you know. I can but then for a moment I get this embarrassment. It's not appropriate. It's not to be proud of myself. You know, to be happy and proud of myself that's hard for me to be proud of myself … because something tells me again, you know, it's not … 'don't kid yourself'… it's all bullshit. It's all talk…yeah. 'You're full of shit'. Exactly. 'Maybe people will believe you but I won't, I don't'. And that person's more important than anyone to me, the one that tells me that I'm full of shit.* [u-6]

> *Sometimes I get these days where I really still get kinda scared about what's ahead and I really hate that uncertainty, like with my new job, I know it's the right decision, so then I feel like I kinda go backwards. Its kinda too much success for me and I don't know how to accept it. That's how I feel.* [n-6]

> *In my head, always I'm a great person and I have a good heart and lots to offer, but my heart won't, I don't know what it is, won't let me live that, won't let me feel that*

> … *I have to behave in a way I know I really am, in hopes my heart will catch it, and I will feel it one day.* [e-12]

As clients explore these contradicting feelings and become increasingly aware of this automatic process of disallowing their positive experiences, they begin to grapple with how to change it.

> *I want it to go and be gone … 'Be gone!' That's what I want to say. But um. I think that's going to happen cause I think the critic is getting not so strong…. cause I think I deserve better. But see you know what my first instinct was when you said that? ... was well um, 'you don't deserve, why do you think you deserve anything. You maybe you don't deserve anything'.* [u-18]

> *I mean, I wouldn't be fighting back if I truly believed it. I mean I feel conflicted. Feel the ... I don't know. I feel the, yeah. If I truly truly believed I'm fat ugly stupid, I wouldn't be struggling so much; I would just be fat ugly stupid. I wouldn't know that that was wrong. All those things were wrong. I wouldn't know that … I wouldn't be angry … and accept it … yeah so that made sense. Now what do I do about that?* [q-12]

Part of the process of change is an increasing recognition of how they hold themselves back from allowing positive emotions, from taking action in life and asking for what they want, and from feeling proud of themselves. The main three processes of change described here, shifting blame for abuse from self to perpetrator, allowing emotions, and awareness of disallowing or blocking positive experiences of self, together create the opportunity for clients to experience themselves differently. The following section will describe some of the changed self-perceptions expressed by clients in the later stages of therapy.

Part Three: New Views of Self

In examining client statements about the changes that have occurred in their experience of self over the course of therapy, I identified three major themes, which

correspond to the three themes on experience of self that were identified in Part One of the Results. The first theme reflecting a new view of self is "Being Myself" – a counterpart to "Unclear Self-Identity". This theme describes clients feeling as though they can behave spontaneously, be "real", trust their inner experience, and feel a sense of integration of the multiple parts of self. Several sub-themes fall under this, including (a) authenticity, (b) integration, and (c) listening to myself. Second is the theme of "Feeling in Control" – a counterpoint to "Not Participating in Life". This theme describes clients having an increased sense of control, choice, and independence in the decisions they make for their lives. The sub-themes identified here include: (a) in control of choices, (b) deciding for me, and (c) empowerment. Finally, the third theme is "Self-Acceptance" – in contrast to "Feelings of Worthlessness". Captured under this theme is the experience of valuing, accepting, and taking care of oneself. The sub-themes under this theme were identified as: (a) rejecting the perpetrator's messages, (b) positive self-evaluation, (c) increased self-care, and (d) feeling happy. Each of these themes and sub-themes will be described in turn.

Theme One: Being Myself

Authenticity. The sub-theme of "authenticity" represents the experience of being genuine in one's self-presentation, and living in accordance with one's own wishes.

> *I'm just now being myself and not … feeling pressured into being anything else or doing anything else.* [m-10]

> *I think it's a good trait to be yourself, be true to yourself and do whatever you want to do.* [u-18]

Another client speaks of a greater sense of peace or freedom in "being myself".

> *I've experienced that in other situations, where I know I am myself, where I know I am calm inside. I'm peaceful and I enjoy the other person.* [i-10]

> *There was a sort of freedom about me that was different from the way I felt before very uh, kind of more self-assured, more um, I don't know, more in touch with me, I had a better sense of self.* [i-12]

Similarly, another client describes a joyful experience in simply "being me".

> *I'm fine the way I am… I'm still me but I'm changing. I'm changing myself. For me … I'm happy, I don't let nothing bother me no more. I feel like dancing in the streets and having a party. I feel so, so good about myself. I feel like dancing all night … it's like yeah, I'm me. I'm happy. I'm healthy. I get to be me. I don't have to worry about being like that. I'm me. I'm me. Just me. Plain little old me. I'm [G], that's me. That's who I am.* [r-15]

For these clients, this experience of authenticity seems to be a clear departure from the previously described experience of presenting a "façade" to the world ("Not Participating in Life" theme). Simply "being myself" provides them with a sense of joy and freedom they have not previously felt.

Integration. A second aspect of "being myself" is the experience of greater integration between parts of the self that felt "split" in the past. One client who previously spoke of having a disconnected part of herself (a little girl who "flew away"), in later therapy sessions describes feeling more connected or integrated in terms of the emotional ("heart") and cognitive ("head") aspects of her identity.

> *Like it's getting connected, where before I didn't feel like head and heart connected. Like I'd have to think okay what's the problem, why am I feeling like this, bla bla bla. Like you know like what the heck. I felt so disconnected. You know I just couldn't even figure out what, what it was. You know, now I feel like it's more you know, like one. Not two pieces.* [k-11]

> *I feel like I'm starting to be a little more connected… brain to stomach or heart. I know that's a good thing, but I feel like I'm just taking baby steps.* [k-14]

> *It's like my brain and my heart is more connected now so I don't feel that break… it's like the gap is shorter. You know like I feel it right away. So I'm not second-guessing myself either.* [k-17]

This concept of integration of multiple parts of self is echoed by another client.

> *[Those feelings] were important from a logical point of view and not from an emotional point of view, because the two were so separate and distinct and now there's sort of a blending. There starts to be this overlap. And really what I'd like to see is the two become one. Um, but there is an overlap to a degree and I'm trying very hard to put the two together more.* [t-13]

Another client speaks of the process of therapy providing him with greater self-awareness and understanding of his identity.

> *It's given me a kind of a newer view of oversight of a view of what things mean and how I am as a person. And what makes me this way. What gives. What makes my things, what gives me my behaviour and attitudes and strengths and weaknesses and all the things that make me a person.* [j-16]

Listening to myself. In addition to an increased sense of integration, clients also speak of feeling as though they can listen to or trust their "gut feelings", and thus experience less self-doubt.

> *Before cause I wasn't connected, I was choosing that, like I was making not the best choices for myself. Um not paying attention to red flags. I'd see 'em but I'd (inaudible) … I'm choosier about who I allow into my life as friends or you know, whatever because I've been listening to the red flags. Like it's more connected… well I'm trusting it … it's a red flag, hello, wait up. You know, pay attention. Where before I didn't pay attention.* [k-17]

> *I always get that uncomfortable in my stomach. And it's that uh in past the signal would mean that I know myself, that I'm about to do something that I don't want to do. So I promised myself to listen. And uh to not force myself into those situations that I'm uncomfortable with.* [e-15]

> *I've noticed an attitude change that I'm checking myself more before I agree to something. I'm thinking about things more and just saying to not do that.* [t-13]

Being able to listen to "gut feelings" about one's own values contributes to the experience of "being myself" – of listening to, and living in accordance with one's preferences and values.

This also sets the groundwork for being able to make decisions based on one's own preferences – a concept that will be explored in the following theme.

Theme Two: Feeling In Control

The second theme, "Feeling In Control", represents the experience of having choices and making decisions for one's life. Three sub-themes were identified: (a) in control of choices, (b) deciding for me, and (c) empowerment.

In control of choices. The first sub-theme under "Feeling In Control" describes the experience of feeling as though they have control over their circumstances, that they can choose between various options.

> *I feel a sense of uh, a lot of pride um. Like I'm in control now because you can't control my life and I'm going to control my life and you can't tell me what to do … I feel so proud that I've got all these options that I don't have to go there, I can just choose another option and stick with that whatever it might be … I feel like I'm in control for a change.* [n-6]

> *And you're gonna fall. And before I didn't get up. Now I'm getting up on my own. That is the difference, I feel like I have (inaudible) because there are times when I'm not even, I can control myself. And there's other times when I'm not. And the fact that I'm able to do it sometimes means that, I don't know if I told you before, but I feel like I can take control.* [t-14]

> *I feel really good. I feel strong now, that I have some power over what happens to me.* [b-11]

This is in stark contrast to the "helpless" and "trapped" feelings that were previously described (see section on "Not Participating in Life: Lack of agency").

> *Now I have a choice and I don't have to do anything that I don't want to do.* [f-15]

> *It was like something I had to, a ride I had to get on, and I had to stop when the ride stopped. There was no control. Whereas now I feel like yeah I can stop this.* [u-17]

Deciding for me. Clients also speak of focusing less on other people's desires, and more on their own needs, wants, and preferences. In this excerpt, the speaker discusses a situation in which her date invited her to spend the night with him.

> *I could've stayed if I had wanted to but I didn't feel that was, it didn't feel right for me and so I was able to say no I think I'm going to head back. And I didn't let his wishes, I didn't let him impose his wishes on me … so I left. And I thought you know, like I did what I felt was right for me. Exactly! I was really happy about it and it felt right … That's a new thing for me cause I would normally let somebody else's wishes, feel like I have to make him happy.* [k-13]

This excerpt clearly demonstrates the connection between "listening to myself" and subsequently acting on what feels "right for me", as well as this client taking steps to protect herself from future abuse or coercion. Clients speak about giving priority to their own needs and opinions rather than making decisions to accommodate the wishes of others.

> *I have to make decisions based on how I feel about things not how she wants me to be … I have to do what I think is best for me and for who's important to me. Not my mother thinks I should do this, or anybody in my family for that matter. Because I usually don't agree with anything she wants … and the funny thing is that usually what she wants is opposite to what the right thing that I should be doing.* [m-18]

> *She wants me to be this little puppet that she can, kind of like, oh you gotta do this, you gotta. No. I'm my own person. You don't like the way I do things, out.* [r-14]

> *It makes me feel like I could actually take charge and make changes and not worry about, you know, just I shouldn't feel so guilty. I shouldn't worry about changing for the other person.* [n-7]

Another facet of this increased decision-making capacity is being able to make choices independently, without relying on others to guide them.

> *It's okay to feel, it's okay to you know, make your own decisions and it's good for you. And when I talk to somebody it kinda gives me that boost of confidence. I feel as if I'm a little bit dependent on people's opinions and I kinda, it's this feeling that then I feel like hopefully I can do it on my own. That's what my goal, is to do it on my own, and not necessarily always need that influence.* [n-7]

> *I'm in control now. I have to find a way to find happiness. I don't need to count on other people to give me that.* [e-12]

Finally, participants begin to assert themselves as being the decision-makers for their lives, and taking full responsibility for the decisions they make.

> *I became my own person. I made my own decisions, the choices that I make are mine now … it took a long time to get there and to know that my life is what I chose it to be … yeah cause you think that circumstances have control to what you do, and then you realize that no, you chose this path.* [p-6]

> *I'm fully responsible for who I am because I chose for whatever reason to respond … to my environment and to activities and so forth. And that was my decision, right or wrong, whatever the decisions were. So I'm fully responsible for the way I am. I'm not responsible for setting the factors up that caused me to respond the way I did.* [t-12]

> *You have to come to a realization I think I did. And then I'm the captain and I have to steer this boat.* [e-15]

This sub-theme has clear connections to other changes in self. Clients who are more clear about their own feelings, wants and needs (captured by the "Listening to myself" subtheme), are then more able to make decisions based on these feelings ("Deciding for me" subtheme). As described in the excerpts above, this in turn contributes to a clearer sense of identity and autonomy ("I became my own person").

Empowerment. Another sub-theme under "Feeling In Control" is the experience of being empowered and able to stand up for their rights; of fighting back against injustice, abuse, violation, or disrespect from others.

> *Wow. I actually stood up to somebody, my parent. I mean wow. Its just like it floors me. But it feels good. The more I do it, the more confidence I build up.* [r-14]

> *I speak up for myself but there's much honour in saying no. It boosts my self-esteem when I have to. I've never straight up, straightforward looked someone in the eye and*

> *said I am standing up for my rights. And I did that. And that was like so empowering.* [e-15]

> *I carry the burden with me all these years. For people to know, understand that I'm not taking second best anymore. I'm standing up for me. For what I believe I should have.* [a-15]

> *I'm becoming more outspoken in the situation where I can actually speak my mind and I don't have to do it in a too aggressive or too forward way ... I have rights and I have feelings too.* [o-14]

This newfound ability to stand up for oneself contributes to an increased sense of confidence and self-esteem (which will be explored in the next section). Related to this sense of empowerment is the experience of self as strong or resilient to the impact of negative life events. Participants recognize the adversity they have been through and consider this evidence of their strength and survival skills.

> *I'm a tenacious woman and tenacious women do not just give up. They work at getting what they need. So I can do that. I'm doing it. I deserve that.* [b-14]

> *Now I'm trying to learn how to take these emotional things ... and reduce that impact so that it's not a piece of glass anymore, it's a piece of plastic that can handle the impact and absorb those shocks … emotional shocks and not allowed me to pull back, withdraw.* [j-14]

> *I feel stronger than when I first walked in the door. I feel like I can handle anything now. I feel like nothing is ever going to bother me.* [r-12]

Finally, clients speak of having learned to express their opinions to others, even when this causes conflict or disagreement.

> *I'm learning how to speak about how I feel and not be afraid, cause often I'm afraid. So I'm not being afraid. And I'm noticing that in my life. I don't, somebody will say something to me and I just, I don't agree, I just, don't agree with that … what changed in me? … Well what I have to say is important.* [b-8]

> *I'm feeling more empowered … I have a choice you know … I have to say it. That's always hard for me. To have to say that, stand up to you and say what you think, what I think.* [k-9]

> *I'm not as angry. It's just I get excited … because I feel so good that I can finally get up and say something. I can finally get up and be myself and stand up for myself.* [r-13]

Again, these excerpts illustrate clear links between sub-themes. The newfound ability to express one's opinions contributes to a sense of empowerment and choice, a clearer identity ("get up and be myself") as well as an increased sense of self-worth ("what I have to say is important").

Theme Three: Self-Acceptance

The third theme, "Self-Acceptance", parallels the earlier theme of "Feelings of Worthlessness". Rather than perceiving and evaluating oneself as negative, "bad", "defective", worthless, "a nothing", and engaging in self-criticism and self-blame, clients now speak of being able to accept and value themselves, and to challenge the messages of low self-worth they received from caregivers or perpetrators of abuse.

Rejecting perpetrator's messages. The first sub-theme is an assertion on the part of clients that the messages of low worth that they received from caregivers are untrue and are being rejected. In these first two excerpts, the client engages in imaginal confrontation and addresses his mother in the empty chair.

> *Mom I want you to listen. I'm better than things you've said to me that I could've, that you made me think that I was. I'm a lot better than that. I can see evidence that I'm better than the things you told me. The things you said it's just so negative and now that I'm older I can see that it's just not true.* [n-8]

> *I realize now that everything you said is contradicting to actually how I am … and so I'm not going to believe you anymore. I'm going to try hard some days when I'm not feeling good to push you out because you're not right or correct. I'm not going to*

believe those stories that are in my head, that I'm no good and I'm not good enough, because I see what I can do that's good. [n-15]

Now I know that it really has very little to do with what my mom thinks about anything. And a whole lot to do with the way I decided to see myself. And to let go of those ugly messages that I was brought up with. [e-15]

I realized I'm not all those things my dad said to me. Like I realized I'm not being insecure or fat in my marriage that it was a lot of it based in my dad … like I realized a lot of the problems I was having was stemming from that but it didn't make me afraid to be who I was. Then when [R] left, then I really kinda I opened up the door and all that stuff came back. [q-12]

Positive self-evaluation. Clients are able to express positive feelings about themselves - feelings of pride, fondness, and self-acceptance.

People say good things about you and I never believed that about me. But now I'm believing that. [b-14]

Now I don't care so much what people think of me, now it's more what I think of me … I like me. [u-17]

When someone likes me, and tells me I'm smart and fully and joyful, and then telling me to go hide or they're gonna find out it's not true … I think I do, I think I'm funny and witty and wacky maybe, but I like who I am, I do. And now I need to be able to feel who I am too, not just know it. [e-12]

I am a worthwhile person. I'm intelligent, I'm capable, I'm a strong woman. And my daughter, have you ever stopped to think maybe she's gotten her brains from me? … I feel better about the decisions I've made … I feel stronger … and more assured of (inaudible) I'm doing what's best for me. [p-13]

They speak of feeling a genuine sense of pride and confidence in their abilities and achievements.

I know I have a lot to offer … I think I've always said those things, but I think before it was my ego talking. But now it's not my ego talking, it's, I actually do. [m-13]

> *I was amazed as to how I was able to accomplish I even amazed myself. I couldn't believe I actually had that inside of me. And you know when I was analyzing that I thought I can't believe that this is happening I'm capable of these things. And uh, I think that in a way gave me a little bit of pride and confidence to to to make some of these changes.* [n-6]

> *I should also think a lot myself to look at my strength a little bit more, you know, how I, how I not only came through this… but I came through it and I was also good to my daughters. And I am good to them. And I'm extremely proud of that … I'm extremely proud of that. Being a good father.* [i-15]

Increased self-care. Another aspect of self-acceptance is how clients behave towards themselves. They speak of engaging in self-care and looking after their own needs, rather than only focusing on the needs of others.

> *I give myself a pat on the back when I go to bed at night. I think hey, you're good. You're a good person, [J]. Nobody hears it but me. But it works, I need to do that.* [u-12]

> *I would've been the last priority, take care of everybody else first. Now I'm taking care of myself a little bit … I'm going to find balance.* [t-12]

> *Gives me satisfaction, makes me feel in charge like I'm finally doing something for myself that I want… taking care of my needs.* [n-7]

> *I am living my life. I'm joining groups and having activities with people who tell me that I'm an inspiration and a very wise, decent person. All the things you could've told me so that I could feel comfortable when I hear them now. Trying to grow into these positive things … I'm opening my life to the prospects and possibilities that life has, without being judged, and that there is no judge left.* [e-15]

Feeling happy. Finally, clients speak of having more positive feelings as a result of the changes in their self-experience. These first few excerpts describe the sense of energy and joy experienced by some participants.

> *My attitude. It's more bubbly, I'm more bouncy, I don't let nothing get to me anymore.* [r-16]

> *I feel lighter … like a empty and there was just that heaviness about me that was there. I feel lighter and sort of feeling like you know, saying there's nothing wrong with me. This is, there's a bounce in my step, emotionally.* [t-13]

> *I feel pretty good right now. First time in a long time, I don't remember ever being really joyous … I don't think I ever experienced joy before. Joy. You know? Only this year that I start to experience joy. Joy. And just joy in life, and just the fact that I'm alive and you know, appreciate what I have. Just be happy for things, before I wasn't.* [u-12]

For other clients, the most prominent feeling is one of peace or contentment.

> *Feelings of anger and resentment … replaced by just a sense of peace of mind, not at my mother anyways. Just something that I went though and it wasn't necessarily my fault. Those angry feelings are being replaced, with almost a sense of satisfied … easiness that it wasn't my fault.* [n-9]

> *I don't think I'm the angry person I was before … I think I'm a little happier inside than I was before. I'm more content with what I'm doing with my life and how I'm doing it.* [m-20]

Clients reflect on the process of change in their experience of self and express that it has been a gradual, ongoing, and long-term process of change.

> *Well I think it's changing I don't think it's absolutely changed or not I still kind of, I still have that kind of doubt in my mind you know that I'm still not quite you know, together I'm still not quite confident I can feel like it's slow in changing the way I feel over time.* [n-10]

> *It's slow journey towards … one day at a time, slow process. Some days are worse than others. But I can feel something. I can feel this constant. It's okay you're right, trust your feelings.* [n-14]

> *It's like a snake shedding, I shouldn't say a snake but shedding skin. Yeah. One layer at a time.* [a-12]

> *You grow up, you know scared and you grow up uh lacking in confidence and so on. And that takes a tremendous effort and time to transcend, to get out of and to shake that. And uh, well I have done that I believe but, there is a slight regret as to why the hell I didn't do this a little earlier. Even though I can't help it.* [i-12]

A new chapter is beginning for the clients; one in which they can view themselves positively, feel clear and confident in their sense of identity, their choices and actions, and their value or self-worth.

> *If you hadn't asked me these questions I wouldn't have to address this and I could then walk away with no problems. But now we're at that point that's why I talk about a new chapter, this is another new chapter, this is a wall. Um every wall or door, this is something that is major. If I open that door and go through, and the door's locked, there's stuff waiting for me and that's a big unknown.* [t-8]

> *I almost feel like I'm stepping into another world of happiness and confidence and I don't think I know how to handle it. I feel happiness, I feel confidence, I feel elation … it feels really strange, really different to be happy. I'm not used to it.* [n-9]

> *But yeah no I feel like I'm just … just being born again or something. (inaudible) it's like to me it's new.* [u-16]

> *But yet there's a sense in the back of my mind that says well it's about time. You know I've been through this for so many years that. And I've been so uncertain for so many years … it's kinda a sense of relief. Yeah it's about time I started feeling that. You know … about myself, yes absolutely … a relief … not totally. But you know it's … beginning. Yeah that's a good word to use. I'd say it's beginning. (inaudible) brand new experience.* [n-15]

Through examination of the transcripts and identification of common themes, there appears to be a general shift for most clients towards greater understanding, self-coherence, self-acceptance, and sense of empowerment. In re-reading transcripts with an emphasis on seeking out disconfirming evidence (Morrow, 2005) I noted that at the end of their course of therapy some clients continue to describe ongoing struggles with negative experiences of self. Some describe an ongoing questioning of their identity and experiencing doubt about what they feel.

> *I feel like I walk around like with all of those fears, you know? Um, and just seems like they don't wanna go away. They just they're there … like I feel like I really don't know who I am. Um, and I try and listen to myself but I, I only for a short while and*

> *then it's like so…* [v-17]

> *You never giving me a place to go. never telling me I belonged, Never telling me I mattered, has me searching at my age now. If I know where I matter or why I don't matter how come I can't even feel what I'm supposed to? … If I'd had that I would've, maybe I'd also find out who I am long time ago instead of reaching now.* [e-15]

Several clients also continue to experience periods of low self-worth.

> *I can't really pinpoint. I just find I'm telling myself like all these negative thoughts about myself all over again, like you're no better than that or you know, I feel like I really that's what I've been dealing with the last … yeah and I just, yeah and I'm really struggling. It's almost like I don't, somewhere inside I don't want this good feeling.* [v-17]

> *It has to do with my parents, obviously, why I'm like that. I don't know why, I mean years and years and years of you're good for nothing, can't that, doesn't that do that to you? No? Doesn't it? … I believed him. I believe them. I don't know how to tell you, I believe in them… No I obviously believed them. I know it's not supposed to be like that. I know it's not supposed to be like that but I believe in them. I believe I'm those bad things; I'm all those things. But like in my self I believe them … I believe them. I believe. I don't know what else to say, I believe that I'm all those bad things that they said I was. How do you change that? How do you change that?* [q-12]

Some clients continue to protect themselves from feeling emotional pain or uncomfortable feelings, even during therapy sessions. This next excerpt occurs after a two-chair intervention exploring the self-critical and vulnerable parts of self.

> *I feel really numb … I don't want to feel … I don't want to feel … it's not, cause I've been doing that, that's just the whole point, I'm not happy with it … just I don't feel anything… maybe I'm just floating in water, just floating there's nothing … and that's the kind of, it's pain … even better than the sadness … it's not as bad as the guilt…* [s-15]

These few excerpts demonstrate the diversity of self-experiences of clients. While some commented on a changed view of self, others described feelings of unclear self-identity or low self-worth, similar to their experiences earlier in therapy. These comments may be

reflective of the circular process of change in experience of self over the course of therapy.

Additional Information

I provide here additional information that may be used to contextualize the results described above. The reader is cautioned, however, that the present study was not designed to compare themes across groups and the selection of clients in the present study was not randomized. The following information is provided for the sake of interest and to generate questions for further study. First, the final thematic map (Appendix D) provides information regarding the frequency of themes across clients and across sessions – we see that "Defining self as bad" is the most frequently reported theme, whereas "Rejecting perpetrator's messages" is the least frequently reported theme. Secondly, a cursory examination of the frequencies of themes across individual clients revealed no obvious differences across genders or different types of abuse. In comparing across cultural groups, the four clients who identified themselves as either fully or partly First Nations (clients a, f, p, and r), did not endorse themes related to Unclear Self-Identity (with the exception of one instance discussing "split self" for client f). Three additional clients (c, g, and h) also did not endorse any themes relating to Unclear Self-Identity. Thirdly, it was noted that two of the twenty-two clients in the study (client c and client h) did not endorse any of the themes relating to "New Views of Self". Finally, the original EFTT study from which the present sample was drawn (Paivio et al., 2010) examined therapy outcome using standard symptom questionnaires. Outcome measures that are related to experience of self include the Beck Depression Inventory (BDI; Beck, Brown, & Steer, 1996), which measures DSM-IV depression symptoms over the previous two weeks, Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1989), which assesses self-worth, and Target Complaints Scale (Discomfort)

(TCD; Battle, Imber, Hoen-Saric, Stone, Nash, & Frank, 1966), which assesses the degree of discomfort on three problems clients wish to focus on in therapy. These problems included negative self-esteem, interpersonal problems, emotion regulation difficulties, unresolved feelings about childhood abuse, and symptom distress. In the original study (Paivio et al.), clients who completed therapy demonstrated significant improvement on all outcome measures, across both therapy conditions (imaginal confrontation or IC, and empathic exploration or EE).

On the whole, clients in the present study began therapy with a negative view of self, which for some included feeling unclear about their identity, feeling ineffective and passive in their actions and life decisions, and experiencing strong feelings of worthlessness and self-blame. Over the course of the therapy, some of these aspects of self were challenged through various internal processes. Clients spoke of becoming more aware of their emotional experience, of beginning to question self-blame and shift the blame for the abuse to perpetrators, and of becoming increasingly aware of how they block positive experiences of self. In later sessions nearing the end of therapy, more clients were able to express an ability to simply “be themselves”, to live their lives in accordance with their own values and preferences; making decisions by themselves and for themselves; and feeling increasingly at ease, happy, and accepting of themselves. These themes have been summarized in a thematic map (see Appendix D). The following section (Discussion) will draw links from these findings to other studies and various theoretical perspectives, as well as speculate on the potential clinical and research implications of these findings.

CHAPTER FIVE

DISCUSSION

The preceding section described themes reflecting clients' experience of self, the process of change in experience of self, as well as new views of self that emerge over the course of therapy. This discussion will draw connections to existing theory and research, identify the contributions of the study to the literature on childhood maltreatment and EFTT, evaluate the strengths and limitations of the present study, and identify areas for further exploration.

Understanding the Experience of Self of Childhood Abuse Survivors

Emptiness, "Something Missing", Being "Unreal"

Excerpts from sessions of EFTT regarding client unclear self-identity described the experience of emptiness, lack of vibrancy, and identity confusion. Similar findings were described by DeRobertis (2004) in his phenomenological study of eleven individuals who experienced psychological maltreatment by their mother figures. These individuals expressed, among other themes, feeling sub-human and being unable to figure out "who they were supposed to be." This is similar to the construct of "emptiness", a diagnostic criterion for borderline personality disorder (American Psychiatric Association, 2013), which is commonly associated with a history of childhood abuse (Zanarini, Williams, Lewis, & Reich, 1997). Although there has been limited research on the concept of "emptiness", Klonsky (2008) has attempted to clarify this criterion, stating that it may be related to hopelessness, loneliness, and isolation. A dissertation study (Buggs, 1997) has linked this concept to a sense of yearning as well as emotional numbness. Another study addressing identity disturbance in individuals diagnosed with borderline personality disorder suggests

that these individuals may experience a sense of “painful incoherence” in their identity, which includes feeling “empty inside”, “unreal”, and having a “false self” (Wilkinson-Ryan & Westen, 2000). In a similar vein, I find particularly poignant the metaphors in the present study that suggest clients experience feeling human-like but not alive (i.e., “skeleton”, “walking dead”) or like an inanimate object (i.e., “robot”, “puppet”, “ornament”). Links drawn by clients between these metaphors and descriptions of limited agency (e.g., “following a little play”, “going through the motions”), also suggest that clients may portray to the outside world a façade of engagement with life, though they themselves do not experience agency in their actions, nor a sense of vibrancy. This could contribute to isolation or feeling misunderstood. These phenomena have not been identified in previous qualitative studies with survivors of childhood abuse, possibly due to the methodology used in the present study. Clients may be more likely to speak in these terms during the process of self-exploration in therapy, as compared to spontaneously identifying this as part of their experience of self during an interview. Metaphors such as these give access to the individual’s inner world and thus provide a richer understanding of the experience of emptiness or lack of vibrancy reported in other studies of childhood maltreatment.

Cutting Off Emotions

Another subject commonly referred to by EFTT clients in the present study was “cutting off” or disconnecting from emotions and memories of abuse, due to fear of being overwhelmed by them. Individuals spoke of the resulting sense of self-doubt, and questioning what they are “supposed to” feel. It is likely that these statements emerged in part due to the emphasis in EFTT on exploring inner emotional experience. Clients engaging in other therapy models without this emphasis may not have recognized or identified their

difficulty in accessing and labelling inner experience. A phenomenological study of six individuals with a history of childhood psychological maltreatment identified a similar theme of "self-inhibition" of one's thoughts, desires, and feelings, as a means of protecting oneself from emotional pain (Harvey, Dorahy, Vertue, & Duthie, 2012). Other clients in the present study spoke of feeling a "split" between their cognitive ("brain" or "head") and emotional experience ("body" or "heart"). This concept of brain-body disconnection was described in another qualitative study of twelve female survivors of childhood sexual abuse (see Fivush, 2004), in which some participants described their minds as feeling "split off" from their bodies, and their abuse memories "split off" from other personal memories. This consistency across studies suggests that disconnection from emotions may be a core experience of childhood abuse survivors, across genders and types of maltreatment. The concept of "disembodiment" may be relevant here. Young (1992) discusses disembodiment in relation to childhood sexual trauma, and suggests that survivors may confine memories of trauma to their bodily experience, and feel a sense of separation of body and mind as a means of gaining some psychological control or distance from the traumatic experience. The concept of disembodiment may hold implications for other psychological concerns often associated with child abuse trauma, such as eating disorders, somatization, self-mutilation, and depersonalization experiences (Turell & Armsworth, 2000).

The overregulation or numbing of affective responses has been frequently linked to a history of childhood abuse and is understood to be a means of coping with high levels of internal distress (Courtois & Ford, in press; Paivio & Laurent, 2001; Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazolla, 2005). Specifically, individuals report feeling numb or inhibited, having limited insight into emotions, or having difficulty verbalizing or analyzing

emotions (Van Dijke, 2008). These are features of alexithymia (Taylor, Bagby, & Parker, 1997), which, in turn, has been associated with a history of childhood abuse and neglect (McLean, Toner, Jackson, Desrocher, & Stuckless, 2006; Paivio & McCulloch, 2003). Related to this is the concept of experiential avoidance (see Hayes, Wilson, Gifford, Follette, & Strosahl, 1996), which refers to the active avoidance or escape from inner experience (e.g., bodily sensations, emotions, thoughts, memories). This phenomenon also has been associated with a history of childhood physical, sexual, and emotional abuse (Gratz, Bornovalova, Delany-Brumsey, Nick, & Lejuez, 2007). Furthermore, the tendency to avoid internal experience has been shown to mediate the relationship between traumatic events and psychological distress, including depressive and trauma symptoms (Rosenthal, Hall, Palm, Baten, & Follette, 2005). Dissociative experiences are also significantly associated with a history of childhood abuse (Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997) and can be similarly understood as a means of coping with overwhelming experiences, by providing protective detachment from intense emotions (Van der Kolk & Fisler 1994). In the present study, some individuals spoke of "blanking out" or "watching" their lives happen, while others drew links between the tendency to avoid emotional experience or trauma memories and the resulting sense of emptiness, which some clients maintained to the end of the therapy. Thus, it appears that "cutting off" emotions, experiential avoidance, as well as various dissociative phenomena hold important self-protective functions for the individuals in the present study, but also are associated with an unclear sense of identity. This may be linked to disturbances of functioning, for example, depression (sense of inner emptiness), or an inability to make important life decisions due to limited awareness of one's own feelings, values, and beliefs.

Other-Focused and False Self

EFTT clients in the present study also spoke of defining their identity in terms of their relation to other people, failing to make their own choices or to express their own opinions, and presenting a public "façade". Similar findings were identified in a qualitative study with four female survivors of childhood sexual abuse, who described a tendency to seek out others' opinions and approval (Saha, Chung, & Thorne, 2011). The concepts of "compulsive compliance" (Iwaniec, Larkin, & Higgins, 2006) and "other-directedness" (Briere, 1992; Herman, 1992) suggest that children who experience abuse over an extended period of time may become primarily attuned to the abuser's moods and compliant with the abuser's demands, as a means of preventing or minimizing continued abuse. This may result in a limited capacity to identify one's own moods, preferences, and desires, or to act in accordance with one's own wishes, and may put such individuals at risk of exploitation or revictimization by others.

The concept of a "façade" (identified under the subtheme "Not expressing oneself") has also been identified in other qualitative studies. Interviews with four female survivors of childhood sexual abuse (Saha, Chung, & Thorne, 2011) yielded themes of hiding feelings while being sociable on the "outside". Similarly, in a phenomenological study of seven female incest survivors (Phillips & Daniluk, 2004), participants described feeling a "sense of incongruence" between how they felt on the inside and how others perceived them, as well as a belief that they had to "keep themselves from being known". Herman (1992), drawing on Winnicott's (1969) object-relations theory, describes "false self" behaviour as persistent attempts to please and appease the caregiver and a desire to hide the "rotten" inner self. Winnicott's concept of the "true self" and "false self" suggests that when a child experiences

punishment in response to expressing authentic feelings and needs he or she develops a "false self" which allows him or her to be accepted socially. Under circumstances in which a child's authentic feelings and needs are repeatedly invalidated or ignored, the child's "true self" remains hidden (Muran, 2001). Rogers (1947) proposed a similar concept, stating that when individuals experience "conditions of worth" from others, they learn to conform to outside expectations rather than value and attend to their inner experience. Findings in the present study suggest that presenting a façade or false self to others serves a self-protective function. In the face of feelings of low self-worth, the façade allows individuals to avoid the judgment they expect to receive from others, however also is connected to a feeling of not knowing one's "true self". This experience of not presenting one's true self may have implications for functioning, such as a lack of intimacy in relationships or feelings of isolation. Indeed, women with a history of childhood maltreatment have been shown to have more relational difficulties than women without such a history, being more likely to experience a lack in feelings of closeness, affection, and personal disclosure in their current relationships, as well as fear of intimacy (e.g., DiLillo, Lewis, & DiLoreto-Colgan, 2007).

Over the course of therapy, clients in the present study reported a shift from an unclear sense of identity to increasing authenticity and sense of integration in their sense of self - an ability simply to "be myself". Similar descriptions were made by participants of a qualitative study of the relational experiences of complex trauma survivors (Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). This study interviewed eighteen female and three male adult survivors of childhood abuse who were engaged in trauma-focused therapy; all but two reported multiple types (physical, emotional, sexual) of abuse. These participants

reported an increased sense of authenticity, the "ability to experience oneself as one truly is", and feeling more comfortable being true to this version of themselves in relationships.

Powerlessness and Helplessness

The themes of helplessness and powerlessness identified by clients in the present study are frequently associated with a history of childhood maltreatment and have been identified in other qualitative studies of survivors' experiences (Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012; Lisak, 1994). The concepts of self-efficacy (an individual's belief in their ability to perform certain actions; Bandura, 1997) and self-agency (the sense that one has "authorship" over one's actions, thoughts, and emotions; Stern, 1985) are relevant here. According to Harter, (1999) childhood abuse disrupts the development of self-agency and self-efficacy. Finkelhor and Browne (1985) identify powerlessness as one of the key traumagenic dynamics of childhood sexual abuse that leads to negative outcomes later in life. When the child's body is repeatedly invaded against their will, and their attempts to stop the maltreatment are ineffective, this reinforces the experience of powerlessness. This concept can be extended beyond sexual abuse, to any situation in which a child feels trapped "if only by the realization of the consequences of disclosure" (Finkelhor & Browne, 1985, p.532). The present study demonstrates that this experience of powerlessness occurs across various types of abuse. Cantón-Cortés and colleagues examined the four traumagenic dynamics identified by Finkelhor and Browne (powerlessness, stigmatization, betrayal, and traumatic sexualization), among survivors of childhood sexual abuse and a comparison group. They found that the dynamic of powerlessness was most strongly related of the four to long-term psychological adjustment of childhood sexual abuse survivors (Cantón-Cortés, Cortés, & Cantón, 2012). Data excerpts in the present study indicated that client experiences

of powerlessness in childhood had an impact on their current experience of self. They perceived themselves as unable to make choices, or feeling as though the choices they did make were not their own, as well as experiencing their actions as having no impact on their lives. These findings expand our current understanding of the notion of powerlessness, describing more fully the way in which individuals understand their childhood experiences to impact their ability to engage with and act with purpose in life.

Saleebey (1996, 2006) raises the concept of "membership" in relation to empowerment, suggesting that belonging to a community or banding together with others contributes to the ability to have one's voice heard and one's needs met. In the present study, some clients spoke of a sense of isolation in having to face their abuser (e.g., "he would just say 'you're on your own, bro' "; "I wasn't even important enough for you to protect me") while others described feeling like an "outsider" or "different" because of the abuse they had experienced. These experiences are likely to contribute to feelings of isolation and could be linked to a limited sense of empowerment – future research could examine this further.

A related concept identified in the present study is client expectation of negative life events, in that they describe feeling "damned" or believing bad things will happen to them. Haatainen and colleagues (2003) examined the connection between hopelessness and adverse childhood events (such as a poor relationship with parents, an unhappy home, hard parenting, physical punishment, domestic violence directed at the child, and alcohol abuse in the home). A higher number of adverse childhood events was related to a higher likelihood of feeling hopeless, particularly for females. This corroborates the present study findings that cumulative adverse childhood events may distort an individual's ability to imagine or foresee

positive life outcomes, which could lead to implications for functioning such as depression or lack of engagement with life pursuits.

Shame, Self-Criticism, and Self-Blame

The third major theme of the present study described the feelings of worthlessness experienced by many clients, evidenced in chronic self-criticism, self-blame for being abused, and feelings of shame about the abuse. This theme (in particular, the experience of viewing oneself as "bad") was identified more frequently than any other, with 19 of the 22 clients in the study endorsing this view. Other qualitative studies have identified similar themes. For example, Saha, Chung, and Thorne (2011) interviewed four female survivors of childhood sexual abuse and found that these women felt shame and isolation, felt responsible and had been blamed for the abuse, and had a sense of self as insignificant, undeserving, and having a meaningless existence. Interviews with thirty-nine men who had a history of childhood sexual abuse (O'Leary & Gould, 2009) also yielded themes of self-blame for the abuse, as well as other negative outcomes (aggression, substance abuse, isolation, fear, and confusion). Another study interviewing twenty-six sexually abused males (Lisak, 1994) identified themes of isolation, alienation and stigma, and feelings of "differentness" and inferiority, in part due to keeping the secret of the abuse from others. Feelings of inferiority and being different often result in a desire to hide oneself from others and may be related to strong feelings of shame about the self. Participants of this study also reported feeling guilt, self-blame for provoking or not stopping the abuse, and negative views of themselves that seemed to develop out of a need to make sense of the abuse (Lisak, 1994). A phenomenological study of six individuals with a history of childhood psychological maltreatment identified a prominent theme as shame-based perceptions of self, which

manifest as low self-confidence and low self-worth and seemed to develop from internalized messages from parents (Harvey, Dorahy, Vertue, & Duthie, 2012). Participants in the Harvey et al. study feared being exposed as inferior, had feelings of self-blame not only for abuse, but for other life events beyond their control, and felt they deserved punishment.

Self-criticism may be an important variable to examine in understanding the psychological sequelae of childhood abuse. According to EFTT theory, self-critical processes generate feelings of shame and a "weak/bad" view of self (Paivio & Pascual-Leone, 2010). One study has explored evidence for a theoretical model with self-criticism mediating the relationship between verbal abuse and internalizing symptoms (Sachs-Ericsson, Verona, Joiner, & Preacher, 2006). The authors suggest that verbal abuse provides direct critical messages that develop into negative self-schemas and self-criticism. Although further research is needed to replicate these findings and explore the role of self-criticism in outcomes of childhood abuse, the present study provides some corroboration, in that several clients considered their self-critical statements to be directly related to negative parental messages they received. Self-criticism and the expression of disgust or contempt towards the self may be important aspects of vulnerability to depression (Whelton & Greenberg, 2005), which is commonly linked to a history of childhood abuse (e.g., Briere & Elliott, 2003).

Chronic self-blame for negative life events is also a common outcome of childhood maltreatment. A negative attribution style (i.e., attributing the cause of negative events to one's self, across situations and over time; see Seligman, Abramson, Semmel, & Von Baeyer, 1979) may be linked to psychological distress. Indeed, Liem and Boudewyn (1999) found that attributions of self-blame act as a mediator between childhood maltreatment or loss experiences and adult victimization, depression, and low self-esteem. They also found

that a greater frequency of maltreatment experiences in childhood (i.e., repeated or chronic abuse) was associated with self-blame. Similar findings were reported by Steel, Sanna, Hammond, Whipple, and Cross (2004), who linked a longer duration of abuse to poorer adjustment in adulthood. This relationship was mediated by the internalization of the abuse (i.e., blaming oneself). In fact, several abuse characteristics (older age of onset, use of force, relationship with offender) were all associated with long-term negative psychological effects, mediated by the victim taking responsibility for the abuse. Finkelhor and Browne's (1985) traumagenic dynamics theory for sexual abuse also suggests that stigmatization (or shaming and blaming the victim) may contribute to the negative effects of childhood abuse, and that these direct messages from the abuser may be intensified by societal victim blaming. Various psychodynamic theories suggest that abused children may also internalize responsibility for the abuse as a means of preserving their attachment to abusive caregivers. This allows them to hold onto the belief that their parents are good ("I deserved this punishment") as well as maintain a sense of control ("If I can be good enough, it will stop") (Andrews, 1998; Briere, 1992; Herman, 1992). Consistent with these theoretical views, clients in the present study appeared to take responsibility and self-blame for the abuse as a means of understanding these events (i.e., "why did this happen to me?"), and to absolve the perpetrator of responsibility ("I triggered that anger").

Relationships with Attachment Figures

EFTT clients in the present study spoke about how their early relationships with caregivers impacted their experience of self, a phenomenon that is described within attachment theory (Bowlby, 1988). Specifically, clients in the present study identified the experience of having a "base", of being "rooted" or "grounded" as an important source of

strength and security. Bowlby's concept of a "secure base" suggests that when attachment relationships are consistent and safe, children feel secure enough to explore their environment, allowing them to develop a sense of autonomy and mastery. Furthermore, individuals in the present study spoke of believing the critical messages of caregivers and that these impacted their feelings of worth and contributed to their own self-critical thoughts. Attachment theory suggests that internal working models of self develop in the early years of life, from the interactions and daily messages communicated from parents to child about his or her worth. Direct messages from caregivers of one's low worth contribute to an internal working model of self as "bad" or "useless". These messages are internalized by the child and influence his or her view of self throughout life (Bowlby, 1988). Finally, clients in the present study spoke at length about their unmet needs for affection, acknowledgment, and protection and how this contributed to feelings of low self-worth. Theorists who draw on attachment theory to understand the psychological sequelae of childhood maltreatment have suggested that when a child's feelings and needs for security, autonomy, and love are ignored or invalidated, this also contributes to a negative internal model of self (Herman, 1992). Thus, the self-experiences described by EFTT clients in the present study are consistent with the concepts of attachment theory in the context of childhood maltreatment.

The findings of the present study are consistent with and vividly illustrate many theoretical constructs, and support other qualitative and quantitative research findings in the current literature on childhood maltreatment. In comparison to other qualitative studies with survivors of childhood maltreatment, the present study offers the distinct perspective of examining client experiences of self as they emerge and are explored during therapy sessions, thus highlighting elements of this phenomenon that may not be raised by clients in

retrospective interviews. Compared to the knowledge gained from self-report questionnaires or symptom checklists, hearing the experiences of therapy clients in their own words brings them to life for the reader, allowing for a greater understanding of the cruelty they have suffered. This may evoke emotional distress in the reader, contribute to empathy, and allow for a less distanced, richer, and more humanistic understanding of this phenomenon. This is particularly important in terms of informing decisions made by social policy makers and those in the legal system. For example, the present study offers a greater understanding of why survivors of childhood maltreatment may hesitate to report abuse or pursue legal action against their abusers, by highlighting core experiences such as self-blame (feeling abuse was deserved), low self-worth ('I'm not important enough to protect'), expectations of negative events ('there's no point in doing anything about this'), and stigmatization (not wanting to be seen as 'different'). Furthermore, those who do speak openly about abuse experiences may be unfairly perceived as providing inaccurate information (i.e., having unclear memories due to dissociative experiences) or of being unaffected by the abuse (perhaps due to "cutting off" painful emotions). Only in recent decades has the phenomenon of childhood maltreatment become widely studied, and ongoing debates about Freud's seduction theory (see Masson, 1984) or false memories of abuse (Loftus & Ketcham, 1994) continue to create barriers and stigma for those most vulnerable to the effects of policy decisions. Studies such as this one can play an important role in providing a greater understanding of the survivor's perspective.

Themes on Experience of Self and Implications for Assessment and Diagnosis

The present study yielded rich descriptions of the experience of self of childhood maltreatment survivors. Several assessment and diagnostic tools that examine the impact of traumatic events on self assess similar phenomena and constructs to those identified in the

present study. For example, the *Inventory of Altered Self-Capacities* (IASC; Briere & Runtz, 2002) includes a scale titled "Identity Impairment", which identifies difficulties in maintaining a coherent identity and self-awareness across contexts. Its "Self-Awareness" subscale describes difficulties understanding oneself and one's identity, while the "Identity Diffusion" subscale identifies problems with confusing one's feelings and thoughts with those of others. The *Inner Experiences Questionnaire* (IEQ; Brock, Pearlman, & Varra, 2006) assesses three areas of self-functioning that frequently are disrupted by childhood maltreatment experiences: the ability to tolerate strong affect, maintaining a sense of self-worth, and maintaining a sense of connection to others. The authors found that these three self-capacities were strongly inter-correlated, and linked to higher levels of trauma symptoms and a history of more severe childhood maltreatment. The *Trauma Symptom Inventory* (Briere, 1995; assesses general trauma symptoms, including an "Impaired Self-Reference" scale which focuses on identity confusion, self-other disturbance, and lack of self-support.

The various trauma symptom scales described above capture some of the experiences identified in the present study (e.g., questioning one's identity, lack of awareness of inner experience, low self-worth). However, current trauma symptom assessment instruments overlook some areas of self-experience identified in the present study, in particular, those captured under the major theme "Not participating in life". The Structural Analysis of Social Behaviour system (SASB; Benjamin, 1974), which is based in Leary's interpersonal circumplex (1957), describes a model of personality functioning that addresses actions and reactions in relation to others as well as actions towards the self (the introject). Two dimensions of behaviour are proposed: affiliation (hostile versus friendly) and autonomy

(control/submission versus separation/autonomy-taking) (Henry, 2001). This model thus accounts for some of the themes identified in the present study relating to “Not participating in life”/“In control of choices”, in that the autonomy axis of the introject refers to self-controlling and self-restraining on one end, and self-exploring or spontaneous-self behaviours on the other end. It may be beneficial to expand trauma-specific assessment instruments to explore this dimension, for example, the ability to make choices for oneself, to act with purpose towards one’s goals, to express one’s opinions, and so forth. However, it is also important to recognize that these are aspects of the experience of self that may be specific to a Western and individualistic cultural context. Other areas for development could include the assessment of positive changes in self-experience that occur over the course of therapy (e.g., authenticity, positive self-evaluation, increased sense of agency).

The present study also has implications for the diagnosis of trauma-related disorders. New diagnostic criteria for PTSD in the DSM-5 (American Psychiatric Association, 2013) include a fourth diagnostic criterion (in addition to re-experiencing, hyperarousal, and avoidance symptoms). This new criterion, “Negative alterations in cognitions and mood”, describes distorted self-blame or blame of others regarding the causes or consequences of trauma, as well as persistent or exaggerated negative expectations about one’s self, others, or the world (Friedman, Resick, Bryant, & Brewin, 2011). The changes to PTSD diagnostic criteria more clearly reflect some of the disturbances of self-experience (self-blame, negative views of self) that are common among survivors of childhood maltreatment. It is to be noted, however, that the proposed diagnostic category of DESNOS or complex PTSD has not been adopted in the DSM-5, as it has been deemed not distinct enough from PTSD to warrant a separate diagnosis (Friedman, Resick, Bryant, & Brewin, 2011). Structured clinical

interviews meant to assess for and diagnose PTSD include the *PTSD Symptom Scale Interview* (PSSI; Foa, Riggs, Dancu, & Rothbaum, 1993) and *Clinician-Administered PTSD Scale* (CAPS; Blake, Weathers, Nagy, Kaloupek, Gusman, Charney, & Keane, 1995), both of which rely on symptom checklists with self-report Likert scales to determine the severity of symptoms. The *Structured Interview for Disorders of Extreme Stress* (SIDES; Pelcovitz et al., 1997) consists of a list of dichotomously scored symptoms measuring current and lifetime alterations in the seven categories of symptoms identified under the DESNOS construct (Herman, 1992): regulation of affect and impulses, attention or consciousness, self-perception, perception of the perpetrator, relations with others, somatization, and systems of meaning. Given that these diagnostic measures report only the presence or absence of traumatic symptoms, they are limited in the information they provide about the experiences of abuse survivors. The present study contributes a richer understanding of the devastating effects on self beyond what these measures can capture, and thus contributes valuable information which can help to identify specific foci for treatment, as well as build empathy and understanding among clinicians.

There is also a strong association between a diagnosis of personality disorder and a history of childhood abuse; in the present study responses on a screening questionnaire indicated the likely presence of personality pathology among 36% of participants. However, the current psychiatric conceptualization of personality disorders fails to account for contextual and environmental factors in the development of disturbance. Various theorists (e.g., Linehan, 1993; Shaw & Proctor, 2005) suggest, for example, that borderline personality disorder may better be understood as an adaptive reaction to early relational trauma, and that when it is defined with no reference to trauma it locates difficulties within

the individual (e.g., labelling them as “resistant to treatment”), rather than within the social and contextual causes of the disturbance. Through the descriptive and poignant client statements about their maltreatment experiences and how these have contributed to current self-functioning, the present study adds to our understanding of the developmental and contextual factors that contribute to long-standing psychological disturbances. This understanding aids in de-pathologizing the concept of personality disorders, and allows us to understand these patterns of functioning as strategies for self-protection, self-regulation, maintaining attachment, and so forth, within the context of their life situation.

Additionally, findings from the present study demonstrate the richness of data obtained through qualitative means and the greater understanding of client experience we can gain in this manner. It may be important to move beyond self-report questionnaires in assessing disturbances of self within this population. This could include making use of narrative or open-ended instruments such as the *Pennebaker Trauma Narrative* (PTN; Pennebaker, Kiecolt-Glaser, & Glaser, 1988) and relying more heavily on an open-ended or semi-structured clinical interview that provides the opportunity for clients to describe their experience of self in their own words. The personalized and poignant language used by participants will provide clinicians with a richer understanding of the participant’s experience as well as a common language from which to begin therapeutic work.

Implications for Broader Populations

The themes relating to experience of self that were identified in the present study are not necessarily unique to survivors of childhood maltreatment, but may in fact have implications for broader populations. For example, themes relating to unclear identity and defining oneself in terms of external roles may be relevant to the literature on intimate

relationships or people undergoing major life changes (e.g., in career, acquired disability or chronic disease, loss of a family member). The themes in the present study regarding cutting off emotions are likely to be relevant to populations engaging in maladaptive emotion regulation strategies (e.g., eating disorders, substance abuse, self-harm). The discussion on feelings of worthlessness could be relevant to self-critical depression, while the concept of lack of agency or difficulty expressing needs may be relevant to programs for assertiveness training or managing social anxiety. Researchers in a variety of areas of study may be interested to explore the experience of self of other populations. This would provide more clarity regarding whether the themes identified in the present study are unique to childhood maltreatment survivors or are more general concepts regarding the self.

Themes on the Process of Change and Implications for Treatment

Shifting Blame

In terms of the process of change in experience of self, clients in the present study identified shifting blame for the abuse from the self to the perpetrator as an important part of their recovery process. Saha, Chung, and Thorne (2011) also found that women with a history of childhood sexual abuse spoke about the importance of externalizing the experience and shifting responsibility from abused to abuser as part of the process of recovery. On the other hand, Cantón-Cortés, Cantón, and Cortés (2012) found that although self-blame and family blame were correlated with symptoms of PTSD (at least among adult female survivors of childhood sexual abuse), attributing blame to the perpetrator did not necessarily have a positive effect on psychological adjustment, or result in a lesser attribution of self-blame. Reducing self-blame for abuse may be a separate process from attributing responsibility to the abuser, which suggests that treatment models may need to specifically

distinguish between blame and responsibility and focus on holding the perpetrator (rather than self) accountable for harm. This is the focus of EFTT – the therapy context for the present study.

Other treatment models explicitly focus on reducing self-blame but do not specify such a shift. For example, some cognitive behavioural models such as Cognitive Processing Therapy for sexual abuse survivors (CPT-SA; Chard, Weaver, & Resick, 1997; Chard, 2005), target self-blame attributions through challenging a variety of dysfunctional beliefs associated with trauma (e.g., self as unworthy, world as meaningless). Narrative therapies help the client transform trauma stories emphasizing shame and victimization into narratives reflecting empowerment and strength; by helping clients voice unspoken feelings, needs, and meanings; transform descriptions of self as wounded to self as survivor; and helping to construct a more coherent and understandable narrative of traumatic events (Neimeyer, Herrero, & Botella, 2006). On the other hand, Emotion Focused Therapy for Trauma (EFTT; Paivio & Pascual-Leone, 2010) promotes accessing previously inhibited anger at violation, which is thought to promote assertiveness, self-empowerment, definition of boundaries, and holding perpetrators accountable for the abuse. Process-analyses have indicated that clients who successfully resolve past interpersonal issues are those who express adaptive emotion, express a sense of entitlement to having their needs met, and experience a shift in views of self and perpetrators of abuse (Greenberg and Foerster, 1996). In the present study, the theme of “Shifting blame from self to perpetrator” demonstrates this EFTT process, in that clients spoke of questioning why the abuse has happened, recognized themselves as blameless in causing the abuse, and identified their rights. Given that the present study was conducted within the EFTT framework, one cannot tease apart whether these are general

processes of change in experience of self for many child maltreatment survivors, or processes more specific to this treatment model. EFTT therapists engage in interventions (e.g., imaginal confrontation) that encourage clients to access previously disallowed or unresolved emotions such as anger at violation or sadness at loss (Paivio & Pascual-Leone, 2010). The present study demonstrates that clients speak of the process of shifting blame as an important aspect of developing a more positive view of self. Further research on the EFTT model might explore the relative importance to therapeutic gains of shifting the locus of blame away from self, and holding the perpetrator accountable, for example, by examining the frequency of, or level of emotional engagement during client statements that address anger at or responsibility attributed the perpetrator, as compared to self-soothing or self-acceptance statements absolving oneself of blame.

Allowing Emotions

Clients in the present study also indicated that allowing and expressing their feelings (e.g., exploring their "gut-feeling" and "listening to red flags") was an integral part of the process of change. They also indicated an increasing ability to "listen to myself" in later stages of therapy, which suggests they have a greater awareness of their inner experience. The concept of "experiencing", which is central to EFTT, refers to the process of attending to and verbally symbolizing one's bodily felt sense or gut-level reaction to the environment, as well as its personal significance (Gendlin, 1968; Klein, Mathieu-Coughlan, & Kiesler, 1986). Pennebaker and colleagues have also suggested that accessing emotions and images related to upsetting experiences and translating these into a coherent narrative can be an important aspect of recovery from trauma (Pennebaker & Stone, 2004). Research has demonstrated physical and psychological benefits to writing about stressful life events,

particularly when individuals are able to explore emotions, causes, and meanings of these events (Pennebaker and Francis, 1996). In the present study the concept of integrating a "split self" – increasing the connection between "head" and "heart" – is consistent with the idea that therapeutic interventions should target not only the cognitive distortions resulting from trauma, but also the experiential aspects (i.e., the "heart") of the individual's memories. Findings from the present study suggest that exploration and verbalization of inner emotional experience was an essential aspect of change in self-experience for clients, leading to a more coherent and connected sense of identity. This suggests that integrative therapeutic approaches that target cognitive, behavioural, emotional, and narrative/linguistic aspects of trauma memories may be particularly beneficial.

Accessing trauma feelings and memories is an essential part of "emotional processing" which is one of the primary mechanisms of change identified in various trauma-focused therapies. For example, emotional processing of trauma memories in Prolonged Exposure therapy requires that these memories be activated and available for modification through exposure to new information (Foa & Kozak, 1986). Emotional processing in EFTT occurs when clients explore trauma memories along with associated feelings, and are able to access and express previously inhibited emotions (i.e., anger at violation; sadness at loss) and the adaptive information (needs and goals) associated with these (Greenberg & Paivio, 1997; Paivio & Pascual-Leone, 2010). Information associated with these adaptive emotions helps transform maladaptive meaning associated with emotions such as fear and shame. A recent study found that therapy events that EFTT clients found most helpful were those in which the client experienced high emotional arousal while exploring traumatic events (Holowaty & Paivio, 2012). Again, the present study is consistent with these findings, and indicates that

for many clients, although emotional exploration and expression can be difficult, it provides a sense of relief and movement towards increased self-awareness and self-acceptance. It should be acknowledged that client statements about allowing and verbalizing emotions may be reflective of the therapy model in the present study. EFTT interventions highlight the importance of accessing and exploring emotions to a greater degree than other (cognitive-behavioural or psychodynamic) trauma therapy models. Individuals with a history of maltreatment who are not engaging in EFTT may be less likely to comment on the process of allowing emotional experience as part of the changes they experience in their sense of self. Nonetheless present findings may provide some ideas about areas for further study, such as the role of productive emotional expression in therapeutic change in EFTT (S. Nussbaum, personal communication, May 9, 2013).

Disallowing Positive Experiences of Self

A theme that has not been explored in depth in other studies is that of "Awareness of blocking positive experience of self", which was one of the processes of change I identified in this study. This concept is also echoed in the "self-sabotage" sub-theme (under "Not Participating in Life"). Both describe the experience of having awareness of one's inner desires, opinions, and feelings, but being unable to act on these in a goal-oriented way, or to allow oneself to experience a more positive (i.e., proud, confident, self-accepting) view of self. The increasing awareness among clients of how and why they block positive experiences appears to be an important element of the process of change, but it is unclear how exactly this fits with current models of trauma therapy. The EFTT model suggests that an important phase of the therapy is addressing self-related disturbances that are blocks to resolving attachment injuries (Paivio & Pascual-Leone, 2010). This can be addressed using a

two-chair experiential intervention in which the client engages in a dialogue between a critical and a more vulnerable part of self or a fearful/avoidant part of self that interrupts or blocks other experiences. This may be related to the process of disallowing or "interrupting" one's positive experiences of self (e.g., clients who state they feel "embarrassed" by their happiness, or feel as though they are "bragging"). It may be that prior experiences of punishment or criticism from others result in beliefs about self or the world that interfere with accepting positive experiences (e.g., 'happiness cannot last', 'something bad will happen', 'I don't deserve anything good'). Excerpts under this theme suggest that some clients become aware of, and explore reasons why they may block their positive experiences of self.

Another important result in the present study was the observation that the process of change in experience of self is not linear, but rather appears to be somewhat cyclical. For example, interventions may help clients explore new experiences of self, followed by clients questioning or blocking this new experience, becoming aware of the process of blocking, and subsequently exploring the self once again. A more specific task analysis approach, involving the intensive analysis of key in-session events (Greenberg & Foerster, 1996) could specify these therapeutic change processes more explicitly. Future EFTT research could include the development of specific markers that could help therapists identify instances of clients blocking new or positive views of self, and thus contribute to the theory of change on when or how to address these markers.

Reflections on the Present Study

Cultural Discourse of Childhood Maltreatment

In reflecting on this study, it is important to recognize that statements generated by clients are themselves subject to the influences of broader cultural perspectives on childhood maltreatment. Crossley (2000b) cautions that even first person experiential accounts of maltreatment experiences are embedded within cultural narratives which are linked to social and political structures of power. In the present study, some clients described feeling "cheated", "ripped off" or having their innocence or childhood "stolen" from them, as they expressed their anger and condemnation of the perpetrator's actions ("Shifting blame from self to perpetrator" theme). This language of highlighting youth or innocence as "shattered" or "broken" is commonly used but can be unintentionally stigmatizing (J. Kitzinger, 1997). For example, older children who are victims of abuse may question whether they were really "innocent" (e.g., if they had prior aggressive or sexual behaviour), and perhaps feel as though people do not care that it happened to them as compared to a "truly innocent" child. This discourse minimizes the idea that abuse is never deserved, even for someone who is not young or innocent. The idea of being "broken" or "different" because of the abuse emphasizes the belief that abuse damages its victims, and thus risks disempowering these individuals, rather than helping them focus on their resiliency or strengths (J. Kitzinger, 1997).

There was also evidence in the present study of societal stigmatization of abuse victims. One client described as positive the attention she received while being sexually abused, but this was countered with the shaming experience that she was "supposed to know it was bad", possibly contributing to feelings of self-blame. Furthermore, several female

clients commented on direct and indirect messages they were given about their low worth as females. Clients experienced these messages as being directly conveyed by their abusers, but they can also be understood to reflect wide-ranging societal perspectives on women's roles.

Personal Reflection on the Present Study

In the introduction to this manuscript, I identified some of the influences and attitudes I brought into the study that may have influenced my organization of the themes. These include my Western cultural background, experiential/humanistic therapeutic style, which involves an individualistic view of the self, and a lack of personal experience with relationship abuse (which makes me an "outsider" to the experience and holds me at more of an emotional distance from the subject matter). I now acknowledge how conducting this study has shaped me. My engagement with this project has influenced my personal views on parent-child relationships – I have adopted the view that communicating acceptance and love to one's child is of primary importance. I have also come to view mental illness from the perspective that this often reflects a person's most adaptive way of coping with external circumstances or stressors. I recognize now that I entered this project with a tendency to blame caregivers or parents for abuse or neglect (i.e., considering even those who are not directly involved in perpetrating abuse as the "neglectful" caregiver who "allowed" abuse to happen). This overlooks the contextual framework of the abuse (e.g., caregivers who may also be victims). I noticed that when some clients spoke of understanding their abuser's perspective (e.g., the abuser also experienced childhood maltreatment), I identified this as an unhealthy "minimizing" or "excusing" the abuser's behaviour, rather than considering that it might be a healthy process of forgiveness or acknowledging human limitations. Reading about cultural discourse on child abuse (e.g., discussion of "damaged innocence" as a

disempowering concept) has helped me to be aware of the influence of language and that it may be important as a therapist to place emphasis on client strengths and resilience to trauma, rather than emphasizing negative effects. I have also begun to view the self from a broader perspective, considering the value of relational views of self rather than emphasizing autonomy and independence.

Implications for Training in Clinical Psychology

The process of undertaking this project during my training as a clinician has influenced my views of childhood maltreatment and understanding of therapy processes. It was particularly beneficial to observe therapy sessions with a variety of therapists and a variety of clients within the same treatment model, in order to recognize how the EFTT model can be adapted to a range of circumstances. I observed that some clients required very little direction from the therapist to explore and draw new connections in their experiences, whereas other clients remained (in my opinion) "stuck" in self-criticism or negative views of self, despite working with skilled therapists who used a variety of interventions to work through these feelings. This highlighted for me that therapist interventions are a tool but not the critical mechanism of change; clients must themselves be able or ready to consider a new view of life events or experience of self in order for change to occur. Furthermore, although I was not a therapist in the present study, I believe that engaging in the process of qualitative research develops skills that are important as a therapist - the process of listening for similarities across clients and sessions in order to identify themes and sub-themes can be applied to the process of engaging with a client's story and listening for common themes across sessions.

Strengths and Limitations of the Present Study

This study was a thematic analysis of client statements made during therapy sessions. As a qualitative study, it served not to test a hypothesis, but to create a broader understanding of a phenomenon, providing a richer and more personal perspective of the client experience of self, and thus contributing to existing and emerging theories on the effects of childhood maltreatment. In comparison to other qualitative studies that have examined the experiences of childhood abuse survivors, the present study offers several advantages. First, I included a large and diverse sample, by including men and women as well as individuals who reported a variety of, and multiple types of abuse (physical, emotional, sexual). This allowed me to address the important point that maltreatment experiences in childhood are often complex and cannot be reduced to a single category. For example, emotional maltreatment inevitably is involved in other types of childhood abuse (Chamberland, Fallon, Black, & Trocme, 2011) because of the clear disregard for the child's boundaries, needs, and reactions to physical or sexual maltreatment. No obvious differences in themes were identified across genders or different types of abuse in a cursory examination. Given that many of the findings in the present study mirror the results of studies that have specifically examined female survivors of sexual abuse, this raises the question as to whether there are differences in the effects of abuse on self when comparing genders or various types of abuse. Further research could examine this question more specifically.

It was noted that clients in the present study with a First Nations cultural background did not endorse themes relating to unclear self-identity. This could be reflective of a more collectivist view of self, with less emphasis on individualized identity, or perhaps be related to a culturally-specific approach to caregiving (e.g., the impact of having a larger community

of adults involved in raising a child). A more in-depth analysis of differences is not possible since the present study was not designed to specifically compare groups of clients, and the selection of clients was not randomized or representative across types of abuse or cultural groups. However, future research could more purposely examine the question of whether any of these themes are more or less prevalent across various client demographic characteristics, and include a broader representation of different cultural groups. Furthermore, although therapy was largely successful and all clients reported at least some change (Paivio et al., 2010), participants for the present study were selected regardless of their scores on various therapy outcome measures, thus ensuring that a variety of client perspectives and self-reflective abilities were included. This is consistent with qualitative research guidelines that suggest seeking out variability and potentially disconfirming data while in the setting (Morrow, 2005).

Another strength of the present study was the exploration of participants' experience of self as they were engaging in the therapy process, rather than relying on their retrospective reports or reflections of the therapy process after termination. This provides two distinct advantages: first, the study provided a live observation of the client moment-by-moment process of self-exploration during therapy, thus revealing clients actively working through their understanding of self, rather than reporting this understanding to an interviewer, a unique contribution to this method of research. Adopting this approach also avoids the risk inherent in retrospective interviews, that client statements will be influenced by interviewer expectations or will contain more statements reflective of general cultural discourse on child abuse. Secondly, the present study provided a longitudinal perspective on the process of change over the course of therapy. Furthermore, the present study sampled 173 therapy

sessions across 22 clients, thus providing significantly more information than would have been obtained from a one- or two-hour interview with each of the clients. This study thus demonstrates the utility of using therapy sessions as a rich source of qualitative data when seeking to understand the client perspective in psychotherapy research.

I have attempted to closely tie my methodology to established guidelines for addressing the trustworthiness of qualitative research (Elliott, Fischer, & Rennie, 1999). Specifically, I have reflected upon my theoretical perspective and personal assumptions towards the subject matter (owning one's perspective), presented the themes in a coherent and readable manner, and included a large number of data extracts to allow readers to draw their own conclusions regarding the fit of the data to the interpretations made (grounding in examples). A way to improve the study design would have been to involve the original informants or other individuals with a history of childhood maltreatment as a means of "checking the credibility" of the themes I identified. This was not done due to the archival nature of the data used. However, I provided detailed data extracts and will thus rely on colleagues and readers of the study as general auditors of the data. Furthermore, comparing my findings with other published qualitative and quantitative studies on this topic allows me greater confidence in the themes I have identified as important aspects of the self-experience of survivors of childhood maltreatment.

A limitation of the present study is that the sample was rather homogeneous in terms of cultural background. There were a small number of participants who identified as First Nations but the majority was of Western European cultural ancestry. Only one general difference across cultural background was apparent in terms of frequencies of themes, but a more diverse sample and more in-depth analyses would be required to further explore this

question. Jobson (2009) suggests that self-construals in the context of traumatic experience may differ across collectivist and individualistic cultures. For example, people from individualistic (Western) cultures may perceive the "self" as an independent entity, focus on private internal experience (abilities, thoughts, emotions), define success on the basis of personal accomplishments and control, and relate to others in terms of social-evaluation. By contrast, people from collectivist cultural backgrounds may be more likely to view the "self" as an interdependent entity, and focus more on social roles and status, emphasize the promotion of others' goals and occupying one's proper place in society, and relate to others in terms of self-definition. Themes in the present study that emphasize individuality (e.g., "Not expressing oneself", "Deciding for me", "In control of choices") would likely have different connotations for therapy clients from collectivist cultural groups. An exploration of the self-experience of individuals from a variety of cultural backgrounds would build upon the work done in the present study and provide a broader understanding of this phenomenon.

The participant inclusion criteria for the original study (i.e., the capacity to regulate emotional experience, form a therapeutic relationship, and focus on trauma memories in therapy) also limit my ability to apply results of this study to broader populations. It is likely that individuals with more difficulties in emotion regulation capacity, those undergoing current crises, or those who have more limited memories of the abuse experiences would have different things to say about their experience of self (I speculate that perhaps there would be more discussion of dissociative states, confusion, or feelings of emptiness). I chose not to include clients who did not complete the therapy, in order to more clearly address my second research question regarding the process of change in self-experience over the course of therapy. This limits my ability to understand what may be occurring for clients who are

unable or unwilling to complete the standard course of therapy. The findings of the present study are thus primarily applicable to clients who are treatment-seeking and who maintain their engagement in the therapy process.

The present study does not account for other external influences on the process of change undergone by clients; thus it is important not to directly attribute all changes to the therapeutic interventions. Furthermore, the clients in the present study were all treatment-seeking individuals, and thus may have emphasized different aspects of their experience of self compared to individuals who would not be interested in exploring their childhood abuse memories. The type of therapy in the present study emphasizes emotional expression and exploration and involves memory work and Gestalt-type interventions, such as the two-chair procedure for self-critical or self-interruptive processes. It is important to recognize that some themes identified in the present study reflect these EFTT-specific processes, and that different themes may have been identified with a different type of trauma therapy.

Finally, although using therapy sessions as a data source provided some advantages (explained above), this also meant that there was no opportunity for an interviewer to query participant responses. There may have been additional aspects of participants' self-experience that were not raised in therapy or that were left unelaborated, and therefore unavailable for analysis.

Conclusions and Directions for Further Study

The present study presents an exploration of the experience of self of individuals processing their childhood abuse experiences in a particular type of therapy (EFTT). Three general themes emerged in the analysis of statements related to self-experience. The first theme is a shift from unclear self-identity towards the experience of authenticity and

integration, or “being myself”. The second is feeling disconnected from life, lack of agency and not behaving in accordance with one’s values and desires, with a shift to feeling in control, making one’s own decisions, and self-empowerment. Third is a shift from feelings of worthlessness, self-dislike, self-criticism and self-blame, towards self-acceptance, liking oneself, and feelings of happiness. I also explored client statements that reflect the process of change in self-experience. These included a gradual shift in attributions of blame for the abuse (holding the perpetrator accountable, absolving self of responsibility for the abuse), as well as an increasing exploration of clients’ own emotional experience, and the ability to recognize how and when they hold themselves back from positive experiences of self, such as confidence, pride, self-acceptance, and expressing personal needs and desires.

The themes identified in this study provided rich examples of the experiences of self of child abuse survivors, and are consistent with findings of quantitative studies as well as theoretical models addressing the psychological outcomes of childhood maltreatment. Several themes and sub-themes that were identified have not previously been reported or explored in depth (e.g., “emptiness”, brain-body disconnection, blocking or disallowing positive experiences). The methodology of the present study (observing the client process of change during therapy sessions) may be one reason why these themes were uniquely identified here as compared with other qualitative studies based on retrospective interviews, particularly given that these three themes appear to be related to limited awareness of self. It may be that these experiences are not as easily observed and reported by the individual experiencing them, but may come to light through observation of the exploration of experiences of self in therapy. The present study highlights these themes as important concepts for further exploration.

An EFTT outcome study has reported increased self-esteem, reduced depression, and reduced target complaints related to self at termination of therapy (Paivio et al., 2010). Target complaints assessed the client's degree of discomfort on three problems they identified as a focus for therapy (including, for example: lack of self-confidence, self-blame for abuse, difficulty asserting self, feelings of inadequacy); the present study contributes to this evidence supporting the effectiveness of EFTT in improving self-development. Furthermore the present study identifies some of the important work that is done in exploring self-experience and promoting self-development (i.e., increasing awareness of internal experience, self-empowerment, self-worth) – this is the explicit focus of Phase II of the EFTT therapy model. While previous process-outcome research on EFTT has focused on the process of resolving issues with perpetrators, this is the first study to examine and report in depth about the process of self-development. Future process-outcome research could specifically examine the therapeutic processes and interventions that target changes in client experience of self.

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Appendix A. Demographic Characteristics of Therapy Clients

Client	Age	Gender	Primary type of abuse	Ethnicity/Race	Number of transcribed sessions (session numbers)	
a	61	F	sexual	Native Canadian	4	(2, 12, 15, 16)
b	64	F	sexual	French/German	7	(5, 6, 7, 8, 11, 14, 16)
c	21	F	sexual	Canadian-Irish heritage	8	(1, 2, 4, 5, 6, 7, 9, 18)
d	49	M	sexual	Caucasian	7	(1, 3, 5, 9, 13, 14, 15)
e	54	F	sexual	Caucasian	6	(5, 6, 10, 12, 14, 15)
f	24	F	sexual	Native Canadian	6	(3, 7, 10, 13, 15, 16)
g	71	M	sexual	French	8	(1, 2, 5, 7, 11, 13, 15, 16)
h	51	M	sexual	Caucasian	9	(1, 3, 4, 5, 7, 9, 12, 13, 14)
i	66	M	sexual	born in Holland	9	(2, 3, 6, 10, 11, 12, 13, 14, 15)
j	40	M	sexual	Italian	6	(1, 3, 6, 7, 14, 16)
k	54	F	sexual	French-Canadian	9	(5, 9, 10, 11, 13, 14, 15, 16, 17)
l	49	M	emotional	Caucasian	6	(3, 5, 7, 10, 15, 16)
m	41	M	emotional	Caucasian	11	(1, 4, 5, 8, 10, 11, 13, 15, 18, 19, 20)
n	38	M	emotional	French-Canadian	14	(2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16)
o	52	M	emotional	Anglo Saxon	9	(3, 5, 6, 7, 9, 12, 13, 14, 16)
p	49	F	emotional	Native American/ English	6	(6, 7, 8, 9, 13, 15)
q	45	F	emotional	Italian	10	(1, 2, 3, 4, 8, 9, 10, 11, 12, 13)
r	31	F	physical	French/Hungarian, Euro-Canadian Aboriginal	7	(7, 10, 12, 13, 14, 15, 16)
s	52	F	physical	Greek	8	(2, 10, 12, 13, 14, 15, 17, 19)
t	53	M	physical	(blank)	6	(2, 8, 11, 12, 13, 14)
u	41	F	physical	German	15	(1, 2, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19)
v	47	F	neglect	Caucasian	6	(7, 8, 9, 15, 17, 19)

Note: Primary type of abuse and ethnicity/race are as indicated by each client during the screening interview

Appendix B. List of Low-Level Codes

abandonment
accept
acceptable
accepted
accomplish
acknowledgement
acting out
action
activities
affection
affects me
affirmation
afraid to feel
afraid to feel life
aggressive
agree
alcohol
alive
allowed
alone
aloof
amazed
analyze
anchor
angry
annoying
antsy
anxiety
appearance
appreciate
appropriate
approval
arrogant
ask for something
asking too much
assertive
asshole
at peace with myself
attack
attempt
attention
avoid
awareness
awful
awkward
baby
backed in a corner
backfire
bad
bad behaviour
balance
barriers
base
battle
be careful
be heard
be myself
be someone
be there for me
beaten down
beating myself up
beautiful
being discovered
being like parents
belief
believe in myself
believed me
believed you
belittling
belong
best part
betrayed
better
black out
black sheep
blame
blank
blessed
blind
blocked
blocked out
blurred memories
bodily sensation
body image
boring
born
born again
bothers me
bottled up
box
bragging
brainwashed
break off communication
break through
breathing
broken
broken-hearted
brushed off
burden
bury
busy
by myself
can’t do anything
can’t get away from me
can’t handle
can’t move
can’t or incapable
can’t remember
can’t say no
capable
careful
caring
castrated
cautious
centering myself
challenge
change
cheated
check inside
choice
clear
close off emotion
close to people
closer to myself
cloud
cold
collapse
comfortable
comfortable in skin
comforting
coming out
comparisons

compassion
competent
complaining
complete
complicated
compliment
conceited
confidence
confidence in feelings
conflict
confront
confusion
connection
consequences
contempt
content with life
contradict
contradicting feelings
control
control my life
convicted
coping
core
could have
could have been worse
could have done
could not defend
courage
coward
co-worker or boss
crap
crappy
crazy
creative
credibility
crippled
criticize
cruel
crushing
crying
cut off emotion
cycle of abuse
damage
damned
dancing
danger
dark
darkness
decision
defect
defend myself
defensive
deflated
degrading
denial
dependent
depressed
deserve
deserved better
despair
desperation
destroys me
destructive
detached
devastated
did my best
did the wrong thing
didn't ask for this
didn't know why
didn't learn
different
difficult client
difficulty expressing self
difficulty
dignity
dimensional
direction
dirt
dirty
disabled
disappear
disappoint
disappointed
disapproval
disconnected
discovery
discredit
disdain
disgusted
disgusting
dishonest with feelings
dismissed
disrespectful
dissatisfied
distance
distraction
do things for myself
doesn't feel like me
doesn't let me believe
doesn't matter
don't believe you
don't care
don't have feelings
don't know what to do
don't know
don't let it get to me
don't matter
don't need you
don't really know me
don't remember
don't show emotion
don't want feelings
don't want to be that way
don't want to go on
done with that
doomed
down the drain
downer
drained
drive
drown
dying
easier
easiness
eats away at me
effects of abuse
ego
elation
eliminate pain
embarrassed
embarrassment
emotional regulation
emotional abuse
emotional development stopped
emotional energy
emotional garbage
empowered

empty
energy
enjoy life
entitled
erase
escape
evaluation
evil
examine self
exceptional
excited
excuse justify others' behaviour
expectation
expendable
exposed
express opinion
expressing emotions
failure
faking
fall apart
familiar
fat
fear
feel better about myself
feel not right
feel nothing
feel terrible
feeling emotions
feeling open or vulnerable
feeling somewhat
feeling sorry
feeling who I am
feelings wrong or right
fight back
fight in mind
fighter
figure out
filthy pig
filthy
find myself
find out who I am
fire
fitting in
fix
flashbacks
floating in a dream
floating
flower
fly away
focus
for myself
for others
forced
forget
forgive
foundation
fragile
freak
free
fried
friend
frustration
fuck up
fuck you
fucked me up
function
fussy
futile
future
gap between self
garbage can
gender
genuine
germs
get into my head
get over it
get rid of
give myself permission
go away
go back to before
go into myself
goal
god
going around
going through motions
good for me
good for nothing
good person
good
goodbye
gradual
grieving
gross
grounded
grow up faster
growth
guard
guardian
guilty
gullible
heart or soul
heavy
hell
helpful
helpless
here I am
hide
hold back
hold in
hole in heart
hollow
home
honesty
hook up
hopeful
hopeless
horrendous feeling
horrible person
horror
how dare you
human being
humiliated
humour
hurt
I let them do this to me
I must be wrong
I'm okay
I'm right
identity
idiot
ignored
illness
imagine
impact
important
imposter

improvement
in charge
in control
in spite of it
in the way
in touch with me
in trouble
inadequate
incapacitate
inconsequential
independent
inferior
inhibit myself
inner conflict
inner dialogue
innocent
insecurity
inside of me
insignificant
instincts
intact
integrate
intellectualize
interesting
internal battle
interpersonal interaction
intimidating
intuition
invisible
isolated
it's not me
it's okay
joke
journey
joy
judgment
just existing
just like you
just physical
justice
justify
keep going back
keep it inside
kid
kidding myself
know my feelings
know who I am
lackey
laugh at me
lazy
lean on someone
learn develop
left out
less of a person
lessen
let it go
let it out
let me down
let myself down
let others down
let others in
let yourself feel
life goes on
lifeless inanimate object
lighter
lights me up
like myself
listen
little
living a lie
living hell
living
loathing
locked up
lonely
long time
look up to them
loser
loss
lost myself
lost
love
loveless
loyal
luxury
lying to myself
lying
machine
make myself better
make no sense
make them happy
maniac
manipulated/taken advantage
martians
metaphor
mind goes blank
mindless
missing
mistakes
mistreated
mocking
mom was right
monster
mope
motivate
move forward
move on
multiple parts of self
my fault
my thoughts are correct
nasty
natural
need
needed
needy
negative thinking
negative
neglect
negotiate
nervous
neutral
never amount to anything
new awareness
new experience
new road
new thing
next level
nice
nightmare
no big deal
no chance
no choice
no control
no emotion
no good
no joy
no one cares

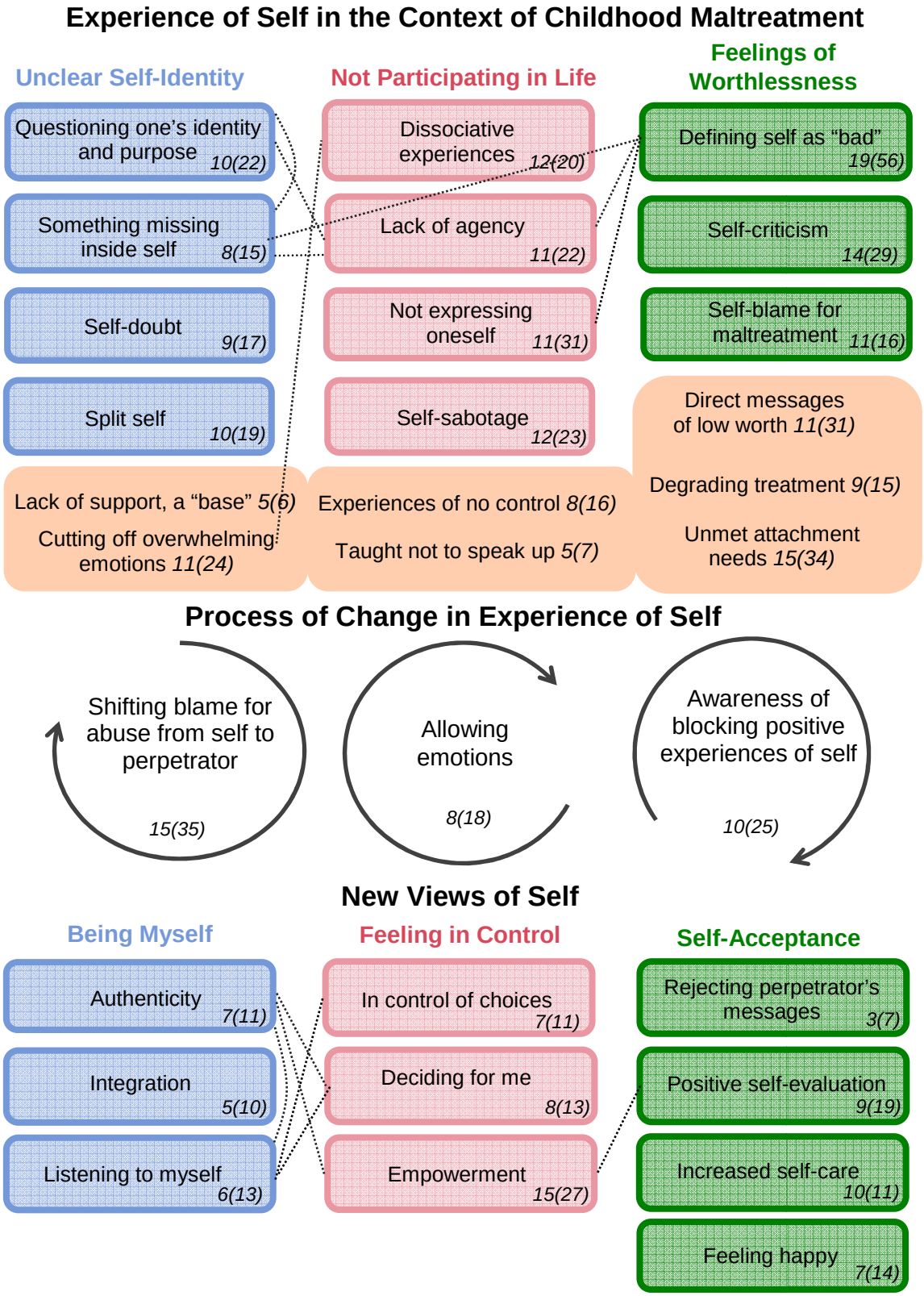
no options
no point
no redemption
no way out
nobody
nobody's gonna make me
nonexistent
normal
not allowed
not appropriate
not fair
not good enough
not grown up
not much left
not my fault
not over it
not ready
not right
not the same person
not there
not true
not used to it
not worth it
nothing to offer
nothing to say
nothing
noticed
now I see
numbness
nurturing
object
obligation
observer
okay to walk around in my body
old bitch
on my own
only one
open book
open self up
opens you up
ostracized
other options
others' perceptions
others vs. me
out of control
outsider
overcome barriers
overpowered
overwhelmed
owe
own children
own feelings
own judgment
own person
own up to it
pain
paranoid
parenting
parents
part of me
passed me by
passionate
passive
pathetic
peace of mind
peace
perfect
peripheral
person I want to be
personality
pessimism
physical abuse
physical fight
physical sensation
piece of meat
pig
pissed off
pit
pity
portray to others
positive attitude
positive thinking
positive
power
powerless
praise
predator prey
presence
pressure
pretend or act
pride
prison
problems
promiscuity
property
protecting my emotions
protection
prove myself
prove you wrong
punching bag
punishment
puppet
purpose
push away
push inside
push thoughts out
pushing me
pushy
put down
put it out of my head
put myself first
questioning feelings
questioning
quitter
rage
rambling
rational
re-evaluate
reach out
reaction
reactions to abuse
real
realistic
reality
realization
reassurance
rebel
recognition
red flags
regressed
regret
rejection
relationships
release tension
relief
rely on myself
reminder

remorse
resentment
resilient
resolved
respect myself
respect
responsibility
restrict
revenge
reverse the damage
ridicule
right for me
right
rigid
ripped off
risk
robbed
robot
rock the boat
roller coaster
rooted
run away
running over me
sabotage
sadness
safe
safety net
same old
satisfaction
saying no
scapegoat
scared to speak
scarred
school peers
screaming
scum of the earth
searching
second best
second guessing
secret
secure
security
seems far away
selective
self abuse
self actualization
self assured
self attribution
self blame
self conscious
self criticism
self destructive
self-directed behaviour
self-directed emotion
self doubt
self esteem
self-focused/self-centred
self-fulfilling prophecy
self image
self loathing
self mediating
self perceptions
self respect
self talk
self worth
selfish
sense of self
sensitive
separate self
set myself up
sexual abuse
sexuality
shallow
shame
sharing self
shell
shine
shit
shock
should have
should not
shouldn't be here
shouldn't feel so bad
shouldn't talk about it
shudder
shut down
shut up
shy
sibling
sick with feelings
sin
sinking feeling
size
skeleton
slave
slimeball
sloppy pig
smart
smile
social interaction
something I did
something missing
something stops me
somewhere else
spark
speak out
special
spirit
split into two
spontaneous
spouse
stand up for myself
starved
statue
stay in my place
stepping into another world
sterile
stick up for me
stomped on
strange
strength
struggle
stuck in a box
stuck
stupid
substance
success
suffering
suicide
superficial
support
supposed to
suppressed
surface
surprising
survival skills
survive

surviving
survivor
take advantage
take back my life
take care
take it personally
taken away from me
taken away
takes over
tape in head
teach
tenacious
terrible
the way I was raised
therapy
thinking vs. feeling
thought process
threatened
tired of it
tired
tongue tied
too much success for me
too much
too strong emotion
tools
torment
torture
tough
toy
trance
trapped
treat myself better
ugly person
ugly
unaware
uncertainty
uncomfortable
unconscious
understand
understanding
unfair
unknown
unlovable
unloved
unsettled
unstable
unwanted
upset
uptight
used
useless
valid emotions
validation
valued
values
verbalize
victim
violated
void
vulnerable
waiting
walk away
walking dead
walls
want to feel
wanted
warmth
wash or clean yourself
waste
watch my words
watching
weak
weight
weird
what did I really think
what I want
what to feel
whining
whole person
why me
why
wimp
winning
wish they were dead
wish
wishy washy
withdraw
wondering
work productivity
work through
worried
worse
worthless
wounded
wrong with me
wrong
you were wrong
yucky

Appendix C. Preliminary Thematic Map

Appendix D. Final Thematic Map



Note: Frequency of sub-themes is represented in italics: *number of clients (number of sessions)*

Vita Auctoris

Elisabeth Sylvia Heidi Mundorf (née Künzle) was born in Edmonton, Alberta in 1982. She graduated from Harry Ainlay Composite High School in 2000 and attended the University of Alberta, graduating with a Bachelor of Science, Specialization in Psychology in 2005. From there she went to the University of Windsor where she obtained a Master of Arts in Clinical Psychology in 2008 and a Doctor of Philosophy in Clinical Psychology in 2013. She is currently working as a clinical psychologist in Edmonton, Alberta.