Re-negotiating Meanings: A grounded theory of core factors in healing shame in adult survivors of sexual abuse

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ABSTRACT

Shame is an issue for survivors of sexual abuse that has received little attention in the literature. Eight experienced therapists following different therapeutic orientations were interviewed about their conceptualisations of shame in sexual abuse survivors and the process of healing from shame. The interview data was analysed using the grounded theory method of qualitative analysis and a theory of core factors in the healing process across therapeutic orientations was derived. Findings suggest that the child victim of sexual abuse makes meaning of their experiences, a process influenced by a number of contextual domains. The key meanings of being responsible for the abuse or being somehow defective as a consequence of abuse were found to be central to the development of shame, and were linked to a number of sequelae by respondents. The core factors in the respondents' conceptualisations of the process of healing shame involved *re-negotiating the meanings* the child had formed, and this process was made up of five key areas; developing trust in the therapeutic relationship, building a positive sense of self, facing the shamed self, contextualisation and integration. Attention was also given to gender issues in order to discover similarities or differences in the experiences and healing process for male survivors of sexual abuse. Findings suggest that respondents' saw shame in sexual abuse and the healing process as being the same for males and females, with differences being largely the result of socialisation practices. Implications of findings are discussed.

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INTRODUCTION

Public awareness of sexual abuse has arisen over the last twenty years seeing a greater number of people seeking help from mental health professionals, the legal system, educators and government service agencies such as ACC. Along with this has come concern and controversy over counselling and therapy practices and a greater call to the profession for accountability. Summit (1983) warns that with the upsurge of interest in sexual abuse comes new dangers for victims as it increases the likelihood that they will disclose but fails to protect victims from further victimization by an inconsistent intervention system. Further trauma can arise from how society reacts. Difficulties occur because abuse is an intrapersonal, inter-personal, medical and societal problem. Therefore, much of the research and literature is multi-disciplinary, having various political, theoretical and ideological biases. Accordingly there is a growing need for a more integrated body of research and literature. Stevens (1992) speaks of the need for a shared conceptual framework in order that an integrated approach to sexual abuse counselling be possible.

In her research Stevens (1992) found that there were differences in the way that counsellors conceptualised sexual abuse in terms of the dynamics of abuse and the healing process and related those differences to counsellor orientation, training and personal experience of abuse. Stevens (1992) states that while diversity of counsellors increases the choices clients have, it is also important that there be improved communication among counsellors and sharing of respective viewpoints in order that clients needs are professionally and ethically served to the highest standard.

The current project partially replicates Stevens work (1992) in that it is a qualitative analysis of the sexual abuse area looking into counselling practice and the conceptualisations of counsellor. However, it attempts to extend this study by looking at the experience of both male and female survivors.

The present study differs from Stevens (1992) in that it is designed to extend of knowledge of the issues of shame in adult survivors of sexual abuse. Shame is a key issue for survivors, and is mentioned frequently in sexual abuse literature. It has however been dealt with mainly in passing by current sexual abuse research and theory. Nathanson (1989) states; "To the extent that psychotherapy itself involves exposure, it must trigger shame; thus it is likely that the therapist, unskilled in the recognition of shame in all its' disguises, will overlook or misunderstand many of the issues that should form the core of our treatment of those whose sexual selves have been abused or exploited" (p388). Based on preliminary findings from a pilot project by the present researcher, the current project will focus on the issue of shame for sexual abuse victims in an attempt to develop an indepth understanding of its impact on survivors and of the process of healing from shame (at both theoretical and practical levels).

Findings from this pilot study for the present project showed that there were many areas of congruence between the perspectives of counsellors, current literature and theories despite the differing terminology used when talking about the counselling role and aspects of the healing journey in sexual abuse. The present project proposes to build on this in an attempt to uncover a core theory from the accounts of therapists, from varied backgrounds, in order to contribute to an integrated approach and understanding of core concepts which inform psychotherapeutic practice.

CHAPTER ONE
THE CONSEQUENCES OF CHILDHOOD SEXUAL ABUSE

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No specific "incest syndrome" has been identified by clinical studies (Kinkl & Biebl, 1992). However, clinical literature is in consensus over a great number of long-term sequelae of child sexual abuse. Research into shame as an issue for adult survivors has been largely over-looked. Attempts will be made to highlight the issues and dynamics of abuse which are relevant to shame during this review of the literature. Meta-analyses of a number of research studies indicate child sexual abuse is significantly related to impairments in psychological adjustment in adult survivors (Jumper, 1995). The extent of negative effects depends on many variables according to current research findings, age of victim at the time of onset, the length and severity of abuse, the number of perpetrators as well as individual responses, personality and social context (Hunter, 1990).

In children, mastery of developmental tasks is thought to be severely disrupted (Draucker, 1992). Adolescents may suffer from confusion over the appropriate uses of power, poor self-image, pseudomaturity, poor social skills, be socially isolated, have poor peer relationships, be hostile, depressed, suicidal and have phobic or psychosomatic problems (Algert & Borman, 1992; Draucker, 1992). Many adult survivors suffer from anxiety, hypervigilance, problematic sexual relationships, intermittent feelings of dissociation, vivid nightmares and flashbacks, sleep disturbances, anger, depression, guilt, low self-esteem and interpersonal problems (Eisen, 1992; Algert & Borman, 1988; Schiller, 1988; Krieger & Robbins, 1985; Briere & Runtz, 1988; Boulton, Morris & MacEachron, 1989). Clinical reports reviewed by Finkelhor & Browne (1985) found that adult women survivors of sexual abuse are likely to experience depression, self-destructive behaviour, anxiety, isolation and stigma, poor self-esteem, substance abuse and a tendency toward being revictimized. Learning difficulties, somatization disorder and poor parenting are also associated with child sexual abuse (Jumper, 1995).

Hunter (1990) lists the findings of a number of studies which maintain guilt, negative self-image and associated depression, unresolved grief, internalized anger (in women), self-mutilation and low self-esteem are commonly experienced by survivors. Studies have shown that higher rates of sexual abuse experiences are to be found among persons with depression, substance abuse, eating disorders, multiple personality disorders, adjustment disorders, somatoform disorders, borderline personality disorders and posttraumatic stress disorders (Kinkl & Biebl, 1992; Finkelhor & Browne, 1985) and research has shown that, of clients seeking help for relationship difficulties, those who were sexually abused presented with higher levels of psychological symptoms, such as those mentioned above, than nonabused clients (Busby, Glenn, Steggell & Adamson, 1993).

Relationship to the Perpetrator

The degree of closeness or the quality of the relationship between the perpetrator and the victim is thought to affect abuse outcomes, the closer the relationship, the more traumatic and problematic the consequences of abuse are (Davenport, Browne & Palmer, 1994). Unfortunately abuse occurs more frequently where the abuser is known to the family - a relative or person given access to the child by the parents such as a babysitter, scout-leader, church leader etc. This means that the dynamics usually involve a known adult in a legitimate power position over a child. Inducement often involves rewards, bribes and threats. Parental response to disclosure has been found to depend upon who the perpetrator is. If the person is known to the family or is a family member there may be conflicting loyalties, denial and guilt on the part of family members and refusal to address issues (Sgroi, 1982). Abuse by strangers has been found to cause less long-term trauma when the victim discloses, is believed and not held responsible for the abuse (Baker & Duncan (1985) in Davenport, Browne & Palmer, 1994)

The Nature of the Abuse

Research supports the notion that abuse which involves vaginal, anal or oral penetration is more traumatic and psychologically damaging (Davenport et al. 1994). Briere & Runtz (1988) suggest that victims who suffer abuse by a number of different perpetrators are more likely to hold themselves to blame. It is also suggested that whilst the use of violence in abuse may increase trauma initially, force may also alleviate guilt in the long-term (Davenport et al, 1994; MacFarlane & Korbin, 1983). Kinkl & Biebl (1992) offer a possible explanation, suggesting that the positive aspects of an incestuous event that includes violence fade making it possible for the victim to attribute blame to the perpetrator. Coercive, non-aggressive abuse can increase guilt feelings and the sense of responsibility for abuse which leads to greater psychological difficulties (Basta & Peterson, 1990) .

Shame

Shame is a common, central and pervasive effect of sexual victimisation. Shame involves a range of emotions between mild embarrassment to severe humiliation and inherently entails avoidance - a turning away of the face, a breaking of contact (Stone, 1992). Fossum and Mason (1986) refer to shame as "an inner sense of being completely diminished or insufficient as a person". Stone (1992) states that shame is the result of "dissonance produced in the self-concept by actions or attitudes that are held to be inconsistent with ones own idea of who one is, or ought to be" (p133). Shame manifests through all levels, body language, posture, tone of voice, interpersonal dynamics, beliefs, emotions and mood, behaviour and motivation. Therefore, it greatly affects the clients ability to function in society, whether it be in work, social relationships or in personal relationships (Davenport, Browne & Palmer, 1994). Nathanson states: "Betrayal, treachery and abandonment can activate shame; in the moment of shame, we feel alone, rejected, shorn from all human contact" (1989, p382). Sgroi (1992) claims that feelings of shame and revulsion do appear almost universally across sexually abused children from different environments.

Lazare (1987) describes the cognitive aspects of shame as "a painful awareness of oneself as defeated, deficient, exposed, a failure, inadequate, wanting, worthless and wounded... the very essence of the self feels wrong". An explanation for shame from cognitive theory is also provided by Stone (1992), that "shame refers to the dissonance produced in the self-concept by actions or attitudes that are held to be inconsistent with ones own idea of who one is or ought to be." (p133)

According to current literature the roots of shame lie within the relationships with those significant care-givers and others whom the child is dependent upon (Evans, 1987; Kirschner, Kirschner & Rappaport, 1993; Kritsberg, 1993; Fossum & Mason, 1986; Bradshaw, 1988; Sanford, 1990; Sanderson, 1990).

Shame is often unacknowledged because it is extremely painful. Authors commonly cite the experience of shame feelings as a consequence of the victim feeling some sexual pleasure during the abuse or for positive feelings they may have experienced toward the perpetrator or for the secondary gains they may have received from the perpetrator (Nathanson, 1989; Sgroi, 1982) as well as the result of experiencing events in which the child is degraded and violated. Nathanson (1989) discusses the issue that the child is often excited by the sexual contact and may derive much pleasure from it, suggesting that it is the overwhelming confusion about good and bad that produces great shame and guilt within the child and leads to personality disturbance.

Shame and negative self-image are commonly linked up with the belief that the victim should have been able to protect themselves but failed. This is attributed to a deficit in character (Boulton et al., 1989). Summit (1983) adds that children are easily ashamed of their helplessness and of their inability to communicate their feelings to adults. Shame and sexuality are very much aligned in our (western) culture. Nathanson (1989) adds that shame monitors our sense of self, the moment of shame exposing a deeply personal, sensitive, intimate and vulnerable aspect of the self. Kaufman (1985 in Nathanson, 1989) explains that when our "interpersonal bridge", our sense of connectedness to the outside world is lost, shame is triggered. Shame greatly interferes with human intimacy as the shamed person protectively distances themselves through a myriad of defenses.

Nathanson (1989) states that competence in treating sexual abuse victims requires an understanding of shame which he describes as a "complex and multi-layered emotion". The cyclical nature of shame is highlighted in the literature. Once the roots of shame are laid the shame cycle is perpetuated by the client and those in their environment. Literature refers to an inter-generational, cycle of shame running through families. Families where problem-solving abilities revolve around a shame/blame dynamic perpetuate shame-based identities in its members (Evans, 1987; Fossum & Mason, 1986; MacKinnon, 1991)

Children in shame-based families learn not to show their needs and act according to parental desires, leading to the development of a false self or mask as this neediness is pushed into the shadow side of the unconscious. The child also learns not to feel, as this is a trigger to shame. Theory suggests that the psyche splits off awareness of the shaming experience to avoid the pain of it (Evans, 1987). Protection from the pain of shame includes defenses such as numbing, depression, narcissism, dissociation, rage and anger, abusive behaviour, perfectionism, denial, becoming "invisible", perfectionism or the abuse of substances to anaethetise oneself (Evans, 1987; Bradshaw, 1988). The therapeutic process must address current self-abuse issues as well as confronting and healing the identity from the past abuse experience(s) (Fossum & Mason, 1986; Bradshaw, !988). Some authors acknowledge a healthy aspect to shame. MacKinnon (1991) states;

"Shame is a learning tool. If you don't have shame you've got baby psychopaths walking around. Shame is what socialises us. It teaches us appropriate behaviour. But when it becomes connected to the identity it becomes dangerous and harmful to the person." (p55)

Sexuality

Abuse has been found to interfere with the development of a healthy sexual identity, damaging trust, self-esteem, personal boundaries, self-confidence, the ability to experience intimacy, love or to have healthy social interactions (Boulton, Morris & MacEachron, 1989). A childs' sexuality in sexualised trauma is shaped in developmentally inappropriate and dysfunctional ways. A child may learn to use sexual behaviour as a strategy for manipulation of others, have misconceptions about sexual behaviour and sexual morality or become traumatized when frightening memories become associated with sexual activity (Finkelhor, 1988 in Wyatt & Powell, 1988). Women survivors are often less responsive to sexual invitations and to partners and experience less sexual satisfaction with current relationships (Gold, 1986, Tsai, Feldman-Summers & Edgar, 1979 in Hunter, 1990). Fear

of sex, frigidity, arousal dysfunction and desire dysfunction was found in female rape victims and primary and secondary inorgasmia in incest victims. Research also indicates many survivors struggle with dissociation during sex (Algert & Borman, 1992). Research findings have shown boys victimised by older men were four times more likely to engage in current same-sex activity (Finkelhor, 1984) and prostitution and hustling was found in male victims (Olson, 1990). Precocious sexuality and promiscuity in women survivors was also found (Gil, 1988). Hunter (1990) adds that many male survivors behave in sexually compulsive and addictive ways, are preoccupied with sexual thoughts, compulsive masturbation and anonymous sexual encounters.

Betrayal

For the survivor of sexual abuse betrayal is often a strong theme. A fundamental betrayal occurs in abuse as boundaries are violated. The respect, sense of wholeness, coherence and integrity that should be theirs is damaged or never achieved. Eriksons' stages of identity development outlines the psychological task for the child of developing a sense of autonomy versus a sense of shame and doubt (Erikson, 1964). Unsuccessful mastery of this stage means less than optimum mastery of successive stages. For Erikson the role of the environment and the role of parental relationships in particular, was pivotal in determining the outcome for the child. For incest survivors where a significant level of trust in the perpetrator has been established, there comes a sense of shame as that trust is betrayed. The survivor may blame themselves for the changes in the perpetrator and feel polluted and "toxic" as a result. A sense of betraying themselves leads to feelings of shame as the survivor often maintains loyalty to the abuser (especially in incest) at the expense of being true to self and exposing the abuse. Violation of a childs' boundaries, emotionally, physically and sexually is inherent in sexual abuse, the effects of which include boundary ambiguity, assuming the victim role, having issues with touch, fear of intimacy/fear of abandonment and a shame-based identity (Evans,1987).

Depression and loss

Abuse causes great losses for the adult survivor, for instance the loss of nurturing childhood experiences and the loss of a sense of well-being (Boulton et al., 1989). From a cognitive perspective, the victim of abuse experiences a loss of internal locus of control which causes helplessness and anxiety. The victim is depersonalized, objectified, losing the self-identity and meaning that normally provide structure for ontological and psychological security (Hunter, 1990). Feelings of being different to others, being dirty and damaged are often experienced by survivors (Algert & Borman, 1992).

Anger and Rage

Rage is often linked with shame in adult survivors of sexual abuse. Many theorists explain shame as actually being "frozen anger" which the victim directs inwards because they may lack the power to direct it toward the perpetrator (Frankel, 1984). MacKinnon (1991) suggests that rage causes the person to feel powerful, blaming somebody else as a defense against feeling defective and ashamed. MacKinnon calls this the "shame/blame system, stating that it is a common dynamic the "shame-based identity" engages in within interpersonal relationships. Research findings on gender influence seem to indicate a tendency for women to internalise their anger more and for men to act out their anger or to adopt anger as a common defensive strategy (Boulton et al, 1989; Summit, 1983). Literature also reports that survivors may struggle with an inability to express anger which eventually leads to overwhelming rage (Algert & Borman, 1992).

Effects on Interpersonal relationships

In women - unassertive behaviour, marital discord, difficulty trusting men and women, feelings of isolation fear of commitment, poor choice of partner, violent relationships are possible outcomes related to sexual abuse (Schiller, 1988; Algert & Borman, 1992). Difficulty in maintaining healthy interpersonal relations was found in males and females (Tsai & Wagner, 1979, Bruckner & Johnson, 1987; Schiller, 1988). Many homosexual males

experienced violence from an abusive partner (Olson, 1990). Parenting difficulties in providing structure, caring for children and in balancing affection and discipline are also cited by Gil (1988) and Gelinas (1983). Research with women survivors found that many interpersonal relationships were marred by survivors being overly defensive, engaging in controlling or fearful behaviours and dynamics and by being out of touch with their feelings, needs and desires (Algert & Borman, 1992).

The Question of Responsibility and Self Blame

Self-blame and guilt are described in the literature as a key therapeutic issue for survivors (Draucker, 1992). Research findings confirm that child victims of sexual abuse usually internalise the responsibility and blame from the adult (Schiller, 1988). Eisen (1992) states "We are willing to deny the blatant hostility of the aggressor before we are willing to admit our own helplessness" p11. Guilt is somehow easier on the ego than shame. Draucker (1992) suggests that guilt may serve a protective function which prevents the victim from being overwhelmed by feelings of powerlessness.

Burgess & Holmstrom (1975) suggest guilt may be experienced on three different levels: responsibility for the sexual abuse, responsibility for disclosure and responsibility for the consequent disruption to the family. Janoff-Bulman (1979 in Allison & Wrightsman, 1993) in working with rape victims describes two types of self-blame: behavioural and characterological, which vary in terms of the perceived control one ascribes to oneself. Behavioural self-blame occurs when the victim assigns responsibility for the abuse to her own modifiable behaviours ("I should have locked the door") whilst characterological self-blame implies that the attack was somehow deserved, due to attributions made about the stable aspects of oneself ("I'm so stupid"). Janoff-Bulman found that where blame was directed at specific, controllable behaviours it was related to more effective adjustment than characterological self-blame (Janoff-Bulman, 1979 in Allison & Wrightsman, 1993; Meyer & Taylor, 1986).

Developmental theory suggests greater self-blame may be predictable among young children due to their level of cognitive development (which is categorised by egocentricity and concrete thinking) which means they have difficulty understanding the perpetrators' manipulations (Hazzard, Celano, Gould, Lawry & Webb, 1995). The child may blame themselves for the changes in the perpetrator and may feel they are inherently polluted or 'toxic', able to cause these terrible changes in others as a result (Kirschner, Kirschner & Rappaport, 1993). Issues of responsibility, attribution of causality and sense of identity are tied up with critical shaming of the child by the abuser and current literature is predominated by this explanation for the presence of shame in adult survivors of sexual abuse (Bradshaw, 1988; Kritsberg, 1993; Sanford, 1990). The child in the face of ongoing abuse must learn to somehow achieve a sense of control and power. Drawing the conclusion that the parent is self-serving and brutal leaves the child psychologically abandoned. This is a terrifying prospect for a child anyway, especially for one trying to cope with the rage and fear that is provoked by the tormenting experiences of sexual abuse. So the only alternative is for the child to believe that they have provoked the abusive encounters and to try harder to be good in order to avoid future occurrences of the abuse (Stone, 1992). When this inevitably fails the child may fall into self-hatred (Summit, 1983). Shapiro and Dominiak (1990) state

> "self-blame, when linked to guilt and shame, becomes a precursor for the development of destructive behaviour aimed against the self and others." (p72)

The Role of Secrecy

Secrecy is referred to as a major obstacle by Eisen (1992) who explains that the secrecy is often based on the victims sense of guilt and shame as well as on threats the perpetrator has made. Secrecy has the "force of fear but also the promise of safety" as the victim experiences conflict over whether to disclose and deal with the repercussions of disclosure (Eisen, 1992). Sgroi (1982) adds that secrecy means that the abuser will never have to take responsibility for the abuse and also may enable the abuse to continue. The absence of

emotional bonding and affection and/or the presence of violence and anger in the home may also affect the childs' ability to disclose.

Threats, by the perpetrator are a common tactic to ensure the childs silence -threats of family break-up, imprisonment of abuser, self-harm, murder, separation from the abuser, separation of the child from the family, from the home or the loss of something significant to the child (such as the killing of a pet) are common. Convincing the child that they will not be believed, bribery of favours, money, toys and the development of a "special" relationship with the child all work powerfully to maintain the childs commitment to secrecy (Sgroi, 1982; Summit, 1983; Boulton, Morris & MacEachron, 1989; Draucker, 1992).

The Role of Society

Stigmatization is a term often related to shame which describes the negative feelings a victim may experience in response to the reactions of others in society. Davenport, Browne & Palmer (1994) claim support for the idea that the likelihood of problems arising and the type of problems that do arise from child sexual abuse, is significantly influenced by societal values. Burgess & Holmstrom (1979) note that in most cultures the first sexual encounter is viewed as an important rite of passage and a sign of maturity. Victims may therefore be viewed with intense curiosity, disgust or hostility, due to transgressing these norms, or be further victimised as others perceive them to be more sexualized due to the abuse. These ideas are incorporated into what is termed the 'damaged goods' syndrome often experienced by victims, which also includes the notion held by both the victim and/or others, that people may react to the victim differently, believing the victim may have experienced physical damage from the abuse, such as sexually-transmitted diseases or a more non-specific "uncleanliness". (Sgroi, 1982).

Society, historically, has contributed to the belief that women were inherently responsible for abuse, believing that females "incite" male sexual behaviour and "boys will be boys", placing the responsibility on to females to control male sexuality. In a similar way

the mythology of the "seductive daughter" is culturally embedded in many religious traditions - for example the biblical story of Lot and his daughters (Draucker, 1992).

Summits Accommodation Syndrome (1983, 1992)

Summits work gives great insight into the world of the abused child. Summit states that children are often subjected to a secondary trauma after disclosure of abuse, by the actions of adults in their family or during legal proceedings. Summits work provides an explanation of the consequences of the abuse experience and of the behaviour of child victims (which is often hard for adults to comprehend). Adult expectations are often unrealistic when applied to the child. Questions such as "why didn't you tell if this really happened to you?", "why didn't you call out?", deny the powerlessness of the child. The ways in which a child copes seem contrary to adult expectations and solutions for how they should have coped. These expectations leave the child abandoned and accused, exacerbating the negative outcomes from the initial abuse.

Secrecy and **helplessness** are two preconditions to the abuse experience, impacting strongly on the childs response to the abuse. Fearing the consequences of retaliation and disbelief, a child will maintain the secret. The expectations that a child will be able to protect itself and stop the abuse are unreasonable. Physically a child is powerless to protect themselves from adult intrusions. Resisting may only increase the torment and invite retaliation. Abuse is often by a trusted adult, known to the child and in authority over it, even a parent. For a dependent child this adult has great power over them emotionally. A mere gesture or the threat of the loss of love and security is often more frightening than the threat of violence or abuse. Therefore the child does not disclose.

Entrapment and **accommodation** are the next phases in the Accommodation Syndrome. The child, powerless and needing to protect themselves by regaining some sense of control, learns to accommodate to the abuse. Self-hate and self-blame are the means of achieving a sense of power and control - the child is thus able to retain a sense of security

in the family by avoiding the conclusion that the parent is ruthless and self-serving. The child structures their reality to protect the parent. This is termed a "reality split". Summit states symptoms such as domestic martyrdom, splitting of reality, projection of rage, self-mutilation and hysterical phenomena are survival strategies of the child, the means of accommodating to the abuse. **Delayed, conflicted and unconvincing disclosure** is another important category in the Accommodation syndrome. Most abuse is not disclosed and there are many reasons for the child not to disclose (contrary to adult reasoning). Often, if the abuse is disclosed in adolescence, authorities will identify with the parents, taking exception to the accommodation strategies of the victim (which may include delinquency, substance abuse and rebellious anger). The childs' compensatory behaviours discredit their disclosure. Summit adds a mothers' denial, commitment to self-protection and to preventing the loss of her children into state custody mean that the victim may be unsupported or even scapegoated within the family.

The final phase in Summits Accommodation Syndrome is **retraction**. Summit says that the normal course of a child who is unsupported in their disclosure is to retract their claims. This often occurs in the context of family break-up, abandonment by the abuser, disbelief and rage from the mother and impending imprisonment of the abuser. The child carries the blame. Intervention to force the responsibility on to the abuser and support for the child is vital in order for justice to be served and for the child to avoid secondary trauma.

The Role of Gender

One aspect Stevens (1992) did not explore is the implications of client gender on the conceptualisations counsellors have of the therapeutic tasks for the sexually abused, her focus being on the experience of women only. Early victim studies have often excluded males, Finkelhor (1986) states that the greater attention given female victims is unfortunate because it has contributed to the mistaken impression that male children are rarely victimised. Societal stereotypes regarding males also influence the misbelief that abuse is somehow less

traumatising for males. The current project includes a focus on the conceptualisations counsellors have of how shame affects both males and females in order to contribute to our understandings of male experiences.

Males as victims

Although much of the research conducted in the sexual abuse area has focused on the experiences of women as victims, efforts have been made in recent times to investigate the experiences of male survivors. Researchers and clinicians have found that societal expectations and gender role stereotypes have a significant role in the difficulties male survivors have to overcome (Hunter, 1990; Finkelhor, 1986; Boulton, Morris & MacEachron, 1989). Nasjleti (1980) states that these role expectations of males "create a climate conducive to their victimization and in turn their victimization of others.

Struve (1990) found nine factors impacting the recovery of males. This research found that many males were reluctant to seek treatment due to beliefs that men are not "victims" and that if they are they will be less traumatized by the victimisation than women (Struve, 1990; Bolton et al., 1989). Males may reject the term "abuse" and minimise the effects of the abuse experience(s). Disclosure is therefore a significant event for many males as in doing so, they oppose the male ethic of self-reliance (Boulton et al, 1989; Nasjleti, 1980). Finkelhor (1986) also suggests that masculine stereotypes of bravado and machoism mean male victims, when they do disclose, may minimise the impact which also contributes to the view that abuse is somehow less traumatic for males than for females. Males may have more to lose by disclosing, as violence and threats from abusers are more common (Rogers and Terry, 1984 in Stewart & Greer, 1984). Kercher and McShane (1984) add that the use of erotic materials to "recruit" boy victims means disclosure is more likely to be shame-inducing, as the victim may feel guilt about being interested in or experiencing pleasure from viewing these materials. Research findings show that when males do disclose they do so in a more matter-of-fact manner than women.

Research into males' behaviour in therapy groups found males were more action oriented than women, carrying out plans when made, showed a greater desire to make the abuse and its impact public in order to educate others and tended not to associate with group members outside of the group. They were also more outwardly aggressive and angry in therapy than women (Bruckner & Johnson, 1987). According to research findings boys are less likely than girls to disclose the abuse (Finkelhor, 1984; Risin & Koss, 1987).

Finkelhor (1979) suggests that men are cast by society as more sexually active than women attributing more consent and less victimisation to male victims. Pierce & Pierce (1985) found 12% of boys compared with 3% of girls were believed to have encouraged their abuse. Men may minimise their experience, especially with that of an older woman, due to the view that sexual activity with an older woman is a privilege (Hunter, 1990; Struve, 1990). Research has found males victimized by another male often struggle with homophobia or confusion over their sexual orientation due to their perceived passivity or sexual arousal they may have experienced during the same-sex abuse. Many abused males behave in sexually compulsive and addictive ways (Hunter, 1990). (see also **Sexuality**). A sense of failure and shame is experienced by male victims who believe they should have been able to protect themselves against the attacks in accordance with societal views of male gender role. Male survivors are more likely to engage in drug and alcohol abuse, self-mutilation and emotional fixation (Hunter, 1990).

Aggressive acting out behaviours are frequently seen in male survivors which theorists explain as an attempt to compensate for feelings of powerlessness, sadness, loss, shame, anxiety and fear by asserting an overly masculine identity (Boulton et al., 1989). Males may avoid any behaviours perceived as feminine, including emotional intimacy with other males. Compensatory behaviours which keep the survivor in a position of power and control are observed in males (Hunter, 1990). Feelings are externalized more by males due to the social expectation that males will act on but not express their feelings. Cultural norms

which demand that men be strong and handle adversity without crying serve to further disempower the male victim. Boulton et al. (1989) state that strong "non-masculine" feelings are triggered by the abuse and survivors must go to great lengths to keep these under control. These survivors learn to be stoic at great emotional cost. In turn research has found males are often vulnerable to compulsive behaviours due to attempts to deny their feelings (Struve, 1990 in Hunter, 1990). Research has shown males may have strong defenses against sadness, loss, anxiety and shame which are perceived to be "unmanly" feelings and responses (Hunter, 1990). Theorists add that males have often learned to assume responsibility for the feelings, needs and behaviours of others as a result of the abusers' messages. Males often struggle with fears of becoming abusers themselves (Draucker, 1992; Boulton et al, 1989).

Three Models of Sexual Abuse

Post-traumatic stress disorder model

A more recent development in sexual abuse theory and research is the use of a PTSD framework to understand the impact of childhood sexual abuse. The advantages of this are that the PTSD framework provides a clear label and description of phenomena that many victims suffer from. The PTSD model views healing from trauma as a relatively natural and nonpathological process, maintaining that symptoms are the consequence of a normal reaction to an abnormal event (Hunter, 1990). This view is helpful in reducing stigma, shame and self-blame in victims. The criteria for a diagnosis of PTSD as found in the DSM-IV includes:

"A. Exposure to a traumatic event in which both the following were present:

(1) the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) the persons response involved intense fear, helplessness or horror.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images,

thoughts or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent, distressing dreams of the event. Note: In children, there may be frightening dreams without recognisable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific re-enactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble as aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings or conversations associated with the trauma,

(2) efforts to avoid activities, places or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C and D) is more than one month.

F. The disturbance cause clinically significant distress or impairment in social, occupational or other important areas of functioning."

(DSM-IV, pgs 427-429)

Therapy from a PTSD framework

Learned helplessness is an important aspect of PTSD theory. Trauma victims with learned helplessness are vulnerable to numbing, denial, repetitive intrusions that may be dissociated as affective (bodily) states or as vivid recollections. Avoidance of people and events which trigger emotional responses is common and symptoms may be obscured by depression, self-destructive behaviour, drug and alcohol abuse. Therapy in a PTSD framework focuses on moving the client from learned helplessness to mastery using stress management strategies. These strategies may involve changes in the clients environment or changes to their expectations of events from being uncontrollable to controllable, by training the person in appropriate responses (Peterson, Prout & Schwarz, 1991).

Specific skills training such as assertion training and self-defence, increase coping and enable the person to have a sense of personal control. Lifestyle choices to moderate stress may also be incorporated, such as relaxation, exercise, avoidance of dietary stimulants and the development social supports (Flannery, 1987).

Therapeutic intervention for PTSD includes encouraging the expression of feelings about the abusive experience, by establishing a safe, communicative relationship. This helps to break the cycle of alternating between denial and intrusive symptoms by allowing them to experience their emotional responses without automatically denying and numbing their emotions. Assisting the client to realize and accept the abuse was the perpetrators' responsibility is an important goal of therapy. Supporting and believing the disclosure can reduce negative self-evaluation, increase trust and result in the incorporation of trauma in a more adaptive manner (Miller-Perrin & Wurtele, 1990). Discussion of ambivalent feelings and feelings or responsibility can relieve guilt or self-blame and group therapy is also recommended as an effective intervention here. Recalling the event with less intense emotional reactions can allow clients to focus on modifying their misconceptions about causation.

Two additional goals include understanding how the abuse has led to current self-defeating behavioural patterns and learning new adaptive behaviours. Cognitive techniques are used to provide clients with a way to conceptualize thoughts, behaviours and feelings and to enhance their sense of power, control and hope. Reliving the experience in order to achieve catharsis is an aspect of therapy, but must include integration of the experience in order to be therapeutic (Miller-Perrin & Wurtele, 1990).

Placing sexual abuse in a broader context with other types of trauma may reveal new insights and findings due to the renewed interest in the area of sexual abuse research. Researchers in PTSD theory have sought to discover how their models and theories fit in the context of sexual trauma. Furthermore a "syndrome" may be uncovered with a core etiology as opposed to the current catalogue of symptoms. This may reduce the stigma victims suffer, as childhood sexual abuse becomes recognised as a major psychological stressor, challenging the notion that the trauma is the result of the victims own pathological response to a non-traumatic event (Finkelhor, 1988).

Critics of the PTSD model claim that this model only accurately applies to some victims and does not present a theory which explains the dynamics of sexual abuse and how it contributes to the development of symptoms. Not all survivors experience PTSD symptoms of intrusive imagery and dissociative symptoms which the model emphasises and researchers of sexual abuse emphasize fear, depression, self-blame and sexual problems above other symptomology (Finkelhor, 1988). Briere & Runtz (1988) cite suicidality, substance abuse and revictimization as common symptoms which fall outside the PTSD boundaries. Finkelhor (1988) states that PTSD locates almost all trauma in the affective realm, whereas sexual abuse symptoms occur in the cognitive realm as well. He warns that the PTSD framework may obscure these cognitive traumas of self-blame and negative self-image. Sexualized behaviours seem better accounted for by learning or conditioning than by the "shattered assumptions theory" of PTSD (Finkelhor, 1988).

Abuse Recovery Model

Altermatt (1985 in Hunter, 1990) developed this model to take into account new areas of knowledge in the intervention process, emphasizing empowerment, active choice making and use of personal resources. The goal of therapy is to integrate the trauma experience through identification and externalisation, exploration of meanings and reconnection of appropriate affect with experience (Hunter, 1990). Reintegration allows the client to reassess his/her life circumstance, make choices and behave out of the current moment, not the past. Exposure to memories is part of the therapeutic process as the therapist assists the client in identifying and classifying traumatic material, developing boundaries, reappraising the meaning of events and developing adaptive responses to them. This helps to reduce shame, self-blame and irrational responses to abuse, encourages exploration of contextual dynamics that reinforce the destructive qualities of the abuse and clarifies the impact of events. Therapy also includes identifying and expressing the emotions and grieving for losses.

Traumagenic Dynamics of Sexual Abuse Model

Finkelhor & Browne (1985) propose an alternative to the PTSD model of sexual abuse which suggests a variety of different dynamics are involved in the development of symptomology. This model incorporates some elements of PTSD but also explains symptomology which falls outside the range of the PTSD framework. Four key dynamics are given in this model; traumatic sexualisation, betrayal, stigmatization and powerlessness. The traumagenic dynamic is an experience which alters a childs cognitive or emotional orientation to the world, resulting in trauma to a childs self-concept, world-view or affective capacities. Rather than the concept of "shattered" assumptions, assumptions about the self and world are seen to be distorted. This model sees these distortions as "adaptive and well-integrated coping mechanisms", developed in response to an abusive experience rather than as a failure to incorporate new experience as the PTSD model holds.

Traumatic sexualisation involves the childs sexuality being shaped in developmentally inappropriate and interpersonally dysfunctional ways. Sexual behaviour may become a strategy for manipulating others, or become traumatizing when memories become associated in the childs mind with sexual activity. Problematic sexuality, promiscuity, prostitution may all result from this dynamic. **Betrayal** is a dynamic that occurs when someone on whom the child is greatly dependent causes them harm. Disclosure which is met with disbelief also feeds into this betrayal dynamic as the child realises the limits of their parents power to protect them. **Stigmatisation** refers to the negative messages about the self the child receives from the abuse. These messages come directly from the abuser or indirectly as the child discovers sexual abuse is regarded as deviant, victims being viewed with curiosity and suspicion. Forms of stigma vary for males and females (Rogers & Terry, 1984). The outcome of this dynamic may be substance abuse, self-destructive behaviour, low self-esteem, a sense of isolation and suicide attempts. **Powerlessness** is the fourth traumagenic dynamic. Having ones body invaded repeatedly against ones wishes, the experience of threats, violence and coercion by the perpetrator attempting to maintain secrecy, ongoing vulnerability and entrapment contribute to powerlessness. Separation from family and legal proceedings may further add to this dynamic. Symptoms of this dynamic may include the development of compensatory behaviours such as the need to control or dominate, learning difficulties, running away and delinquency, impairment of coping skills and a low sense of efficacy. This model enables sexual abuse to be viewed as a situation or a process rather than simply an event as survivors are affected as much by the initial event as the subsequent events such as disclosure and prosecution (Finkelhor, 1988).

CHAPTER TWO
OVERVIEW OF THERAPEUTIC INTERVENTION THEORY

Chapter Overview
Cognitive therapy
Behavioural therapy
Gestalt Therapy
Rogerian Theory
Narrative Therapy
Psychodrama
Bioenergetic Analysis
The Role of Therapist

In this chapter some of the theoretical orientations to therapy, which were found to inform the work of the respondents in this study are reviewed in order to orientate the reader to some of the terminology and concepts contained within these approaches to therapy.

Cognitive Therapy

Distorted perceptions and beliefs contribute to low self-esteem, shame, guilt, sadness and depression in adult survivors of sexual abuse (Sanderson, 1995). Cognitive theory proposes that, if beliefs are distorted then feelings and actions are likely to also be distorted, and the correction of beliefs will alleviate mood disturbance and many problem behaviours. This theory sees individuals as actively participating in their environments, judging and evaluating stimuli, interpreting events and judging their responses to them. Personality is viewed as being shaped by "schemas"; cognitive structures consisting of the individuals fundamental beliefs and assumptions. These beliefs and assumptions are seen to develop early in life, out of personal experiences and identification with significant others. These schemas may be adaptive or dysfunctional, general or specific. In this way cognitive theory emphasizes learning history of an individual and the influence of significant life events in the development of psychological disturbance. The way an experience is structured is determined by the consequences of past behaviours, vicarious learnings from significant others and expectations of the future.

The role of the therapist is a collaborative one, assessing the sources of distress and dysfunction and clarifying the clients goals. The agenda for each session is collaboratively set, the cognitive therapist acts as a guide to help the client gain insight into how their behaviour is influenced by their beliefs and assumptions. Identifying beliefs, recognising distortions, and replacing these with more accurate beliefs are the tasks that underlie the process of cognitive restructuring. Three fundamental concepts assist in this therapeutic process; collaborative empiricism, Socratic dialogue and guided discovery. **Collaborative empiricism** occurs when the client and therapist investigate the evidence to support or reject the clients beliefs and assumptions. These are treated as testable hypotheses, subjected to logical analysis and empirical evidence. In **Socratic dialogue**, questioning is used as a therapeutic device to clarify and define problem areas, to identify thoughts and assumptions, to examine the meanings of events and to assess the consequences of maintaining the certain thoughts and behaviours. **Guided discovery** involves the therapist designing "behavioural experiments", guiding the client to use information, facts and probabilities to obtain a more realistic perspective (Beck & Weishaar, 1995).

Strategies which assist the sexual abuse survivor to generate alternatives to cognitive distortions include normalisation of abuse, providing accurate information, logical analysis, encouraging objectivity, reattribution of blame and responsibility, decatastrophising and the use of specific exercises to confirm or refute cognitive distortions (Sanderson, 1995). Criticisms of this therapy are that as it is predominantly verbally orientated clients who are able to articulate may benefit most whereas those with less verbal ability may not make the same improvement. Intellectualising about the abuse experience and dissociating from their feelings may also be a problem. Cognitive theory and behavioural theory share some features; both are empirical, present-centred, problem-oriented and require problems, and the situations they occur in, to be explicitly identified. Whilst cognitive techniques are effective in addressing many symptoms the use of such techniques are most effective and beneficial

when used in conjunction with experiential/exploratory and behavioural techniques (Sanderson, 1995).

Behavioural Therapy

Behaviour therapy uses corrective learning experiences in order to help clients to acquire new coping skills, improve communication or learn to break habits that are maladaptive. This theory is based on the principles of learning (operant and classical conditioning) and views the person as actively participating in their situation. These corrective learning experiences address both cognitive and affective functioning as well as overt behaviour. The client is required to be an active participant, carrying out homework tasks between sessions. The behavioural therapist is directive and involved and the quality of the therapeutic relationship is seen to be significant to therapy outcomes. The client and the therapist collaborate over the goals of therapy, the therapist role is to assist the client in achieving the goals the client has set for themselves (Wilson, 1995).

Assessment of problem areas is an essential part of therapy, the therapist asks the client questions relating to situations and circumstances which influence a behaviour. Guided imagery may be used to symbolically recreate a problematic situation, in order to uncover specific thoughts and reactions a client may have to certain events. Role-play is another technique useful in helping the therapist assess problem behaviours or for rehearsing new behaviours the client is developing as a result of therapy. Clients are often required to monitor themselves, diarying behaviours and thoughts in order to detect patterns of behaviour related to their problems. Relaxation can assist the therapeutic process by reducing anxiety. This is useful when survivors are exploring details of their abuse and is believed to improve recall (Pearson, 1994).

Behavioural techniques such as systematic desensitization, biofeedback, fantasy training and relaxation may be used to reduce stress, promote adequate behaviour and develop satisfactory sexual responses (Pearson, 1994). Assertiveness training and anger

management may be goals of the client which are readily suited to behavioural therapy approaches. Cognitive restructuring may also be included in the therapy. Therapy is generally short-term (25 -50 sessions) and therapy length is usually contracted with the client (Wilson, 1995).

In the case of shame, a behavioural therapist may ask the client to self-monitor the situations and incidents where they feel shame in an attempt to identify the environmental triggers. If this assessment reveals shame in interpersonal situations, therapy may involve assertiveness training, anger management or parental training, for example. The past is examined only in order to understand what the influences were on the clients' learning and behaviour, and to discover the individual contingencies of a client.

Gestalt Therapy

For the Gestalt therapist, therapy is focused on the here-and-now, past experience is relevant only in as much as it is being lived out in the present, and the future is the product of 'now'. Therapy is about awareness and experience, the therapist diverts the client from talking about their life to experiencing their life in the present moment. Gestalt theory holds that negative affect is merely shadowing the discovery of a need we have (Frankel, 1984). The therapeutic process is described by the Gestalt Awareness Cycle - growth and change start with awareness of a need, next comes mobilization as we prepare to initiate action to meet that need. Appropriate action will put us into contact with that which meets our need and withdrawal occurs when we are satiated (Polster & Polster, 1973). Ideally people should flow through the cycle freely. However, problems arise when resistances prevent this free flow. Commonly resistances are found at the awareness and contact points of the cycle (although they may occur at any point). Compulsive behaviours and all forms of substance abuse would be viewed by the Gestalt therapist as resistance strategies, used to avoid both awareness and contact.

Awareness of 'unfinished business' is an important part of the therapeutic process, therapy involves discovery of how the need that was not met in the past is still not being met in the present and of how the client is preventing/resisting the fulfilment of this need. Correctly labelling, experiencing and meeting the need 'in the now' enables the business to be finished, this is known as 'closure'. For the client struggling with feelings of shame and worthlessness the therapist will be looking for ways in which the unfinished business of the abuse is being replayed in the present, helping the client to become aware of how this is occurring. These themes are uncovered as the client leads, Gestalt therapists believe the person ("organism") will freely bring up those themes that are relevant (Frankel, 1984, Clarkson, 1989). This belief goes against other views of therapy (such as the more psychodynamic approaches) which believe that those themes that are relevant may also be very painful and are therefore well defended against by the person, who may require much assistance to make these connections.

Another important Gestalt concept relevant to shame issues is the resistance strategy of retroflection. Here the client resists contact with others in two ways - doing to themselves what they would rather do to someone else and doing for themselves that which they would rather have others do for them. A negative retroflection is where these strategies work to harm the client. The rationale for negative retroflection is that it is far safer to depreciate (mutilate, destroy) ourselves than it is to depreciate others, to this extent one would describe the shame as 'hidden anger'. In the case of sexual abuse survivors, it has been suggested that negative retroflection was often the safest way to deal with abuse. The process may be described in this way:

1. The client has experienced abuse, violation, violence often by a trusted other.
2. The client receives a message from that other, verbally and/or non-verbally that they deserved this treatment, that they caused it, that they were responsible for the abusers actions.

3. The client agrees with the message.

4. The client repeats the message with internal statements and perpetuates it, retroflection occurs. The client avoids contact with the abuser and passively accepts the message instead.

Once awareness of these messages is gained the Gestalt technique to resolve negative retroflection is to undo it, changing the "I am worthless, dirty," etc. to "You are worthless, dirty..." statements directing those messages back on to the abuser. Techniques such as enactment, fantasy and double-chair work, work through any resistance and may also be used to facilitate contact, through which the client achieves release and relief, facilitating closure (Frankel, 1984; Polster & Polster, 1973; Fagan & Shepherd, 1970).

Another Gestalt concept relevant to the issue of shame is that of figure and ground (Clarkson, 1989; Clarkson & MacKewan, 1993). Like a picture, a figure is that which is attended to against a background which provides a general context. For a client the ground is the pool of their life experiences, the figure is that which is prominent in their life now - a belief, theme, situation, feeling etc. Theory holds that the "organism"will attend to the familiar figures and will have a limited background from which figures emerge leaving many experiences unavailable, leading to over-generalisation and exclusion of alternatives.

In the example of shame, the clients' ground may contain action, thoughts, situations that characterise them as dirty, not valued, rejected, from which figures emerge with prominence - that figure may be a current experience of feeling unworthy. The therapeutic goal is to alter the perspective by allowing other figures prominence, for example by having the client attend to and experience situations where they were indeed competent and successful, thus enlarging the ground and the range of contact experiences they are open to in the future. Resistances are not fought but heightened and brought out - often using double-chair techniques. Polarities are often used by clients (good-bad, right-wrong, strong-weak, etc.) which limit the range of experience the client is open to and these may

need to be addressed, particularly in working to uncover the authentic self and refute the false self (Frankel, 1984; Polster & Polster, 1973; Fagan & Shepherd, 1970).

The therapist role is very directive although the agenda for sessions comes from what the client brings. Pearson (1994) cites a number of studies which state the value of gestalt techniques or a combination of gestalt and psychodramatic techniques for survivors, helping them to psychologically confront the perpetrators, uncover and express their emotions and to integrate the abuse experience (Faria & Belohlavek, 1984; Rencken, 1989; Joy 1987, in Pearson, 1994).

Rogerian Theory

A Rogerian view of therapy emphasizes the client-therapist relationship as an important key to change. Carl Rogers, in a similar way to Gestalt theory, believed that all people have an innate drive towards wholeness which he termed the drive toward self-actualization. The role of the therapist is central in that the therapist must possess qualities of genuineness (versus presenting a façade or hiding behind the role of professional), unconditional positive regard and acceptance of the person, allowing the client freedom to explore their feelings and experience them fully, and empathic understanding of the clients view of life. Rogerian theory holds that there are seven stages to the therapeutic process which the client moves through. Rogers sees the process as being on a continuum and the client may operate at varying levels in the interview according to the issues involved. The process is facilitated as the client experiences himself as being "received" by the therapist - this concept involves being accepted, understood and empathized with. The earlier stages are characterised by an unwillingness to communicate the self, focus on externals and a quality of "psychological fixity" (Rogers, 1961; Rogers, 1980). The client then moves to freer expression about self-related topics, initially without acceptance of feelings or recognition of contradictions, and in the final stages, to acceptance, free expression and experience of feelings. For the client struggling with shame the basis of the client-centred therapeutic intervention is the

development of the relationship between the therapist and the client. By conveying warmth, genuine acceptance and unconditional positive regard the therapist is challenging shame and the beliefs the client holds by facilitating an experience contrary to the clients prior experience, whilst providing a safe place for the client to experience, uncover and integrate their true identity, process emotions and confront issues. Listening, caring and empathising validates the clients worth. Defenses are respected with the rationale that when the client feels safe enough they will choose to let these go as the self-actualising drive works within them. Techniques such as reflective listening, paraphrasing and summarising are used as a means of conveying attention and concern as well as helping the client to better express and identify feelings and thoughts, thus facilitating movement through the stages of the therapeutic process (Rogers, 1961; Rogers, 1980).

Critics of Rogers take exception to "his gross inflated trust in, and regard for, the individual" (Thorne, 1992, p76). Rogers view of the person was seen as underrating the forces of the unconscious and of evil, to which Rogers argued that his view of the person was developed during his experience as a therapist where he saw the person as being "positive, forward-moving, constructive, realistic and trustworthy", and believed these characteristics to be inherent (Thorne, 1992). Another criticism of the Rogerian approach was that the experience of empathy and acceptance may engender dependence on the therapist. Since this time, research looking at the influence of the client-therapist relationship on the therapeutic process has been done. Findings support therapist qualities such as empathy and acceptance as being beneficial to the process. The inevitability of the therapeutic process (that is, that clients will naturally move toward healing without great intervention), as Rogers saw it, has also been questioned and Rogers has been criticised for his neglect in addressing transference processes. Despite its' criticisms Rogerian theory has widely influenced the practice of psychotherapy to date.

Narrative Therapy

Developed by Michael White & David Epston, narrative therapy is a growing strand of psychotherapy in recent times. This therapy involves some fundamental ways of approaching problems. For example, externalizing the problem; that is, the objectification of problems, separating them from the person and personalising the problem, giving it a life of it's own. In doing so the person becomes free of being the problem, that is the problem becomes less inherent in the person and its' impact on the person becomes less fixed and restricting. This is a vital orientation the narrative therapist takes to client issues. Through ongoing, failed attempts to solve problems, families and individuals begin to attribute negative personal and relationship qualities onto themselves and come to therapy "problem-saturated". This perspective on their experiences becomes their dominant story in Whites' terminology. New possibilities for themselves and others arise through externalization - the movement away from a problem-saturated (shameful) view to a new, non-problem-saturated perspective - an alternative story is possible. This openness allows new information and "facts' to be perceived that were not possible before.

White lists the following outcomes in his experience with this practice; a decrease in unproductive conflict amongst family members over blame for a problem; an undermining of the sense of failure that had often developed; increased co-operation between persons, family members uniting against the problem rather than against each other; opening up of possibilities for action in order to take back their lives and relationships from the problem and it's influence; a lighter, less stressed, more effective approach to problems is possible and an option for dialogue, rather than monologue, about the problem is created (White, 1989).

Narrative therapy proposes that people 'story' their experience of life and that this 'story' determines the meanings they ascribe to their experience. It provides a sense of coherence and continuity, allowing persons to make sense of their lives and to achieve a sense of purpose. Stories, whilst determining the meanings they ascribe to events they

experience also determine the aspects of the experience they will attend to for the ascription of meaning - much like the figure and ground metaphor in Gestalt theory. Therefore these stories continue to shape the persons life in a self- sustaining manner (Durrant & Kowalski, 1990).

Externalizing the problem allows separation from the dominant story and allows for the identification of unique outcomes - aspects not predicted by the dominant story. Plotting these unique outcomes forms the basis of the alternative story or unique account. The use of questions is central to assisting the person to "locate, generate or resurrect alternative stories that will make sense of the unique outcomes" (White, 1989). Therefore the person or family is able to derive new and unique redescriptions of themselves and their relationships - they re-author their lives.

The use of questions is a significant part of the narrative approach, relative influence questioning involves two sets of questions - firstly the person maps the influence of the problem in their lives and relationships and the second maps the influence of the person in the life of the problem. Once the process of externalisation has begun people can more readily separate from the problem and are less fixed in their perceptions of events surrounding the problem which allows for the discovery of unique outcomes. These practices assist persons to become aware of their relationship with the problem and therefore take responsibility for it in a way they could not do beforehand.

Collapsing Time is a technique which is used to identify the fact that often the problem has become more influential over time and that members in the system have adapted to the presence of the problem, habituating to it, participating with it. 'Time' language is introduced, predicting the future state of affairs, and distinguishing past and present states help to locate the problem and the persons responsibility/role in its course (White, 1989).

Psychodrama

Developed by Jacob L. Moreno, psychodrama is based on the recognition that people are role players, each individual being characterised by a certain range of roles that dominate behaviour (Blatner & Blatner, 1988). Role theory is used to encourage creative change. Moreno believed that roles should be continually re-evaluated and experimented with. Psychodramatic methods are often used to enhance the effectiveness of other therapies. Specific techniques include role-reversal, dialogues between parts of the self, act fulfilment and role-playing. The work is often in a group setting and is spontaneous and creative, and is described as having the capacity to reconcile many dualities of experience -rational and imaginative, reality testing and emotions, action and reflection future and past, playfulness and seriousness(Blatner 1995, in Corsini & Wedding). Psychodramatic methods are often used to assist integration within the client. Blatner & Blatner (1988) define the goal of the psychodramatic method is to "help the client experience his/her situation as vividly as possible; help unspoken thoughts be expressed; help group members to help each other; help clients to develop and apply their own creativity to their lifes' challenges" (p9).

Catharsis is a fundamental element in psychodrama although theory stresses that after catharsis should come integration, the replacing of unhealthy behaviours for healthy ones. Experiential learning and the development of insight which facilitates personal growth are the function of psychodrama as it aims at rediscovering various aspects of the self and developing constructive ways to utilize these. The principle of concretization means that clients specify their problems in dramatic form within the group, re-anchoring clients in their experiences which allows the therapist and the group to understand and aid the client more effectively. A sense of connectedness and belonging are some of the benefits of group work. Clients are required to "show" the conflict as opposed to talking 'about it'. Externalizing internal dialogues help to clarify issues, this is the principle of the encounter, a dialogue in the present moment where the action is spontaneous and creative.

Bioenergetic Analysis

Bioenergetic analysis integrates work with the body into the analytic process. It aims at helping people to understand by deeply connecting to the events and forces that are influential in the present - a connection made by getting in touch with the body - as opposed to understanding merely intellectually. Dream analysis, slips of the tongue, character analysis and transference are important aspects of bioenergetic therapy. Body work is influenced by the concept that the more energy a person has the more alive they are. The theoretical progression is that energy leads to movement which creates feelings and leads to thinking. This is a "bottom-up" approach in contrast to the "top-down" approach of cognitive theory. A holistic principle of unity underpins theory which holds that the organism functions as a whole so the psychological processes and the physical body must all be attended to for fundamental, deep change to occur. (Lowen, 1995).

Bioenergetic theory proposes a character structure analysis of character types and the ways in which the body may be affected and reflect these types. Healing must include awareness, insight and change in the body structure as the character structure is believed to exist on a bodily level. The old structure must be demolished so a freer mode of being can develop. Breathing and specific body exercises are incorporated into the therapy which aims to understand and work with muscle tension, analyse associations, behaviour and transference, understand energy dynamics and focus on the role of sexuality. Areas of contraction and tension are noted and interpreted and the body is mobilized through breathing and movement to release the contraction. Two principles underpin this bodywork; 1) that the limitation of motility is the result and the cause of emotional difficulties - every physical rigidity interferes with and prevents a unitary response to situations, 2) restriction of natural respiration is both the result and cause of anxiety, childhood anxiety disturbs natural respiration. Deeper contact with the body is made through special movements and body positions, during which the client begins to understand the connection between their present

physical state and the experiences of childhood that created it. Denial of the body is seen as a rejection of a need for love, used to avoid hurt and disappointment. Rigidities in the body are seen as defenses against impulses toward rage, clients are given the opportunity to express this during therapy. Bioenergetic analysts claim that any increase in a persons contact with their body will produce significant improvement in self-image, interpersonal relationships, their quality of thinking, feeling and enjoyment of life. Despite the use of character structure types, therapy is specific to the individual, one must understand the individual in specific and holistic terms in order to move toward health (Lowen, 1995).

The emphasis on emotional expression of Bioenergetics has been criticised. Critics argue that more vulnerable clients may be retraumatised by this process, and in fact, that learning how to manage and avoid extremes of emotion may be a more appropriate intervention for some clients. As part of the bodywork, clients may be required to maintain postures that are painful, during the therapy and to fully express this physical pain along with their psychic pain. Critics claim that, in doing so, the client may be in a more highly suggestible state, and may therefore be vulnerable to therapist suggestion and the possibility of "recalling" false memories (Oats, 1994).

The Role of Therapist

Current research indicates that the therapeutic relationship is a significant factor in therapeutic outcomes. The therapeutic relationship is a unifying factor, underpinning the various approaches to therapy and is therefore important to mention in this overview of approaches to treatment.

Research indicates that therapist hopefulness, (that is the view of the client as worthy, treatable and capable) was significant to the successful outcome of treatment. Not overly identifying with the pain or despair of clients (termed "empathic attunement"), not pushing clients to confront the past, having an equal partnership and mutuality in the therapeutic work and developing a bond by working through any disruptions to intimacy from transference etc. were also factors found to contribute to successful therapeutic outcomes (Schave, 1993). Hunter (1990) states that the therapeutic relationship is the best place to address trust issues, providing a testing ground for future peer and adult relationships. Believing the victim and supporting them, validating feelings, empathising with the effects of abuse and of disclosure and giving the client as much control as possible within the therapy are important considerations for the therapist (Hunter, 1990; Pearson, 1994).

CHAPTER THREE
THE PRESENT STUDY

Chapter Overview
Results from pilot study
The Present study
-objectives
-sample group
-procedure
-interviews
-participation of the researcher
-transcripts
Methodology
Qualitative research
Grounded theory
-data analysis
-assessment

FINDINGS FROM THE PILOT STUDY

A pilot study was carried out by the researcher interviewing four therapists about their work with adult survivors and their theories about shame. Results found that there were many congruities in the ways the participants understood shame, which they saw largely as a result of messages the survivors received from the abuser, and which played out a cycle of negative effects reaching far into the adults identity and experience. These participants saw the road to recovery as involving the development of a trust-relationship between counsellor and client, increasing awareness and exploration of emotions, experiences and personal meanings and the building of an accurate self-concept. These findings provided support for the idea that there may be some "core factors" in the therapeutic process, despite the given orientations of individual therapists which this project has attempted to discover. The conceptualisation of shame as being the consequence of messages from the abuser was also an interesting finding, which lead to this present study investigating shame conceptualisation more fully.

OBJECTIVES AND AIMS

The objective of the present study was to examine therapists understandings of the role of shame as an issue when working with survivors of sexual abuse, in order to develop a core theory of shame and the therapeutic process relative to shame. This would begin to address the need for a shared conceptual framework in order for an integrated approach to sexual abuse counselling to be possible. Attention was also to be given to the role of client gender in an attempt to uncover any similarities or differences in the type of therapeutic goals counsellors saw as being relevant for males and females working through shame issues, to provide a more complex understanding of shame for adult survivors. Both male and female therapists were targeted in order to find respondents who had worked extensively with male and female survivors, and to gain the perspectives of therapists of both genders. The respondents were asked to describe their understanding of the issues, the therapeutic goals and ways in which they would work with the clients, in order to elicit the therapists' understandings of what strategies and concepts they saw as being essential components in promoting healing in the client.

From the data a complex theory of shame in adult survivors of sexual abuse was to be derived. This theory would capture the core factors of shame and the process of healing from shame, across the varied frameworks adopted by the therapists. Examining the therapies and theories currently informing the work of counsellors in this area, and identifying the core therapeutic factors within each (as they relate to shame in adult survivors) will provide an opportunity for critical reflection, consolidation and may open the way for new learning and movement forward for those who work in the area of sexual abuse counselling.

A grounded theory approach is most valuable to the objectives of the present research as it enables the researcher to categorise and conceptualise themes and like terms, allowing a framework to emerge rather than imposing a framework on the data (which would not serve

the purpose of integrating data from varied frameworks).

THE SAMPLE GROUP

(Details regarding respondents are expressed generally to preserve the anonymity. The respondents identities are confidential, within the text they are represented by pseudonyms.) Eight therapists were interviewed, 5 male therapists and 3 female therapists. Criteria for selection of therapists were that they were listed as ACC Sexual Abuse counsellors which was a convenient way of locating therapists with a high level of experience, working in the sexual abuse area. This list was available to the public. Therapists were sampled rather than the survivors themselves because the research questions in the present study are looking at how counsellors conceptualise and work with shame. No doubt further research with survivors themselves (who have undergone counselling) to discover their experiences and perceptions of shame and the healing process would be valuable additional research but is unfortunately beyond the scope of this project.

The range of therapeutic orientations and frameworks that influenced the therapeutic work of these respondents included cognitive-behavioural approaches, bioenergetics, psychodrama, post-traumatic stress disorder frameworks, narrative therapy, family systems therapy, client-centred/Rogerian therapy, psychodynamic and psychoanalytic schools of therapy. The majority of respondents held post-graduate degrees from a wide range of related disciplines, including Clinical and Community Psychology, Education, Social Work, Guidance and Counselling and Counselling Psychology. Five of the respondents were in private practise while the remaining three worked within social service agencies. The female therapists all worked mainly with children and adult women. Of the male therapists, only one didn't work with women (in sexual abuse work) while the others worked with a range of couples, adolescents, adults and groups. At least three of the male therapists had experienced working with perpetrators of abuse and one female therapist had worked with abusing mothers.

THEORETICAL SAMPLING

Within this sample active or theoretical sampling occurred within the interviews themselves as questions and topics, not anticipated, emerged out of the initial interviews shaping the nature of the questions in later interviews in line with emerging theory and conceptualisation. For example initial respondents introduced the concept of a spiritual or generational aspect to shame which then became a question put to future respondents for clarification and exploration.

PROCEDURE

10 potential participants were contacted by letter asking if they would like to participate in the present study. This letter was followed by a phone call and those who were willing made a time for their interview to take place. Of these, eight were interviewed.

THE INTERVIEW

The individual interviews were generally ninety minutes long, with the exception of one which was two hours long. During this time the respondents were asked to complete the informed consent form and a biographical sheet asking for brief background information on their training, experience and therapeutic orientation (see Appendix). Following this the audio-taped part of the interview began. The counsellors were presented with two case studies of "John" and "Jamie" (see Appendix) which provided an initial context for how the counsellors might engage in the research inquiry, guiding and stimulating their thoughts regarding shame issues and counselling process. The active interview is guided by the research agenda of the interviewer, accordingly the interviewer used a set of questions in an advisory capacity rather than in the form of a standardised questionnaire, serving to orientate but not restrict conversation topics. As explained the theoretical sampling procedure means that at times the interview guide was abandoned as other lines of inquiry came up for exploration.

PARTICIPATION OF THE RESEARCHER

My participation was diverse from asking questions which directed the respondents to general subject matter, to clarification of meaning, to adding comments to respondents narratives which encouraged them to elaborate and communicated mutual interest and sensitivity to the subject matter, all of which took place quite naturally. Having some active knowledge of many recent counselling theoretical schools, knowledge of professional issues and awareness, both academic and experiential, of the dynamics in the counselling process and the counselling relationship provided the researcher with a foundation which allowed me to explore and track respondents narratives into deeper conceptual realms. Having studied in both academic psychological and counselling settings has given me a multidisciplinary grounding which increases the likelihood of being theoretically sensitive to the data.

TRANSCRIPTS

Transcription of interviews started as soon as the interviews were under way. The interviews were largely transcribed word-for-word except for conversation not relevant to the research. Transcripts, once completed, were posted back to the respondents to allow them to change, clarify or retract anything they felt was necessary. Transcription and data analysis, as is appropriate in grounded theory, was a side-by-side process. The audio tapes of the interviews were listened to comprehensively in order for the researcher to catch the tone of voice, the flow of conversation which is not represented in a transcript in order to enhance sensitivity to the data.

METHODOLOGY

QUALITATIVE RESEARCH

The qualitative method arose largely out of the disciplines of sociology, anthropology and other social sciences, quantitative research being criticised for "squeezing the meaning" out of sociological concepts by operationalizing those concepts into quantitative indices (Hammersley, 1989). Qualitative researchers reject the positivist philosophy that knowledge is 'out there', 'facts' existing free of interpretation. The positivist stance is a refinement of empiricism, taking the ontological position that we have transparent access to a reality that exists independently, aspects of which can be broken down into variables and processes, isolated, controlled and studied, even out of context and yet preserve their properties, and which are related generally in a cause and effect, linear manner (Packer, 1985). On the contrary qualitative researchers hold that reality is in fact socially constructed and multi-layered, enabling many "realities" to exist at once as they are influenced by cultural, social and historical factors (Hammersley, 1989; Packer, 1985; Patton, 1990; Gergen, 1985).

Another important position of the qualitative researcher is that of who is the 'knower' and what is their relationship to what is 'known'. Because the positivist paradigm holds that knowledge is 'out there' in observable hard facts they believe it is possible to separate the knowledge from the knower, the observed from the observer. Qualitative paradigms refuse to separate the 'knower' from the known, the subject from the object, hence an understanding and awareness of context is primary and vital (Packer, 1985; Gergen, 1985). The qualitative researchers role is to gain a holistic (integrated) overview of the context under study as well as trying to capture the perceptions of participants in a rich "thick descriptive" way, aiming for empathetic understanding -or verstehen, rather than the traditional positivistic methods which aim to measure, control and predict (Hamid, 1995). Critics of quantitative research claim that its commitment to a research method modelled on that of the natural sciences

neglects the distinct nature of the social world. Human behaviour is complex and fluid, not restricted to fixed patterns and it is argued that mere quantitative observation will miss the individual meanings subjects ascribe to action and behaviour, information vital to true understanding and 'knowledge' (Packer, 1985). Accordingly qualitative research is often classified as naturalistic, the researcher attempts to understand 'real-world' situations with as little intervention as possible into that world in order to preserve the real life context they believe is so significant, understanding"naturally occurring phenomena in their naturally occurring state" (Patton, 1990, p41). Glaser & Strauss (1967) state that both qualitative and quantitative forms of data are necessary and valid, both are useful for theory generation and verification. These theorists insist in fact that the validity of our 'scientific knowledge' is increased by the side by side investigative methodologies where theory is induced from data and hypotheses are verified by data, richer detail is prided by the linking of qualitative and quantitative data. Within qualitative research there is much variety in methodological approaches including feminist theory, post-positivism and constructivism. The present study employs a grounded theory method of analysis.

GROUNDED THEORY

Grounded theory is a methodology which aims at developing an inductively derived theory of a phenomenon which is grounded in the data. It is described as "a general methodology for developing theory that is grounded in data systematically gathered and analysed" (Strauss & Corbin, 1994, p273). The method involves the use of techniques for analysing data referred to as theoretical coding and follows a rigour of constant comparison, where each piece of data on a phenomena is compared with all other pieces of data for similarities and differences in meaning. This method is then ideal for core theory development, the aim of the present study, allowing the researcher to investigate what is actually occurring in the world of sexual abuse counselling, paying great attention to context, meanings and complexities of relationship as opposed to verifying a preconceived theory. The qualitative

paradigm holds that theory generation is also a socially-constructive process, concepts and hypotheses do not exist ready-made in reality (Gergen, 1985).

Grounded theory's emphasis is on discovery, not verification of theory (Glaser, 1992). It allows for rich description of data, so the complexity of data, of relationships, is able to be explored through the constant comparison procedure where the data is theoretically processed. Grounded theory produces many conceptual relationships and is concerned with the discovery process, in changes in patterns of action/interaction from changes in contextual factors and in changes in conditions outside the process (Strauss & Corbin, 1994). Glaser (1992) argues against the use of grounded theory methodology for the verification of theory claiming that it is a generational methodology, the conceptual hypotheses being "probability statements not verified facts". Another important concept in grounded theory is that of theoretical sampling. The concepts and ideas initially emerging from early data analysis of initial data provides the basis for subsequent data collection. It does not refer to the sampling of particular subject groups but rather the sampling of particular incidents relevant to emerging theory (Glaser, 1992). Becker (1993) states that theoretical sampling is essential to the inductive-deductive process of grounded theory.

DATA ANALYSIS

The aim of grounded theory's analytic procedures is to meet the rigour of 'good science' and allow for the development of a "rich descriptive theoretical framework of loosely interwoven concepts" (Strauss & Corbin, 1990, p57). Two general types of codes exist in grounded theory, substantive and theoretical codes. Theoretical codes enable theory generation by allowing the researcher to see the data and concepts in new ways. They conceptualise how the substantive codes may relate to each other, being integrated into emerging theory as hypotheses (Glaser, 1992). Analysis involves three types of coding procedures; open, axial and selective coding and data collection and analysis is a parallel process as analysis directs the data sampling. The first stage of data analysis involves open coding, data is

conceptualised, broken down as a word, sentence, idea or phrase is representative of a phenomenon - these are labelled in ways which conceptualize, not summarize the data. As this process develops groups of labels which refer to similar phenomena are categorised although these categories are still loose as relationships are provisional, modified and adjusted as the comparison process continues (Strauss & Corbin, 1990). The general characteristics of a phenomena are termed its properties and dimensions refer to the continuum an individual case can be located on. Categories are developed in terms of their properties and the dimensions of those properties.

Axial coding involves procedures which make connections between the categories developed during open coding, based on a coding paradigm which includes specifying the conditions in which a phenomena occurs, the context or "specific set of properties that pertain to a phenomenon" (Strauss & Corbin, 1990, p101), the action/interactional strategies which manage or handle a phenomenon and the consequences of those strategies. These are termed subcategories and are linked to a category in a set of relationships in a paradigm **model:**

(A) CAUSAL CONDITIONS ----> (B) PHENOMENON ---> (C) CONTEXT ---> (D) INTERVENING CONDITIONS ---> (E) ACTION/INTERACTION STRATEGIES ---> (F) CONSEQUENCES

(Strauss & Corbin, 1990, p99).

The paradigm model provides an aid to organizing data in a systematic way which allows the theory to be represented. The axial coding process involves both inductive and deductive reasoning as questions are asked and comparisons made.

The final stage of coding is selective coding. At this stage the core category for the paradigm model is selected and related systematically to the other categories. This category must be central in order to be related to as many other categories, it must appear frequently in the data, being easily recognised and give the sense of the research moving forward as it develops as a core category.

Theoretical sensitivity is important to research outcomes and refers to a personal quality of the researcher, who needs to have insight, creativity, the ability to give meaning to the data, the capacity to understand and the capability of discerning what is vital from what isn't (Strauss & Corbin, 1990). Glaser (1992) defines theoretical sensitivity as "the ability to generate concepts from data and to relate them according to normal models of theory" p27. Without theoretical sensitivity Glaser adds that one will end up with a combination of preconceived conceptual description and empirical description but not grounded theory. Theoretical sensitivity comes from various sources; literature, professional experience and personal experience as well as from the analytic process itself - one's sensitivity to the phenomenon increases as the data is continually interacted with (Strauss & Corbin, 1990). Respondents being interviewed within the qualitative paradigm are not viewed as stores of knowledge waiting to be tapped but rather as co-constructors of knowledge in collaboration with the interviewer. Therefore the interview is seen as an active meaning-making process (Holstein & Gubrium, 1995). Kvale (1988) refers to the "co-authoring" of data rather than "data collection" to capture the active nature of the qualitative interview. It is advantageous to the research for interviewers to be familiar with the cultural context, vocabulary and practical circumstances which respondents may link to and draw from as a way of shaping awareness as well as understanding the perspectives and interpretations respondents may have (Holstein & Gubrium, 1995).

ASSESSMENT OF GROUNDED THEORY RESEARCH

Strauss & Corbin (1990) outline the issues in assessment of research which purports to generate theory as including the issues of validity, reliability and credibility of data, the adequacy of the research process, and the empirical grounding of findings. In the construction and assessment of a grounded theory it is required that a theory must fit the data it proposes to represent and it must account for the variability within the data. Data must not be forced or selected to fit preconceived categories or ignored in order to keep an existing

theory intact. Grounded theory requires that a theory be grounded in the data, generated systematically from the data with new data and ideas having the potential to modify emerging theory (Glaser, 1992). Relevance, workability and the possibility for modification are further qualities necessary in a theory along with face validity, that is, a theory must seem plausible, believable, comprehensive and account for most of the data. Finally a theory must be applicable, lead to hypotheses and additional investigations. In terms of grounded theory it is necessary that categories emerge from the data, are systematically related, well-developed and have conceptual density which gives the theory its explanatory power (Strauss & Corbin, 1990).

CHAPTER FOUR
DATA ANALYSIS

The aim of this research was to identify core factors in the process of healing shame in adult survivors of sexual abuse. These core factors were to be identified through analysis of data collected from therapists operating from different theoretical orientations, discussing their approaches to therapy and their conceptualisations of the factors involved in that process. From this, a grounded theory of core factors in the healing process was to be derived. This analysis, in line with grounded theory, is grounded in the data. The concepts have come from within the data and no concept or category that is included in the theory has been imposed on the data, rather the data has been interpreted according to the researchers' conceptualisation of what the respondents were revealing.

The data was carefully scrutinised during the coding process, each "piece" of data being compared and contrasted against other "pieces" of data until substantive codes were established. These codes came quickly and phenomena were identified throughout the data. Theoretical sampling enabled more data to be gathered on phenomena which emerged during the initial coding of the first transcripts, and therefore a greater depth of understanding of phenomena has been gained.

The data fell into distinct areas of phenomena; respondents talked about their part in the counselling process, the work of the client, and the actual process itself. As respondents described the healing process, categories began to emerge which contained similar phenomena, despite differences in the strategies therapists used. The categories, as analysis and theoretical sampling continued, were refined by asking questions and the method of constant comparison. These categories seemed to encapsulate the core factors in the process of healing shame.

The core category emerging from the conceptual analysis is the process of **negotiating meanings.** This category was of a higher order than the other categories and,

as is required of a core category, all other categories were related to it. This process was seen to be an integral part of both the development of shame and the process of healing from it. The core conceptualisation respondents had of shame development was that it was the result of the meanings and learnings (or messages) the person has taken from the abuse experience and its context. The predominant meaning taken was one of personal responsibility for the abuse and/or the meaning/belief that one was different, soiled, defective as a consequence of the abuse.

Results of the data analysis are presented in sections. The findings regarding the respondents' views of shame development will be presented first and then the theory of the healing process. Finally the core category will be addressed. It is hoped that greater clarity will be achieved by presenting findings in this order. The conceptualisation of the development and nature of shame informs the therapeutic work of respondents and provides an introduction to the core category. Once again, the results presented here are grounded in the data. Concepts not found in the data were not able to be included, no matter how relevant they may have seemed.

Shame in Adult Survivors of Sexual Abuse

Overview
The abuse event
-demographical features
-the childs experience
Meaning-making
Contextual influences on negotiated meanings
-developmental
-societal
-familial
Consequences of the shame
Mediating events
-disclosure
-further victimisation
-therapy

The pre-condition for the development of shame in adult survivors of sexual abuse (ASSA) is the **abuse event** itself, according to the therapists interviewed. Respondents provided data on the nature of the abuse event and the different dynamics which provide conditions for shame development.

Within this category "the abuse event", are two sub-categories; the **demographical features** of the abuse, and the **childs experience** of the abuse. Properties of the demographic category, and the dimensions of those properties include; the nature of the abuse (violent-nonviolent), the relationship to the abuser (close-distant), and the use of rewards (many-few). This sub-category was found to have causal links to the next sub-category (childs experience) as its' features determine to a greater extent what the experience of the child may be. The properties of the **childs experience** found in the data include powerlessness, ambivalence, degradation and sexual pleasure. (This is not an exhaustive list of the properties of a childs experience of sexual abuse but includes merely those properties seen by respondents to be relevant to shame).

Demographical features

The nature of the abuse

The data suggests that respondents viewed the type of abuse (violent/fearful - non-violent/manipulative) as influencing the childs experience of that abuse, which affected shame development. Where the abuse was less violent and where the child was close to the perpetrator, the child was more likely to be ambivalent about the abuse and therefore may take greater responsibility upon themselves for the event. This sense of responsibility was found to be a key component, related directly to shame. Where the abuse was more violent and degrading, the child may take less responsibility (although not necessarily) but experience a greater sense of powerlessness. Shame may also come from the child feeling degraded, powerless and sub-standard as a consequence of the abuse event.

> **Jenny,** *"Some peoples' abuse experience is only painful and disgusting, other peoples has an element of sexual pleasure in it and that is something that I think causes them tension when they reflect on it... There's real stand-over abuse, violent, thoroughly impositional stuff and there's also a more sweet syrupy version, you know, "I'll be nice to you and I'll tickle you and it will feel good", and maybe it does "*
>
> **Diane,** *"If it's not sort of violent and full of fear, then they are very open to that person, and if their bodies are being seduced then their bodies are very open, so I believe that they have got few defenses against that shame...[Jamie's] got a deep bond, probably it's her only bond with a male, never mind that it's sexual and very damaging"*
>
> **Jenny,** *"Shame is related to...the ways a person catches themselves thinking or feeling now and considers that to be loathsome and bad...parts of the persons life that they feel are sub-standard, "*

The relationship to the abuser

The relationship to the abuser appears to be significant to shame development because it affects the ambivalence a child may feel about the abuse (see ambivalence section below). It also affects the degree of responsibility the child may take on - if the perpetrator was known to the child and the family, and is viewed by the family to be good, the child may blame themselves for the abuse experience in order to reconcile their contrary experience with the perpetrator. The relationship with the abuser affects the impact of the abuse because, where the abuser is a family member or care-giver there is a lack of the appropriate loving relationships and role-models a child needs. (see also "abuse context" below)

> **Grant,** *"Rather than being sources of love and inspiration and motivation and caring, her grandfather abused her..."*
>
> **David,** *"Jamie is held into a place where there is not much contradictory information anyway, there is no other loving relationship to be an alternative, so that's going to greatly contribute to her being in a place where the only message she can take is one of deep shame."*
>
> **Jenny**, *"May be the kind of relationship the person has generally with the victim is [what is] really relevant, if they are someone who has a lot of care responsibility for them, there is more betrayal than if it's a babysitter or a stranger where it is less binding emotionally, it's just an event to deal with."*
>
> **John,** *"I suppose it comes down to exactly what was the relationship like with the abuser at the time, was this a distant remote figure...or someone that Jamie felt very close to and trusted."*

The Childs Experience

Degradation

Grant, *"The victim experiences the whole act as bad...and shame is associated with the badness of the experience and the feeling of responsibility for that badness."*

Doug, *"The person has been degraded in themselves, ...and they have formed impressions and taken on in fact, some of what has been communicated to them in the degradation, they'll feel, I think a sense of being lowered in their own sense of who they are as a person. That kind of degradation happens."*

Tony, *"The perpetrator often verbally abuses them, holds them responsible for why they are being abused, vilifies them verbally, might humiliate them with a number of humiliating acts they do to the victim or that they may require the victim to do towards the perpetrator ...all of those are obvious sources of shame."*

Powerlessness

Tony, *"[victims may] hold themselves unfairly to blame, both as the cause of what's happened to them, and as a reason for not being able to deal with what happened to them because they were rendered helpless...the reason for shame is that whenever people bring up those issues they're really saying, at least to themselves, that they had far more control in the situation than they actually did"*

Ambivalence

As mentioned above, the nature of the abuse seems to influence the development of shame, due to its effects on feelings of ambivalence the child may experience and the meanings they may make about why they felt ambivalent. The key phenomena found to contribute to ambivalence are the context of abuse, the presence of rewards and sexual pleasure.

<u>The Abuse Context</u>

Diane, *"Children that get sexually abused are often previously neglected children,*

so that when they get this attention, this is very, very powerful because it's against a context of neglect. So the children get very, very powerfully drawn because they need to belong and feel special, that's a basic human need."

Diane explains how the context of the abuse influences the childs' experience of that abuse. For those children who come from a context of neglect, the abusive relationship may be the only way to get some of their basic emotional (or even physical) needs met. Therefore the child experiences ambivalence about the relationship, causing the child to doubt themselves and therefore their responsibility (wholly or in part) for the abuse.

Rewards

Rewards function in a similar way to the abuse context variables, the child may receive gifts and special treatment from the abuser, which the child may enjoy, causing confusion and ambivalence in the child.

Jenny, *"There's sexual abuse relationships that are set up entirely out of fear, but often there's a strand of attention and gifts and so on, that has been seen positively in some way, by the person (who we would call the victim) and when they reflect back on that they wonder if they were guilty of having contracted into that."*

Sexual pleasure

Sexual pleasure was considered to be very significant to the development of shame by all respondents. A child, not knowing the physiology of their own body, experiences some pleasure and concludes that they must have wanted the abuse after all. This is often exploited by the abuser who offers the same explanation.

Doug *"Depending on how the abuse took place, if the abuse was not physically painful and was done in a way that the child may have been confused over their own feelings, there may have been actually some tactile pleasure in it, and there is another kind of shame that comes from feeling that kind of pleasure, like "if this is so yucky and so wrong, then I shouldn't be feeling this, why is my body feeling good*

about it?"

Diane *"the adult [abuser] often feels full of shame and disgust towards themselves but in fact, rarely owns that and projects that on to the child...because [the child] is open they often absorb that...but there is kind of a little trick in that as well in that, often the child has felt pleasure themselves at some stage in the sexual abuse, then it's as if that pleasure is the childs proof to themselves that all that's being said here is true"*

Jenny *"There is also an issue about any sexual pleasure that may have occurred in the abuse act themselves. These are not things you can say are always there, because every situation is different and some peoples' abuse experience is only painful and disgusting, but other peoples' has an element of sexual pleasure in it and that is something that I think causes them tension when they reflect on it"*

John, *"I've come across males who have had sexual reactions or physical responses whilst being abused and at times the shame might be around that. [There's] not only the suggestion that they caused or didn't stop this thing from happening but if they had a physical reaction then that somehow means that it wasn't abuse, that they were enjoying what took place."*

Meaning-Making

The next significant aspect in the respondents conceptualisations of shame development involves the process of survivors making their experiences meaningful. The respondents talked about the "messages" the child received during the abuse, and the "meanings" they made of these messages. According to the data, it was in this way that respondents largely understood the link between the abuse and shame. The abuse event and the childs experience of it become **experiential learnings** which go on to be processed and made meaningful. This category grew, during the coding process to become the core category, **negotiating meanings**.

Diane, *"There is no doubt about it, every person I have ever worked with if they have been abused, they just decide that they are bad, and I've come to the conclusion that that is the least painful approach to take, "that I am bad", otherwise...that's kind of bearable, "I'm getting abused because I'm bad", and that sort of becomes manageable, if I am getting abused and I'm not bad, and I don't deserve it, there's too much pain for one little body to take on board and I think a child just gets overwhelmed."*

John, *"[Shame] seems to come up most frequently when the person has got doubts about how the abuse happened and in particular, believes themselves to have been responsible in some way for what took place"*

In the case of shame, the abuse experience is interpreted as being shameful on the basis of both the experiential learnings from the abuse event and pre-existing experiential learnings. The data suggests two key learnings may come from the experience; "I am responsible for this shameful event" or the learning that "I am shameful because I experienced sexual abuse, I am defective, different to others".

John infers this learning in this statement,

"...if the shame is based on some belief that they caused the abuse to happen to them, then that's what I'd see as really unhelpful and unhealthy for the person."

Grant, *"Everyone who has been victimised, in my experience, experiences some degree of shame and the shame is usually imparted by the person who abuses. Like "you shouldn't tell, don't tell anyone" which immediately places the responsibility for the "sin" on the victim..."don't you tell anyone or you'll be in big trouble" or "it's because you did this that I did it", it's an elevating or shifting of responsibility for the behaviour onto the victim...experienced as being very shameful."*

Contextual Influences on Negotiated Meanings

The process of shame development, as found in the data, involves the learnings being processed in the context of (what I have termed as) **existing experiential learnings.** The sources of **experiential learnings** include societal influences, cultural influences, learnings from personal history and familial learnings. Meanings are therefore "negotiated"; the current experience being weighed against existing experiential learnings. Respondents saw shame development as being greatly influenced by a number of these contextual factors. The Developmental context of the child.

The childs developmental stage affects their ability to reason and whether they can in fact hold to some of the painful conclusions (or meanings) they must draw from the abuse. **David** explains;

> *"A child cannot envisage that someone who has all importance to them (maybe a parent or someone who is meant to care for them, someone who is really significant in their life, on who they are really dependent for almost all of their needs), cannot envisage that that person would be doing something wrong for them. So, the only way of giving it meaning is to say 'there must be something wrong with me', so the child internalizes the belief that there is something wrong with them rather than saying there is something wrong with how this person is acting."*

Societal Context

Tony refers to the influence of society on an individuals' existing experiential learnings and the meanings they may take from these learnings.

> **Tony** *"There is shame related to a different type of dynamic, where the reactions of other people towards the victim...makes them feel in part as though they are soiled, second-hand goods, and there are cultural and social issues that pertain to that because in some societies such a person could be blamed, stoned or expelled, ridiculed or even shamed out of their social fabric and environment..."*

The Familial context

The family environment and history influences the process of negotiating meanings and shame development.

> **Theo,** *"If she's [Jamie:case study] lonely and isolated it means she's not having good relationships. Dads not around anyway, so Dad left, I mean that might be bad enough. She might feel shame about that, she may have assumed or have got some messages that somehow he left because she was not a good enough little girl...there is something not happening in the mother-daughter relationship and she may be feeling issues around shame in relation to her mother and I'd want to explore that..."*

David also refers to the impact of the familial context on shame development;

> *"Shame is almost given a legacy...there's no way of relating deeply mother to daughter, social relationships poor...even in the very early stages of her life there's probably a sense that already Jamie has shame, like 'what's wrong with me, why can't my mother deeply hold me, bond to me?', before this even happens I'd say shame already has a life of it's own. Then comes the events of a person ...giving love, or what seems to Jamie [to be] at least more attention, perhaps, than she has ever had. So that would multiply shame exponentially."*

The context of the child therefore greatly influences the development of shame. Experiential learnings from these contexts provide the basis for interpreting and making meaning out of subsequent events and learnings.

The Consequences of Shame

The Shamed Self

These learnings are **negotiated** into meanings. The learning: "I am responsible for this shameful event", once negotiated, becomes internalised into the self-concept as the **negotiated meaning**: "I am responsible for this shameful event, therefore I am a shameful

person". This shamed self-concept becomes the reference point determining how the person should and will act.

> **Doug,** *"[Shame] has got to be reinforced. You see, once you get that going, and it becomes part of one's own self-concept and way of seeing the world, it's self-sustaining. Everything that's done then reinforces it."*

Respondents made a connection between shame and the self identity, as opposed to the concept of guilt. The childs' identity becomes negative, they feel they have no positive value.

> **Diane,** *"I would tend to use the word "shame" about things about the person as a whole and I would tend to look at "guilt" more about things the person has done and behaviours they take responsibility for. I see shame as more about the person as a whole."*
>
> **Theo,** *"Shame comes from an experience of something that is done to you, and it is at a very core level because it is an attack ...on a persons' sense of self...sexual abuse in an attack on the very core of a person...and it creates a sense of not having a right to exist, a sense of worthlessness...which is different from guilt which I think has more to do with an action that you may have done."*
>
> **Doug,** *"Shame is when you hate yourself, when you judge yourself."*
>
> **Grant,** *" Shame; a feeling of being totally bad, having a very negative value"*

Shame was conceptualised by many of the respondents as functioning to continue the abusive attack on the self that occurred during the sexual abuse. **Doug** understands many of the symptoms that occur in adult survivors to be stemming from the conflict that occurs between the shamed self identity and the part (or side) of the person which has more positive characteristics. He explains that the shamed self may function in a manner similar to that of the victims perpetrator.

> *"...the other side which has been kind of conditioned in from the abuse and which*

is the side that really is kind of like a "not-self" side. This compulsively acts out the problem of the perpetrator. Many of the issues, such as the symptoms that arise out of that, like depression, anxiety, self-mutilation, compulsive behaviour, perhaps borderline personality...they are all stemming from that initial conflict."

David, *"The sense of almost being separated from their self...having a non-integrated personality, so they have two distinct sides, both roles in a way, rather than being an integrated whole kind of personality."*

Doug talks about his work with victims who had become abusers,

"We were talking about it as kind of a psychological virus. A virus that somehow is taken on by the victim from the perpetrator...they took on, somehow, the characteristics of the perpetrator...Many of them recognised that they had created almost a false identity."

Diane, *"...she's kind of joined her abusers...she's very angry, she's not actually in touch with her shame, it's like she's building shame upon shame and not actually feeling it, she's actually defending with anger...her anger is covering the shame, she's not actually in touch with the shame at all"*

Another consequence illustrated by these quotes is the avoidance of shame. This is thought to result in acting-out behaviours such as anger, promiscuity, sexual encounters with strangers, and self-mutilation as well as interpersonal difficulties.

Grant, *"Shame can be at the bottom of all kinds of things, self-destructive behaviours, that stop people acknowledging that it is there...promiscuity can elicit shameful feelings but in the same sense it can bury shameful feelings, so people can get into highly sexualized relationships with others as a way to avoid shame. The avoidances of shame are multiple...the ways people avoid shame are many."*

David, *"There is a sense of anxiety, of unsureness, of how to respond in*

relationships because they see themselves as a two-sided character in a way, one that seems nice and one that seems not..."

Theo, *"Shame is going to contribute to her inability to form good relationships, she's not going to be able to do that, she just hates herself, and then not doing that adds to it because she's more isolated and alone and it's like the whole thing just keeps on building on top of itself."*

Grant, *"I would expect [Jamie to have] some degree of anger and resentment towards children of probably around the age of four years old onwards, just from the straight projective identification on a child, male or female."*

Theo, *"I think self-mutilation is associated with shame in that often people feel so bad that they are willing to hurt themselves, or they feel so bad they have cut off so much, that they want to cut themselves so they can feel things again."*

Grant, *"The self-mutilating...there is some part of her that wants to hurt herself, probably because she feels so bad, she's such a bad person, the shame element would be there..."*

Mediating Events

Disclosure

Results suggest that whether the child discloses or not, and the consequences of disclosure attempts can affect meaning outcomes, in either a positive or negative direction.

Diane, *"There's a shame that comes out of the sexual abuse incident but there's probably a more serious shame coming from her mother that she is not good enough to be listened to...a message from her mother is more difficult because it is implicit, it's easier to work the shame that comes in words."*

John, *"It looks like Jamie tried to disclose the abuse to her mother and it says that those attempts were not successful, so that would be a time when shame may have*

come in to it, perhaps there weren't any other significant people (like Jamies father) listening to her or taking her seriously, or believing Jamie and I suppose that can start that shame process off."

David, *"I think that shame can be minimised (I don't know if it can be totally taken away)...if a person hears, if the mother had listened and responded, and heard and been angry and had taken steps to break the secret of the grandfather..."*

Further Victimisation

Experiencing further victimisation from different perpetrators was found to be a factor that contributes to the child believing that they were responsible for the abuse events, which contributes to the negotiated meaning that they are shameful and bad as a person.

John, *"I think having already been the victim of abuse and then having further abuse occur, unless that has been dealt with therapeutically the danger is that any shame that was already there would be doubled up on, if you like, by further abuse. It may raise the question 'was there something about me that caused this abuse to happen?'"*

Theo, *"I think having sexual abuse repeat itself in the teenage years...if those very same things get reinforced at all these different developmental stages then as a child, because she still a child she is going to say, 'What does this say about me?', so there are more shaming experiences added on to earlier ones."*

Therapy

Respondents had mixed responses to the question of how therapy may benefit the child (in this case, Jamie/John) and how that would effect the development of shame. Under conditions where the abuse stopped and therapy was of a good standard, most respondents acknowledged a decrease in symptoms and negative behaviours could be expected. Therapy at this stage may also have meant the negative behaviour patterns and coping strategies would not become so entrenched and therefore may be easier to address. There may be a greater chance of the child achieving the normal developmental tasks with the assistance of

the therapist' and the chance that the "shamed self" would not develop as the major identity.

> **Tony**, *"I think it would make a major difference in that you would have better access to the event itself, better ability to put the person on track for proper development in terms of achieving milestones"*
>
> **Doug**, *"By getting the child to deal with it closer to the actual event, it is less likely the behaviours will become entrenched, reinforced over time, to help develop new strategies and new defenses and new kinds of ways of expressing it...in time it does become more difficult"*

A number of respondents stated that therapy would only be progressive if the whole family was part of therapy and if the consequences of therapy and disclosure were for the child to be in a safer situation.

> **Jenny**, *"Counselling might help but it depends on the care situation of the child. If the family context is not addressed and there is little adult support there may be little help for the child. You can't set up children to lead their families to mental health. If the mother went first for example, and then the child, perhaps layers of shame-inducing events could have been avoided..."*
>
> **Grant**, *" To work with a child who is in an abusive system is a waste of resources for everyone. Unless the child is removed from the abuse system any intervention is likely to exacerbate the problem, not only will the child know that they are in a sick place and being ill-treated, they'll know that they are sick, they will be labelled and identified as the problem....Interventions that don't offer the child some real support are not progressive...Often removing the child from the situation is equally unprogressive...often the abuse they have experienced in the hands of the foster home is significantly worse than they were getting at home."*
>
> **Theo**, *"I don't believe in kids going to therapy unless they are in a really bad state.*

I think the family is the place in which healing should take place, so I would say no, the whole family has to go...and face up to the abuse...I think to send a kid to therapy makes it their problem..."

Readiness was an issue raised by two respondents which they saw as affecting the outcome of therapy at this stage. Respondents did not generally see therapy as being able to totally prevent difficulties from occurring in adulthood.

John, *"I don't think that it would have entirely eradicated all of those effects but made them maybe not as severe".*

David, *"My first thought would be to say yes, it would have an enormous advantageous impact, however there's part of me that also says...that we change when there is a right timing too...sometimes we do need to reach 26...and at ten we might not have been ready despite the best therapy and the best therapists in the world".*

Doug, *"Sometimes people are not ready, sometimes it takes them until they are 26, or 28 or 32 to kind of be ready to face up to it. They may have thought they needed to but pushed it away or dealt with it in the best way they could..."*

Summary of Results

Respondents viewed shame as being an initial response to the abuse event, the consequence of the child experiencing degradation, powerlessness and ambivalence. Respondents saw the child as going on to make meaning of the abuse, drawing on learnings from many contexts (including cultural/societal, familial, developmental and personal/historical) to process the experience. Where the child experienced ambivalence around the abuse (influenced by factors such as the abuse context, sexual pleasure and rewards), the child may take greater responsibility for the abuse, causing them to feel guilt and shame. Shame may also come from the child concluding that they are damaged and defective as a result of the abuse.

When this is internalised into the self-concept, the child views themselves as shameful. As a result the child may develop a number of coping strategies and symptoms, thereby continuing the abuse against themselves, defending against the shame with compulsive behaviours and anger which further perpetuates the shamed self-view. This process was mediated by particular events. That is, certain events were seen to affect the process of meaning-making by influencing the child towards a particular conclusion. The mediating events found in this study included disclosure and the response to it, further victimisation and therapy. (Refer also to **Figure One**, page 105 for an overview of findings.)

CHAPTER FIVE

Negotiating Meanings: A Grounded Theory of Core Factors in Healing Shame in Adult Survivors of Sexual Abuse

Chapter Overview
The Healing Process: Core Factors across orientations
Creating a Context for Change:
-developing trust
-building a positive sense of self
Facing the Shamed Self
Contextualisation
Integration
Speed of Healing Process
The Core Category

The core category emerging from the data analysis is the process of **negotiating meanings.** This core category was found to be present in both the conceptualisations of the development of shame and the process of healing from it. (In the healing process this is conceptualised as **re-negotiating** the meanings the survivor has developed as a consequence of the abuse experience. The core factors discovered amongst the work of respondents were found to encapsulate the process of re-negotiating meanings. This category captures the core factors in the process of healing from shame as found in the data. The following selective codes are the phases in the process of re-negotiating meanings: **Creating a context for change; Facing the shamed self; Contextualisation** and **Integration.** Although the degree to which therapists emphasised these categories varied, elements of these categories were present in the work of each respondent. The following chapters provide an in depth look at the analysis and the formation of these categories. **Table One**, page 104, provides an overview of these findings.

Creating a Context for Change:

Developing Trust and Building a positive sense of self

Two categories made up this part of the therapeutic process, that of **developing trust** in the relationship and **building a positive sense of self** in the client. Although these categories involved the use of different therapeutic strategies, they both appear to be vital in creating the context for the healing of shame. Respondents suggested that trust must be developed first in order for a sense of positive self to be built and that failure to develop trust would halt the healing process. These categories will now be discussed in detail.

Development of Trust in the Client-Therapist Relationship

Substantive Codes:

Therapist Characteristics

*philosophy of the client and of the therapeutic process
*personal values and openness to difference
*training and experience

Practices within the relationship

*boundary setting
*role-taking
*empathic listening
*acceptance of the clients experiences, view and defenses
*encouragement
*maintenance of confidentiality
*support and guidance for addressing problem symptoms and behaviours
*respectful pacing

The properties of this category fell into two domains; that is characteristics the therapist needed to possess and practices carried out within the client-therapist relationship. Strategies for these properties were also identified.

Therapist Characteristics

The properties identified in the data which referred to characteristics of the therapist included the **philosophy of the client and of the therapeutic process, training and experience,** and **personal values and openness to difference**. The following quotes reveal the philosophy

of therapy and the healing process held by respondents, who seemed to value the therapeutic relationship over theories, models and techniques.

> **David,** *"Your personal relationship has got to mirror this deep sense of respect....The therapeutic approach is not the thing that can be totally relied upon. A therapeutic approach can be dangerous no matter what it is. When I lose that [respect], when I'm treating the other person as an object that I'm just using one model on, I think then I've become the perpetrator of abuse, I've objectified the person."*
>
> **John,** *"How that relationship goes may make a big difference to whether that person gets something out of it or actually subtly goes through either an unhelpful or perhaps even an abusive type experience...the issues of trust and pacing become very important."*
>
> **Theo,** *"I don't think the techniques are that important because it is about how this experience* [therapy] *is for the person, whether it is a healing experience or not and whatever you do, whether it's psychodrama or gestalt or bioenergetics, that's not the most important thing. I think it has much more to do with the way the relationship and the healing process is conducted, to face any of the awful things people have to face."*

All respondents stressed the importance of being non-judgmental in order that the client experience the relationship as safe and trustworthy, which was seen to be necessary for facilitating the healing process. This seemed to be particularly relevant in dealing with shame, where the client is judging themselves to be bad and defective already. Some respondents suggested that those therapists whose personal values and culture were very different from the experiences of the client, and who could not be open and accepting of those differences, would not be able to achieve this trust within the client-therapist relationship.

Jenny, *"I think it is really wrong to be heterosexist and monocultural because that shuts down dimensions of peoples shame that they might very well need to be exploring so all personal orientations are potential constraints and any therapeutic work that you do that reflects only that would be counter-productive"*

Another group of phenomena relevant to the characteristics of the therapist was that of **training** and **experience**. This was a category implied in the data. Many respondents spoke of doing things differently now as a result of experience. For example one respondent says;

"Catharsis as a goal is usually practised by less experienced people because it, and I identify this with myself, if somebody got into half a box of tissues worth of crying, that must have been good. But it didn't help people very much, not unless there was some integrative gain from it..."

David, *"I started to move on and search for other models [because] the kind of Laura Davis work didn't seem to work for me as well, it was like it did the very thing that the abuse seemed to do to people, make them into components. Encouraging them almost that you'll work through shame, that you'll work through this bit, that you'll identify broken dreams, all of which there is nothing wrong with, but it's sort of like it's compartmentalising."*

Implied here is the characteristic of the therapist having expertise as a result of **experience**. Through experience, therapists gained the ability to facilitate this process more effectively, by avoiding some practices and choosing others. In a similar way, the type of **training** one received was seen by respondents to affect the ability of the therapist to develop trust and facilitate the healing process. **Grant** says;

"People who have great shame issues have great shame at being labelled as having any kind of sickness, illness, whatever. Again it reinforces to them that they are bad, that there is something wrong with them, that they are no good. The whole psychiatric profession is based on the one-over power relationship with any

presenting person. The psychiatrist is the expert. I mean calling someone a patient for a start puts them in a one-down position. These processes do not help people grow in my experience."

Whilst this piece of data refers to therapist role within the client-therapist relationship (discussed below) it also implies that the training of therapist is important in developing the philosophy of the client and the way the therapist conceives of their role in therapy.

Practices within the Relationship

The respondents referred to a number of practices in the client-counsellor relationship which ensured that trust was established. **Boundary setting** involved the therapist outlining the way in which they might work with the client, their availability to the client and the way they saw their role. The strategy for doing this involved some form of contracting with the client. Many respondents questioned the acceptability of physical touch, with most of the respondents avoiding touch, especially across gender. This practice and the avoidance of personal disclosure on behalf of the therapist were practices which came under this heading.

Grant, *"Personal disclosure on my behalf is usually pretty useless...a lot of counsellors see their role of counselling as permission to sit there and tell people all about their lives and how well they've done and how they've got on with it, how well they overcame this and that, in my experience that doesn't help the client at all."*

Theo, *"I would ask the person where they think they would need to start because people will start with the thing they can most manage"*

David talks about gender issues when counselling women survivors, illustrating boundary setting.

"Just the fact that a man hearing their story and acting in a way that acknowledges their sexuality, but at the same time does not cross the boundary of it actually has a fundamental healing place.

Role-taking was a property seen as significant to the development of trust, with respondents

insisting that the therapist take a collaborative role of "facilitator" or "guide" to the clients process, as opposed to taking an "expert", "problem-solver" role. Strategies that supported this practice included giving permission and opportunity for the client to give feedback on the sessions. Feedback may be about the things the client found helpful or unhelpful about the work or how the therapist was approaching it. Using the words the client used to describe things, beginning with the client issue and contracting were also strategies supporting this practice of taking a collaborative role. Role-taking was also influenced by the therapist characteristics such as their philosophy of the therapeutic process.

Jenny, in talking about the obstacles to resolving shame, refers to outcomes of the role taken by the therapist;

> *"[The therapist] somehow losing the process and getting themselves, in my terms, in front of the client instead of being behind them. So in the way you have set it up they are looking to you to solve the problems, you've rendered yourself useless because the responsibility is all with you. The responsibility and the locus of power always has to be with the person and if you've somehow distorted that or lost the plot there then most likely they won't be experiencing counselling as very trustworthy because it might feel like badgering or cajoling or even judging, and that shuts people right up."*

> **David**, *"It's like what the parental role or what the grandfather relationship was meant to be, its sort of like a reparenting, a re-grandparenting, where the love, the respect is offered, which is what should have happened in the first place..."*

This piece of data illustrates role-taking, pacing and also illustrates a philosophy of the therapeutic process (that is, that the process must empower the client to be in control and responsible for their own healing, in order for that healing to occur).

Empathic listening involves hearing the things which are concerns and issues for the client and communicating those back to the client. Respondents spoke of the need to

"join" the client as they tell their story. **Tony** explains that he always begins with the issue the client brings and adds;

> *"the way a person tells his or her story is always important so therefore you don't want to ask too many questions, you want to empower them to talk, give them permission to talk...you've also got to work with the person in such a way that they believe you have joined them in their story, from where they are starting, although that's not necessarily where you want them to end up..."*

Along with hearing the clients story, the **acceptance of the clients experiences, view and defenses** was seen to be a significant aspect in establishing trust with every respondent stressing the need for the therapist to withhold their judgement of the client.

Jenny speaks of this need for the therapist to be accepting of the client, despite what is presented;

> *"to be open enough as a person to be ready and able to hear things quite outside my experience...they might be pretty hard to hear"*

Grant describes the therapeutic relationship as needing to be "*a loving, open and equal process.*"

Encouragement of client in regard to the therapeutic process and of their progress was perceived to be part of developing trust and building rapport with the client. **Doug** refers to the practice of encouragement during the initial phases of therapy;

> *"Usually I'll start with just developing the therapeutic relationship, I want the person to feel okay about talking about things with me, that I am going to be accepting, not judgmental. I want the person to start to look at and be encouraged about the nature of healing. From this we talk about more as the person discloses more and I'll start to use more techniques..."*

Tony, *"There is the fear and the doubt and even in a sense, shame, that one can [change and heal]...that really needs an awful lot of empowering of the victim to try*

and help them to see that the task is not impossible or hopeless".

Maintenance of confidentiality. This was a professional practice which was not stated outright but implied in the behaviour of the respondents during interviews. They were careful not to disclose personal details or any features that may identify any of the clients they have worked with during discussions. I have chosen to include this practice under the "Development of Trust" category, because it seems to be part of creating a safe environment for the client that is necessary for healing.

Support and guidance for addressing problem symptoms and behaviours was seen to be important in order that the therapeutic process is seen to be helpful for the client and in order for them to collaborate with the process. This is placed under the "Development of Trust" category, as it appeared that by addressing distressing symptoms and experiencing some relief from these symptoms, the client was more able to trust the therapeutic process and to trust in the competency of the therapist. Therapists who used Trauma frameworks, Post Traumatic Stress Disorder frameworks and cognitive therapies emphasized this practice, in this initial phase, more than other respondents.

Respectful pacing of the process was a practice mentioned throughout the data. Here the need for the therapist to be mindful of client readiness before approaching the painful aspects of the abuse and to be wary of pushing the client to face things too soon was emphasized.

> **Jenny,** *"Developing a trust in a therapeutic context, never being judgmental, and without that you could never have the next thing which would be saying the things that originally seemed to be unsayable."*

Outcomes

The outcomes of successfully moving through this phase of the therapeutic process were thought to be the development of trust between the client and the therapist, which means that disclosure on a deeper level was more likely to occur and that clients would have a greater

degree of committment to the therapeutic work. Disclosure on deeper levels is necessary in order that the survivor be able to face the shame and make the various links necessary in the later stages of therapy. Committment to the work was also vital, in order that the survivor endure the more painful and challenging aspects of the work. Developing trust was thought to be vital to these outcomes, which were in turn, seen to be vital to the facilitation of the next phases in the process of healing from shame.

Creating a Context for Change:

Building a Positive Sense of Self

Substantive Codes:
Client Process
*openness to new information and experiences
*ability to be objective, grounded
*decrease in self-destructive behaviour and negative affect
*psychological strength
*sense of self-control and worth
*integration of aspects of personality
Therapist Action
*Assisting client to find inner resources and strengths
*Normalising the experiences
*Providing support and strategies for reduction of problem symptoms
*Teaching grounding techniques
*Dialoguing techniques

The next category identified in creating a context for change was **building a positive sense of self.** **Theo** says,

> *"I want to, first of all, build the relationship with the client, people need to have some positive sense of themselves before they go into what may be the more difficult things to go into."*

As mentioned above, the establishment of a trusting therapeutic relationship seems to be a key factor in building in the client a positive sense of their identity.

> **Diane** states, *"...it's like a feeling inside of oneself that you matter, that you are worth something. It's not a head thing, it's a heart thing, and obviously, you work that out because someone has given it to you at some stage, and if you don't have it all, then, hopefully, the therapeutic process gives that to you. That you do matter. That the therapist is there, that the therapist doesn't say you are disgusting and revolting, so I think that [therapist-client] relationship is very important."*

Although respondents used a variety of terms (such as "building ego-strength", "developing a healthy role", "building health", "developing a sense of self") when further data was gathered on these phenomena it was discovered that these terms were referring to similar phenomena. The core properties of these terms were identified and coded as the **positive self**, with the core therapeutic task being coded as **building a positive sense of self** .

The therapeutic goals of this phase of the healing process included the ability of the client to be objective and grounded, having psychological strength and a sense of self-possession, self-acceptance (awareness of personal value, positive characteristics and qualities), a sense of self-efficacy and an integration of different conflicting aspects of the personality. Although different therapeutic orientations determined the strategies that therapists used, a number of core therapeutic goals were found across orientations. (It is important to note that these goals are similar to the outcomes of healing from shame but there is a qualitative difference. This phase is building a sense of self, not the positive self, the more solid identity, which is the outcome of the whole process of re-negotiating meanings. This is however where the beginning of that growth occurs.)

One core therapeutic goal was that of facilitating and assisting the client to find their **inner resources and strengths** by examining a persons life history in order to discover these.

> **Theo** states, *"I think that by looking to the whole picture and looking for a persons strength you are actually assisting them to find their own internal resources to deal with the awful things...a person needs to feel their own sense of assertion, their own sense of self-possession. I would use some cognitive [techniques], some behavioural [techniques], I'd use narrative work...so I'm trying to find what resources a person has and building on those"*

Strategies for addressing this therapeutic goal used by some respondents included the use of narrative techniques such as searching for "unique outcomes", and externalising problems (for example externalising shame) as well as basic reframing techniques.

> **David**, *"one of the things we need to do is externalise shame, because shame is something that deeply becomes part of us, so we don't say, 'there's this bit of shame in me', we say, 'I'm shameful' or I live my life as if I am shameful, promiscuity, self-mutilating, so part of my work would be to assist that by the externalisation of shame,*

so the person can then attempt to start to identify their relationship with shame, then they can start to see shames impact on their life and on their relationships with others.[**facing the shamed self**]*"*

The data suggests that this aspect of the therapeutic process may be vital to the success of therapy and stressed the need for building a positive sense of self before beginning the work of addressing the painful memories and issues a client may be experiencing. Many of the therapists expressed a caution that, without this aspect in the therapeutic process, movement into addressing and facing the painful aspects of the abuse can be re-shaming and re-traumatising to the person.

Theo,*"The person needs to have strong enough resources to deal with [shame] otherwise you are just going to take them back and they are going to re-shame themselves or the process is going to do that"*

Diane affirms the need to balance up visiting the painful things with building a positive sense of self,

"Yes, otherwise you are just in danger of re-traumatising the person because they are just going back in the same broken and defeated way"

Doug, *"I think if you are going too quickly, with some kind of uncovering sorts of therapy, it can be very dramatic, it can be retraumatising, the person may not have the reference in reality and in the moment or their own inner strength to handle that. So I try to set a foundation of what is supportive within them, from which to actually experience the things that come up; the painful memories."*

Diane, *"Building in a balanced way otherwise she could get bogged down with the sexual abuse remembering"* and *"Ego-strength has got to be stronger than the shame to master it"*

Data suggests that by doing this work many symptoms and exacerbating issues are resolved.

David, *"It's always about getting some sense that the person gains a sense of self because if you can do that, then some of the issues will begin to solve themselves."*

Jenny shares a similar viewpoint. She explains,

"I'd always worked on the principle that a very significant and strategic intervention for people with a history of abuse of any sort is the positive growth and development of self-efficacy, so that therapeutically, if you do that, a lot of other things solve themselves because there is no longer so much to be depressed about, because you can make progress in life as a person and you can gain some self-respect from that."

Normalising the abuse experience (in the sense of conveying to the client that they were not abnormal in having experienced sexual abuse) and normalising the difficulties the client may be experiencing subsequent to abuse was a therapeutic goal facilitated by therapists. This was found throughout the data.

John, *"Having some bad feelings and shameful feelings may in a sense be a normal reaction but does it reach a point where it starts to really block the person from getting on with their life?"*

Strategies to facilitate normalisation included the use of literature and group work to help clients to become aware of the stories of other survivors, and in doing so, counter the sense of stigma and isolation which is believed to be a common source of shame.

John, *"I may be giving out some basic information about who is responsible for the abuse and being very clear about that but also, if it is appropriate, maybe talking just generally about incidents of abuse, and trying to normalise that experience for that person so that they don't have to feel different in a negative kind of way."*

Tony, *"You're getting them to understand that when they have been in an abnormal situation and you have abnormal experiences...and therefore no coping strategies, [problematic symptoms] may be perfectly reasonable under the circumstances"*

John, *"...the advantage of group work [is] the sense that other people have been through those experiences, but also realising that you can get through and get out the other side..."*

Providing support and strategies for the reduction of problem symptomology were also included as a way to build a positive sense of self, the client gaining a sense of relief and control from the reduction in intrusive symptoms.

Tony, *"You also want to give them a number of coping strategies to deal with symptoms, which may be behavioural, cognitive-behavioural affective therapies making analytical linkages, psychotherapeutic type linkages, helping them to modulate their feelings so they are more easily managed, more controllable."*

Diane talks about "building health". She explains,

"I'm talking about taking the time to look at the cognitive, to watch how she's thinking, what her self view is, what are the patterns that she's re-enacting that abuse her. [I'd be giving her] lots of reinforcement around healthy things she does, there'd be a lot of looking at the thinking patterns and the ways she organises her life"

Teaching grounding techniques, such as relaxation, breath work or body work were used to achieve similar ends. The cognitive-behavioural approaches used strategies such as progressive relaxation and systematic desensitization, exposure and thought-stopping in order for a client to gain some objectivity over intrusive feelings and thoughts whilst those therapists from the experiential approaches used strategies such as breath work and meditative techniques. These strategies were used to assist the client to gain some objectivity and groundedness when approaching the emotionally disturbing work to come.

Dialoguing between the shameful self and the positive self was seen by a number of therapists to be necessary for the integration of these polarities, in order that the positive self be established as the predominant identity.

> **Grant** *"The loving [positive self] is within everyone, it's just a matter of finding the right vehicle or approach to getting them to make contact with that, and integrating that. By integrating, I mean dialoguing with the unloved part of themselves and the loving part of themselves. The process of the dialoguing is integration. I also mean the kind of polarities you describe here [in the case study] where she has two sides. They usually start coming together relatively quickly when people can access the loving middle ground."*

Psychodramatic, narrative, cognitive and gestalt techniques which enabled **dialoguing** were used by many of the therapists to address "polarities", the two sides of the personality. This practice is also part of the final integration of meanings.

The Outcomes

The data suggests that the respondents perceived the outcomes of successfully developing this positive sense of self to be: an increased openness to new information and therefore an openness to an increased range of experiences, objectivity to feelings which once overwhelmed the person, a decrease in self-destructive behaviour, a decrease in negative affect (shame, self-hatred, depression, anger), psychological strength to face the painful aspects of the clients history and a sense of control and worth.

> **Doug,** *"In that consciousness* [the positive sense of self] *a person has a way of looking at the way they are feeling. They are not dominated or overwhelmed or absorbed in compulsive behaviours, and that stuff starts to fade."*

Facing the Shamed Self and Contextualisation

Throughout the data respondents referred to the need for clients to "face the painful experiences". Phenomena referring to the clients' process, such as recalling early experiences, exposing themselves in telling the story of their past and present, the cathartic expression of emotions such as grief, fear and anger, were identified in the data. This part of the healing process became the selective code of **"Facing the shamed self"**. Alongside of this process was that of **contextualising** the abuse, that is, looking from a more objective, "adult" position at themselves, as a child, experiencing the events of their life. This appeared to be a significant part in therapy where the clients would uncover new information, and gain understanding and perspective on the events of their lives by exploring behaviours and their origins, exploring the shameful events for messages and responses, and seeing themselves as a child in context, from an adult state. This is the main work of re-negotiating meanings and these became the next categories identified in the process of re-negotiating meanings. (This will be addressed fully in the Core Category section).

These "phases", whilst involving separate issues and the use of different therapeutic techniques, seem to occur in an over-lapping manner during therapy, as clients faced the painful memories and the symptoms maintaining their shame and then contextualised those memories and symptoms. These elements were present in all therapeutic approaches sampled. These categories will be addressed separately to give the reader a more comprehensive understanding of these components.

Facing the Shamed Self

Substantive Codes:
Client Process
*recalling and re-telling of experiences
*gaining awareness of links to
behaviour & problem symptomology
*exploring responses to experiences
*releasing emotions
Therapist Action
*empathic listening
*observing client safety and readiness
*observing defenses
*guiding to contextualise

> **Diane,** *"At the end of the day she has been shamed by somebody else, and my own belief is that actually remembering and accessing those moments, I still don't think there is anything as healing as remembering the words...it's to get that projection out of the head"*

Facing the shamed self involves the client **recalling and retelling their abuse story** and discovering it's effects. This therapy involved operating on a number of levels; cognitive thinking states, emotional and physical states. Results suggest that although different therapeutic orientations deal with this phase in different ways (some emphasizing it's role in the healing more than others), all of the therapists interviewed considered it to be a vital part of the healing process. It is in this phase that the effects of the abuse experience, the shamed self and the **negotiated meanings** the client has made as a result, are uncovered and identified. It seems that whilst these meanings and their effects remain unconscious they cannot be re-negotiated, hence the healing process is halted. Doug explains that once the person has a positive sense of self (in his words another "consciousness", capable of being objective) they are able to look at their feelings objectively, become aware of the meanings they made and the ways their behaviour and other problem symptoms are influenced by them.

> **Doug,** *"They are not getting absorbed by [the feelings as they start to become objective to them], because usually they are absorbed by them, almost like a living dream or a waking dream...They are not dominated or overwhelmed or absorbed in*

compulsive behaviours, and that stuff starts to fade. It is sustained in unconsciousness, or in the struggle against it. That is what sustains it. Once you observe it and become more objective to it, it starts losing its power."

David also speaks about informing the client about the nature of the therapeutic work, as a way of raising their consciousness to the fact that they make meanings and to look for the meanings they have made. This is part of the work of **exploring responses**.

"I think the person needs to explore, first of all the concept that we are built to interpret and give meanings to events, so we are building our own stories, our own interpretations, so the person has to understand that concept is what we are doing, and then they have to look at what meanings did they give to the events and that has got to be quite deeply explored."

This "uncovering" appears to happen on different dimensions, and therapists may "go in" at different dimensions (ie: thoughts or feeling states). Those therapists using a cognitive framework did not emphasize getting the client into the feeling states of the shamed self as much as those bioenergetic therapists, however all attempted to get the client in touch with this part of their experience. Most therapists emphasized the need for this to occur in a way that engaged both the feelings and the thoughts to avoid mere intellectualising about the experiences which they did not see as being conducive to therapeutic change.

Diane, *"Working with the body, that will bring up the feelings also working with the body will bring up the memory as well. It's not much use just remembering with the head, the memories need to be body memories."*

Grant, *"I would use the experiential approaches that go beyond a persons ability to talk about what they are doing and get them into themselves so they experience themselves and their truth in some way."*

John talks about engaging the feelings and the thoughts,

> *"to try to get John to experience that feeling of shame [during the session], but in doing that, to be clear about what's setting that off..."*

Gaining awareness of the sources of shame is a significant part of this exploratory work.

Empathic listening was seen to be an important therapeutic strategy in this phase, in order that the clients' trust in the therapeutic relationship be maintained whilst they confront the more painful aspects of their life. Tony refers to the need for the therapist to hear the clients' story and also be objective to that story, leading the client to examine and reassess the meanings they have made from their experiences. This reassessment and examination largely occurs during the contextualisation process.

> **Tony**, *"You've also got to work with the person in such a way that they believe you have joined them in their story, from where they are starting, although that's not necessarily where you want them to end up... you don't want to be an ally to anyones' story because you can't do your job therapeutically"*

Strategies used to support the client facing the shamed self included therapists validating the feelings the client had, providing "space" and encouraging the exploration of issues. **Releasing emotions** appears as part of this phase, although respondents differed as to how central they saw the emotions were to healing.

> **Diane** states *"I believe that all therapy is about having the feelings that were never allowed to be expressed, there is enormous grief that she wasn't good enough to be looked after. There's rage at all she's lost, at losing her sexuality and of all the time that she's lost, and the mess that she's made. There might be terror. At the end of the day what you are doing is trying to get expression of feelings that are plastered over by layers and layers, and in the end, by acting-out behaviour."*

Here Diane illustrates one strategy of getting in touch with the abuse experience (which will enable the client to get to the negotiated meanings) via the feelings, which are not conscious

to the client, but are hidden and defended against by acting out behaviours.

Other therapist actions identified in the data were **observing client safety and readiness, observing client defenses** (including respecting and challenging of those defenses based on the judgement of the therapist) and **guiding the client toward contextualisation**. Therapists used the grounding techniques, taught during the early phases, to assist the client and emphasised the importance of bringing the client to the positive-self state during this phase, in order to keep the client safe, psychologically and otherwise. This phenomena was part of observing client readiness and safety. **Doug** emphasises the role of this phase in the healing process;

> *"If they know that they can be safe experiencing the pain in the present, if there's a part of them that's strong enough to support them in it, then whether they get full insight into the whole picture or not (some people do, some people don't), it's not necessary. For healing to take place it actually takes facing the pain of it in the right way."*

Many respondents continued to check back with their clients each session in order to monitor client readiness and safety.

Therapists stressed the point that catharsis alone was not conducive to healing, and needs to be accompanied by the contextualisation process to be beneficial. Therefore, respondents would **guide the client to contextualise their experience**.

> **Grant**, *"Crying from a very deep, child place from within, but without an understanding or insight into where that's coming from and without integrating that into some of todays' perceptions (integrating childhood experiences with adult experiences) is not usually progressive in my experience...I don't believe in people getting mindlessly willy-nilly into their experiences...it might make a counsellor or therapist feel like they have had a good day ...but it doesn't actually help the person progress."*

Diane adds, *"Catharting isn't the answer, it's actually getting to those decisions,* [negotiated meanings] *that insight moment that involves both the feelings and the thoughts, the person thinks "Oh I don't need to do that any more", those are the magical moments, those are the moments which bring about profound change"*

Theo *"You need to find out who shamed you and what it was about"*

David implies the timing of the contextualisation process in the overall healing process, although he is using terminology from narrative therapy, that of "the dominant story". This has been conceptualised to be one way of contextualising the clients' experiences.

David, *"It can't be done until the person senses that you have a good understanding of their story, that you have grasped their story and have built up a trusting relationship where they are more deeply sharing its impact for them. However, in another way, from quite early on, even if it's in a minute form, there is a sense of drawing out the possibility of another story."*

Outcomes

The outcomes for the client during this phase of the process involved recalling and retelling of the painful experiences, exploring cognitive, emotional and physical responses to experiences, releasing emotions (catharsis), and gaining awareness of shame sources, their meanings and the impulsive thoughts and behaviours engendered by them.

Diane, *"Being able to express [the feelings] (and therefore the learnings) brings about reassessment from an adults' point of view. It's like, with the feelings you stay locked in the childs' perception, "I am bad", you know all these things their life has taught them, so somehow the expression of feelings gives rise to a reassessment from an adults' point of view."*

Jenny implies that after saying those things that seemed to be to painful or shameful to say (Facing the shamed self) the client is more able to contextualise;

Jenny, *"in doing that...you then open yourself to hearing new information and perspectives on those events which you have previously interpreted in a certain way"*

Intervening Conditions

A number of obstacles were seen to be associated with this phase of the healing process which had the potential to constrain this process. Characteristics related to the client were clients fear of doing the painful work of facing the shamed self. This was found to be one intervening condition which prevented movement through this phase.

Doug, *"Convincing some people that facing the pain is therapeutic doesn't always work ...this is an obstacle in terms of the persons unwillingness to face that sort of thing...its a matter of readiness and resistance...when a person is ready, resistance decreases."*

Grant, *"Shame is something that usually people run a country mile from, it's not something people like to face. It's actually an all pervasive, powerful experience."*

Theo, *"I think being frightened of feeling, of approaching the traumatic events,...fear of feeling all the grief and pain that is behind that, a fear that they cannot do that, that they cannot cope with that, that it's too much, that its too big so that's an obstacle."*

Tony, *"She needs an awful lot of courage to do the painful work over a prolonged period of time and confront some painful issues which she has kept secret, often from herself"*

Defenses

Strong defenses were seen to intervene in the healing process. Respondents suggested that those clients who had coped by using anger and denial had to learn to let go of these defenses in order to face the shamed self and move towards healing.

Diane, *"Her lifestyle, while she is continually shaming herself and acting out that behaviour she won't get down to the shame, she won't get out of the anger."*

David, *"Shame helps Jamie, it acts as a protective shield to help her not get hurt any deeper."*

John, *"some of the men have felt shame about what has happened but haven't been able to acknowledge those shame feelings. They have all been channelled across into feelings of extreme anger towards other people"*

Theo, *"defenses [are an obstacle] but then they may be for good reasons...anger which is a defence but staying stuck in an angry rageful state doesn't allow the person to connect with that other side, there's a lot plus-ses to staying in those angry states in that sort of fighting state, but it's probably fear that stops most people."*

Therapist Actions

Characteristics related to the therapist which were intervening conditions consisted of not successfully facilitating the movement through the earlier stages of the process. That is, failing to create a context for change by not achieving the necessary quality of relationship, failing to establish trust, and/or failing to facilitate the building of a positive sense of self, and therefore not being aware of the clients' readiness. The outcomes of this failure were the client not entering into the work because they feel unsafe, or being retraumatised by facing the shamed self.

Contextualisation

Substantive Codes:
Client Process
*Awareness of influences on negotiated meaning
*Renegotiating meaning
Therapist Action
*Exploration of the context
*Educating the client
*Exploring the function of shame
*Normalising the experience
*Assisting the client to renegotiate meaning

> **David,** *"Often we need to look at and give new meanings or be helped to discover new meanings to events, new ways of looking at that...counselling is more like a mirror that says "can't you see?, haven't you seen within the way you have described this story an alternative explanation is totally possible...initially that is like a little mustard seed because the victim story, the shame story, is so huge."*

Diane, referring to the case study of Jamie, states that once she has recovered the shaming messages [in facing the shamed self] she is able to contextualise these meanings;

> *"Once she has recovered that she can then start to reflect on it, "now hang on, whose problem is this, does a child deserve that?", and then you can start to work the adult and the real perception, but until you do that she's stuck with the childs' perception."*

Contextualisation involves **exploration of the context** of abuse on many dimensions; familial/ intergenerational, developmental, societal and intra-personal. These domains are explored in order for the contextual influences on shame to be identified and to gain understanding about the behaviours and feelings that are linked to these. It is during this phase that meanings are re-negotiated. It is as if the therapist assists and guides the client to re-negotiate the meanings they make about the abuse event by providing new information and perspectives. In doing so the sources of existing experiential learnings and their influence are brought to consciousness and challenged, and the childs' experience of the event is carefully explored in light of the context of the abuse.

As mentioned in the opening paragraph, the context of the child is explored for influences on shame and the process of negotiating meaning. For example, examining the

familial context may bring an awareness of isolation and neglect the client may have endured during childhood, providing a context for their ambivalence toward their abuser - a common source of shame.

> **Theo,** *"I'd want to explore the context to see if [having few friends] was there before the sexual abuse happened. Obviously if she's lonely and isolated and dad's not around, she's going to be vulnerable and there's grandad, who is probably being very nice to her..."*

Likewise, understanding the physiology of the body (part of the context of sexual abuse) may give rise to insight into why they felt pleasure whilst believing the abuse experience to be bad and awful, allowing them to re-negotiate the meaning of that and to release themselves from this shame source. Exploring the strategies used by the abuser and understanding the power dynamics inherent in the abuse context may assist the client to relinquish a false sense of responsibility for the abuse and to place the responsibility on to the abuser, where it belongs. This aspect of contextualisation also involves **educating the client,** in areas relevant to the individual client. (For example, educating the client about the physiology of the body).

Exploring the Function of Shame

Many respondents spoke of the need to make linkages between the abuse experience, the feelings and the behaviours or symptoms that the client may be struggling with. They also viewed problematic behaviours as strategies the client has developed in order to cope with their world, rather than seeing them as evidence of pathology. In this way the present conflicts are linked to the past. **John** speaks of this aspect of the healing process,

> *"So trying to look at those same sort of connections, the shame experience, the feeling but also is shame actually driving some of these things, like the sexual encounters with strangers for example."*

David, *"I keep coming to "what is the function of the abuse in the present?". Not that it comes from a historical thing, but it is actually serving a function in every day relationships now. It avoids intimacy etc, so for me the overcoming and the working through of shame must then introduce the concept of function, ...a new way of looking at it, that it is working in the present...would [shame] function as saying, 'It's really all me and grandfather is okay' or if he did anything, I mean, look at his background, and so take away his responsibility for it...?"*

Tony, *"You've got to start to help them link up where these things have come from dynamically because you want to increase their understanding and by increasing their understanding they are rebuilding their schemata* [re-negotiating meanings]*."*

Jenny explains the benefits of facing the shamed self and contextualisation,

"you then open yourself up to hearing new information and perspectives on those events which you have previously interpreted in a certain way, so differently contextualising things, like, how big the grandfather was and how little you were, maybe that might alleviate things like 'you should have been able to do something about it'."

Theo, *"Another task is to help the person to approach what the shame was, what this shame is , in whatever way you can get to do that so that they can set themselves free of it. [They can] claim if it wasn't their shame, they can give it back to whoever it belonged to."*

Therapists may use photos of the child, genograms, psychodramatic techniques, diarying, relational maps or gestalt techniques to assist this exploration of context.

Normalising the experience can have the effect of contextualising the experiences, especially if the client is able to clearly see the context of another survivor, the context which releases them from responsibility and the shame that incurs. **Jenny** speaks of another effect of normalising the experience, releasing the person from the sense that they are now different

and shameful because this happened to them;

"Sometimes different contextualising can happen by seeing and hearing about experiences of others. Seeing that what happened happens to a lot of people, it just didn't happen to you."

Outcomes

The outcomes of contextualisation are an increased awareness of the context of the abuse experience and an increased awareness of how the meanings taken from the abuse were made. Often the key meaning of being responsible for the abuse is no longer held, as a consequence of this process. During this phase and the following "integration" phase, the therapist assists the client to re-negotiate their meanings, to look at new perspectives. Subsequently, the responsibility for the abuse is placed back on the abuser, causing a release from the shame and guilt which was associated with that responsibility. A more positive self-concept is possible as a result of this as well as an increased ability to understand and cope with the effects of the experience.

Theo, *"It's not that it is going to go away entirely but they are able to understand it more, cope with it more, not have it be so much the basis for how they live their lives."*

Integration

Substantive Codes:
Client Process
*integrate learnings
*establish positive self-concept
*decrease in negative behaviour
Therapist Action
*assist integration
*dialoguing
*encourage new directions

The final category of the healing process involves the new meanings which were re-negotiated as a consequence of the information discovered in the phases of **contextualisation** and **facing the shamed self,** being **integrated** into the clients' experience and self-view. (Refer to **Table One**, pg 104). Data showed that the therapists actively encourage and facilitated this process in their clients, assisting them to re-negotiate the meanings of their life and of their self. Aspects of this work were begun in the contextualisation category.

Once the client has begun to make links between the past and the present they may start to intervene into that scenario using various strategies for change.

> **Grant,** *"With people who find it very difficult to be expressive I certainly wouldn't use any psychodramatic or role work. I would probably use some degree of Gestalt fantasy work...for example, if I was working with Jamie and she went back into being five or six years old and she had just been abused by her grandfather, she was numb and crying and hurt I would use the fantasy model of getting her to enter the bedroom or wherever she was...and have her talk to the child in fantasy and start to reparent the child in fantasy, that's an integrative process. If I was doing group work I'd do that with psychodrama..."*

A **dialoguing process** was also seen to be part of this phase as new learnings are integrated and existing learnings are reassessed in the light of this experience. Using psychodramatic, narrative, gestalt and cognitive techniques the client is encouraged to externalise, and work

through, these inner conflicts, producing a more positive identity and thereby resolving shame.

David gives an example of this externalisation of both shame and the conflicts that occur in the healing process;

"I think the obstacles [to resolving shame] can be huge because shame can be pretty powerful as a friend. It will be saying that "that alternative story [re-negotiated meanings] that guy David is trying to introduce is a lie" and that kind of fight fundamentally can be very deep indeed. In a way it needs to be given a language of its own, "So what does shame say about this new story?". So you're almost getting the inner voice to come out to an outer voice, that is one of the ways of getting the fight from being an internal fight to an external fight..."

Grant, *"By integration I mean dialoguing with the unloved part of themselves* [the shamed self] *and the loving part of themselves* [the positive self]."

John talks about a similar process, from a cognitive-behavioural perspective, of using self-talk as a way of dialoguing with the old meanings and thoughts in order to bring about change;

John, *"...Jamie being more clear about what parts of the problem she has to own or not...that may come back to quite specific self-statements Jamie might begin to say, like 'I feel bad but it wasn't me, I was very young at the time, I had no control over what happened, this other person was the one who did this to me'...things that she actually believes..."*

New Directions

During this phase of integration, the respondents spoke about the client trying new things and moving out of old behaviours and situations.

> **David**, *"That may also mean that I* [the client] *start making choices to form new friendships, to go to new groups or do new things which help maintain my new story, my shame-less story, my freedom from shame story."*
>
> **Grant,** *"From there a person may need to do some self-esteem work, in a cognitive sense. They may need to go and try and experience things that they haven't done, to prove to themselves that they can do it. Self-esteem is as self-esteem does."*

In this final phase the client integrates the new meanings they have discovered and begins to shape their experiences accordingly. The data shows that this process may be returned to again and again as the client addresses further issues that may arise.

The Speed of the Healing Process

Most respondents spoke of the process of healing from shame being a lengthy one.

> **Theo**, *"I don't believe there is a short way to do it. I really don't. I think that's great if some people think they can do something in three or four sessions, but not in my experience...I don't think it happens like that. If you are wanting a person to heal at a very core level, which is what this is about then it takes time to do that and I think you have to allow the time to do that, to me that's honouring it."*
>
> **Grant**, *"Healing from shame can be a lifelong process"..."I'd say that shame would almost be an eternal issue for a person in this position [case study] ,male or female, there would be triggers and connections going back into the shame that would take years and years and years to work through..."*

The movement through these phases was not found to be strictly linear although movement had to be linear initially. Data revealed that the development of trust was vital to the healing process, building a positive sense of self could not be achieved unless trust was established. In order for the work in the category of "facing the shamed self" to occur, the work of "building a positive sense of self" had to be achieved to some degree first, in order for that work to be therapeutic. In order for contextualisation to occur, facing the shamed self must happen however, these processes were seen to be side-by side. Integration occurred last. Once progression through the phases of developing trust, building a positive sense of self and facing the shamed self/ contextualisation had occurred, as therapy continued, the therapist may return to any of these phases in order to solidify, maximise and maintain the outcomes. This may not happen in a linear order but rather as the therapist (or client) perceived necessary. A visual metaphor may be that of a wheel with the spokes representing the categories in the healing process. As the healing process begins movement around the spokes is slow, but gradually momentum grows, until the wheel returns to the categories and moves

through them again, this time at a faster rate. One factor which affects the speed of the process is that the client begins to do some of what the therapist has modelled. They may start to make connections between feelings, thoughts and past experiences and themes, thus moving through therapy process more efficiently. Certainly this is one of the key goals of therapy, that is the empowerment of the client, which is reflected in the philosophy of therapy and the client these respondents have.

The Core Category

Overview

The Core Category: negotiating meanings
Shame development
healing shame

Negotiating meanings was not a term that respondents used, although some did refer directly to "meanings". Rather it was a term chosen by the researcher which seemed to capture the essence of respondents conceptualisations of the therapeutic work. This term was rooted in the conceptualisations respondents had about how shame develops in the adult survivor of sexual abuse. As analysis and data gathering continued, the category of negotiating meanings became larger, mapping much of the data together. This category appeared to be central in the data, not only as the process by which shame developed but it was also discovered in the therapeutic process, encapsulating the core factors in the healing of shame in adult survivors of sexual abuse. Therefore it became the core category; central in the data, appearing throughout the data and encompassing the existing lower-order categories.

This theory conceptualises people as **meaning-makers**. That is, results indicate that fundamentally these respondents understood the person to be carrying out a constant, unconscious and intrinsic process of taking meanings from experiences and using these meanings as a reference point from which to understand their reality. These meanings were also seen to determine future behaviour and future experiences. This factor has important implications; the range of experiences a person may have limits the range of meanings one could make from these experiences, and the range of meanings made limits the behaviour (and therefore the experiences) a person may have, from which to derive meanings. This relationship is therefore reciprocal.

David *"There are 'stories'. They are shaped, not as some genetical inheritance, but they are shaped by learning environments. That's not to ignore that we have personality and things that are perhaps more set, but a lot of it is shaped by learning, the learnings that we've got from significant events. But the difficulty we've got is that we give those events meaning and often those meanings can be faulty, because of our stage in life, our developmental stage. Often we need to look at and give new meanings, or be helped to discover new meanings to events, new ways of looking at that."*

The negotiation of meanings involves cognitive processing of events, with the person arriving at conclusions (making decisions) about how to understand an event. The person draws on information from all dimensions of the self: their store of existing experiential learnings, their emotions, thoughts, perceptions/projections of others, body feelings, in order to negotiate these decisions/meanings (a process which could be happening at an unconscious, subconscious or conscious level). The negotiated meaning is conceived to exist on many dimensions of the person, including cognitions, the emotions and the body/physical dimension. Therefore meanings do not exist in the end merely as cognitions/schemata and intellectual knowledge but exist in a holistic way, evidence of which can be seen in the thoughts, affective states, and in the physical states of the person. This conceptualisation is necessary in order to locate each respondents' approach within the theory.

This process involves new information and experiences being processed in light of (what I have termed as) **existing experiential learnings,** which come from a number of sources, including societal influences, cultural influences, learnings from personal history and familial learnings. Meanings are therefore "negotiated", the current experience being weighed against existing experiential learnings, which has certain outcomes for the meanings made. Existing learnings are able to be shaped by new experiences and new experiences could shape/change existing learnings in a reciprocal, fluid relationship.

"Experiential learnings" and "negotiated meanings" are terms very close in meaning. Negotiated meanings, once processed, become experiential learnings, although not all experiential learnings are negotiated. (For example; some learnings come straight from cultural mores and customs). I have chosen to differentiate these two terms in order to define the process more clearly; existing experiential learnings help to negotiate the meaning of experiences, which become future experiential learnings.

> **Tony** *"When a person experiences a trauma, from a cognitive theory point of view there is usually a rupture in the cognitive schemata that have governed the way a person normally sees the world* **(existing experiential learnings)**...*with shame it comes up in the rupture to oneself as a competent actor within the world* **(meanings/learnings about the self)**...*when you lose personal control over that world in that way, you try to regain control, as part of the healing and learning to cope with what has happened to you* **(people as meaning-makers)**,...*[by] holding [yourself] unfairly to blame both as the cause of what has happened [to you] and as the reason for not being able to deal with what happened to [you]."* **(The negotiated meaning)**

Once again, this interpretation of the data was carried out in light of all of the data, as is fitting for grounded theory analysis, therefore it does not capture all the conceptual details of cognitive theory. Those respondents operating from a bioenergetic viewpoint saw experiential learnings in terms of beliefs and cognitions as well, but also included feelings as having a powerful influence on the process of negotiating meanings rather than seeing them as merely the product of those (cognitive) meanings. **Table Two** (pg 104a) gives an overview of the various therapeutic orientations employed by respondents and **Table Three** (pg 104b) shows how the theory of renegotiating meanings maps onto these orientations.

> **Theo,** *"[Shame] comes from the experience of having something done to you, and it creates <u>a sense</u> of not having a right to exist, a sense of worthlessness, such an <u>awful feeling</u> that you have no right to be there, to exist as a person."*

These respondents valued the emotional/feeling dimension seeing it as influencing the process of negotiating meaning, and subsequently reflecting those negotiated meanings. Consequently the emotional/feeling dimension was also seen as a legitimate means of uncovering, or tracking back to, those negotiated decisions/meanings during the healing process. Changes in the emotional/feeling dimensions could therefore affect change in the process of negotiating meanings.

Once meanings have been negotiated, they are then internalised and acted upon. In the case of shame, the meanings are internalised into the self-concept and become important experiential learnings which determine how future events and experiences will be interpreted and responded to.

Shame Development

Accordingly, this theory views shame as being the consequence of the child making meaning of the abusive experience. **Figure One** (pg 105) illustrates this process. The experience of degradation, powerlessness and/or ambivalence during the abuse experiences provides significant experiential learnings, which are taken by the child and are influential in negotiating meaning. The child also draws on learnings from many contexts (including cultural/societal, familial, developmental and personal/historical). The meanings the child may make, which result in shame, may be synthesized into two key statements: that is, they were responsible for the abuse, or they are damaged and defective as a result of the abuse. These learnings are internalised into the self-concept, leading to the development of the "shamed self". This becomes a reference point from which the child understands themselves and the world around them. Their behaviour, thoughts and feelings will reflect this negotiated meaning. It is possible for experiential learnings from other subsequent events to influence this process of negotiating meanings. Events that were examined as mediating this process were disclosure and the response to it, further victimisation and therapy. Many other possible events from various domains could influence outcomes (eg: the childs experiences with their peer group, school life etc.).

Healing Shame

In terms of the healing process, the emergent theory in this study reveals that therapy provides an opportunity to gain awareness of the meanings the survivor made of the abuse experience as a child, the ways and influences on how these meanings were negotiated and the chance to re-negotiate these meanings in light of new experience and learnings as an adult. As **Figure Two** (pg 106) illustrates, four main categories of phenomena make up this therapeutic process across orientations. Firstly a context must be created in order that the process of re-negotiating meanings can occur. This context involved establishing trust between the client and the therapist and building a more positive sense of self within the client. The work in these phases of therapy enables the client to face the painful aspects of their experience. As the survivor revisits their experiences, awareness is gained of the meanings they have made, the awareness of their shameful-self view and the consequences of this view. Therapy then involves the client contextualising these meanings, that is examining the influences on the process of negotiating meanings that were present when they were a child. In doing so new information is uncovered, exposing the inconsistencies in reasoning and any misinformation they may have received. This provides new experiential learnings for the client to use in re-negotiating meanings, which is encouraged by the therapist. The experience of therapy and the therapeutic relationship itself also provides significant experiential learnings. As outlined in the "Development of Trust" section, many respondents viewed these learnings as being crucial to the healing of shame. The outcome of re-negotiating meanings is the healing of shame. The survivor concludes that they were not in fact responsible for the abuse, that they have personal worth and possess many positive qualities and attributes. The final stage of therapy involves the integration of these learnings, the relinquishing of responsibility for the abuse and the establishment of this more positive self-concept.

Table 1: CORE FACTORS IN THE PROCESS OF HEALING SHAME

Creating the Context for Change

i) Development of Trust

Properties:

Therapist characteristics

philosophy of the client, of the therapeutic process

personal values and openness to difference

training and experience

Practices within the relationship

boundary setting

role-taking

empathic listening

acceptance of the clients experiences, view and defenses

encouragement

maintenance of confidentiality

support/guidance for problem symptoms/ behaviours

respectful pacing

ii) Building a Positive Sense of Self

Properties:

Client Process

openness to new information and experiences

ability to be objective, grounded

decrease in self-destructive behaviour and negative affect

psychological strength

sense of self-control and worth

integration of aspects of personality

Therapist Action

assist client to find inner resources and strengths

normalising the experiences

provide support/strategies for reduction of problem symptoms

teach grounding techniques

dialoguing

Facing the shamed self

Properties:

Client Process

recalling and re-telling of experiences

gaining awareness of links to behaviour & problem symptomology

exploring responses to experiences

releasing emotions

Therapist Action

empathic listening

observing client safety and readiness

observing defenses

guiding to contextualise

Contextualisation

Client Process

awareness of influences on negotiated meaning

renegotiating meaning

Therapist Action

exploring the context

normalising the experience

educating the client

exploring the function of shame

assisting client to renegotiate meaning

Integration

Client Process

integrate learnings

establish positive self-concept

decrease in negative behaviour

Therapist Action

assist client process

dialoguing

encourage new directions

TABLE TWO: OVERVIEW OF THERAPEUTIC ORIENTATIONS

	Cognitive-Behavioural	Bioenergetic Therapy	Narrative Therapy	Experiential approaches (Psychodrama/ Gestalt)
Philosophy & orientation	Behaviour as result of learning & conditioning. Stimulus response chains Cognitive processes. Working alliance with client is essential. Empirically based	Behaviour as result of energy/ physical states. Energy leads to movement which creates feeling & leads to thinking. Body stores memories, reveals personality & character Therapist as interpreter.	Behaviour as result of interpretations of experience. Problems due to ways of being & thinking re: self & others. Constructivist. Therapist role as equal.	Behaviour as result of interplay between persons needs & the demands of the environment. Concern with Here-and-now. Real relationship emphasised. Therapist as director.
Aetiology	Conditioned reflexes, biology, contingencies of reinforcement.	Early childhood experience. Sexual drives.	Ways of thinking & being which are socially constructed.	Biological, social & creative needs from child to adult.
Techniques	Thought-stopping, role rehearsal, modelling, desensitization, guided imagery etc.	Analytic techniques, body & breathing exercises. Expression of feelings. Character analysis.	Externalizing conversations Unique accounts. Exploration of alternative accounts. Mapping the influence of the problem.	Expression of feelings, active, interventionist. Creative. Invitation to take responsibility etc.
Goal	Adjustment or elimination of problem behaviours/ cognitions.	Improve energy to improve quality of thinking & feeling.	Co-Author progressive ways of thinking & being.	Self-realisation. Self-responsibility.
Focus	Why? The present, including immediate past.	How? The present & past.	How? The present including past & future.	How? The present including past.

(Adapted from P. Clarkson & M. Pokorny (1994). *The Handbook of Psychotherapy*. London; New York: Routledge.)

TABLE THREE: RE-NEGOTIATING MEANINGS WITHIN DIFFERENT THERAPEUTIC ORIENTATIONS

	Cognitive-Behavioural	Bioenergetic Therapy	Narrative Therapy	Experiential Approaches (Psychodrama/ Gestalt)
Shame Aetiology	As result of cognitions learning, & reinforcement about abuse experience.	As result of childhood experiences, repressed feelings & responses to the abuse experience.	As result of socially-constructed framework of thinking & being about the abuse experience.	As result of unmet needs, affect & cognitions related to the abuse experience.
Meanings	Primarily as cognitions or schemata.	Primarily as feelings & then cognitions.	As cognitions & affect.	Primarily as feelings & then cognitive beliefs .
Developing Trust	Client-therapist alliance essential to therapy	Essential to therapy	Partnership vital for successful therapy.	Significant part of therapy
Building Positive sense of self	To gain co-operation of client, to refute faulty belief system, eliminate anxiety & problem beh'rs.	Creating safe environment, to prepare for emotional therapeutic work.	As start of constructing an alternative framework.	To encourage exploration of issues & sense of personal power.
Facing the shamed self	To uncover reinforcing factors & specific belief statements.	To release feelings & gain insight into responses (physical, cognitive, affect)	To discover dominant story & opportunities for alternative view.	To gain awareness of self & release of feelings.
Contextualisation	To refute existing beliefs & reinforce more helpful cognitive beliefs.	To raise self-awareness, to confront & heal destructive,. unprogressive beliefs..	To deconstruct dominant story & construct new progressive story.	To increase awareness of social impact, of self & to creatively respond to own needs in present & for "child-within".
Integration	To reinforce & maintain new behaviours & beliefs.	To establish new ways of being.	To establish & reinforce alternative story.	To integrate experiential learnings & their effects.

SHAME DEVELOPMENT

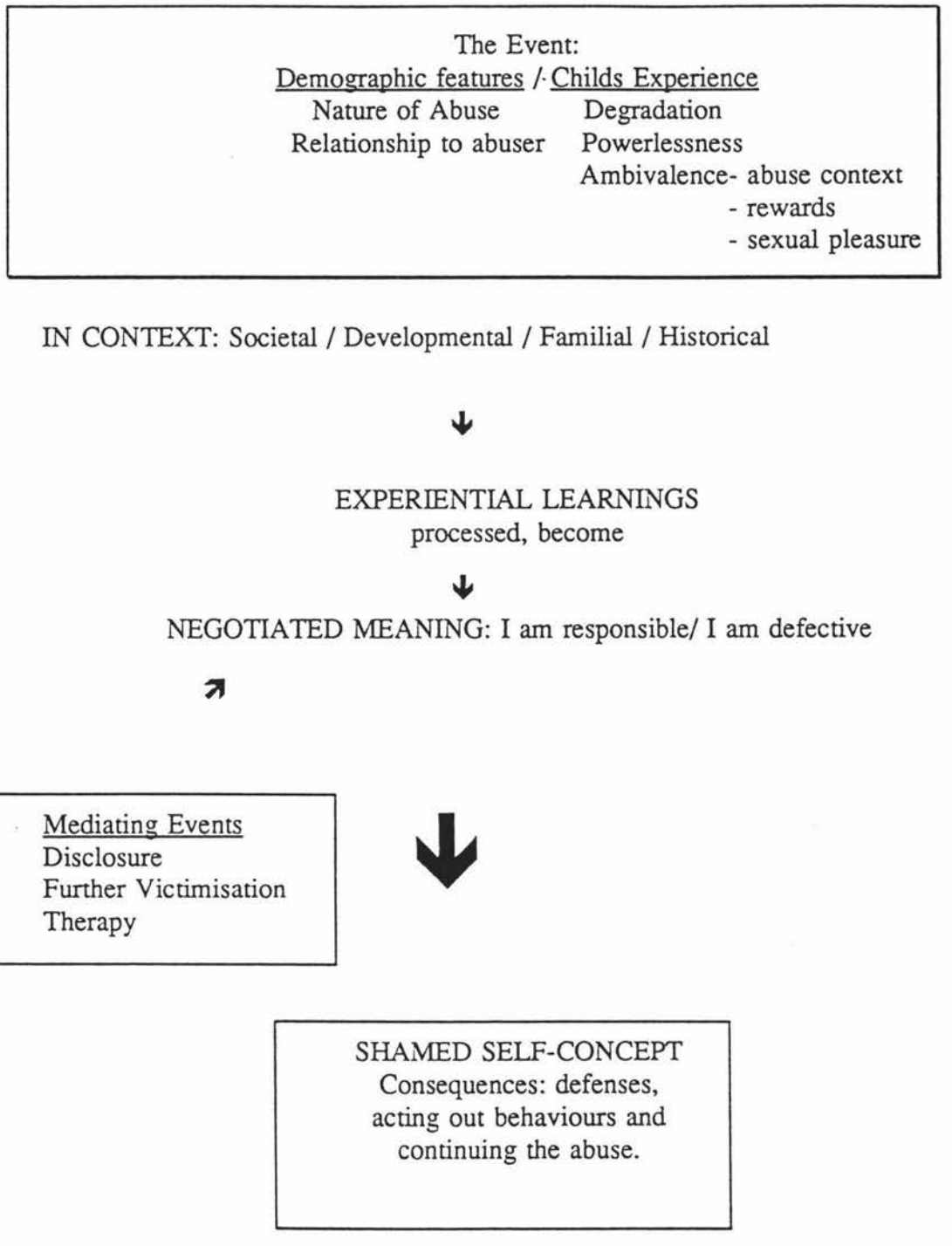

Figure 1:**NEGOTIATING MEANINGS: A GROUNDED THEORY OF SHAME IN ADULT SURVIVORS OF SEXUAL ABUSE**

HEALING SHAME

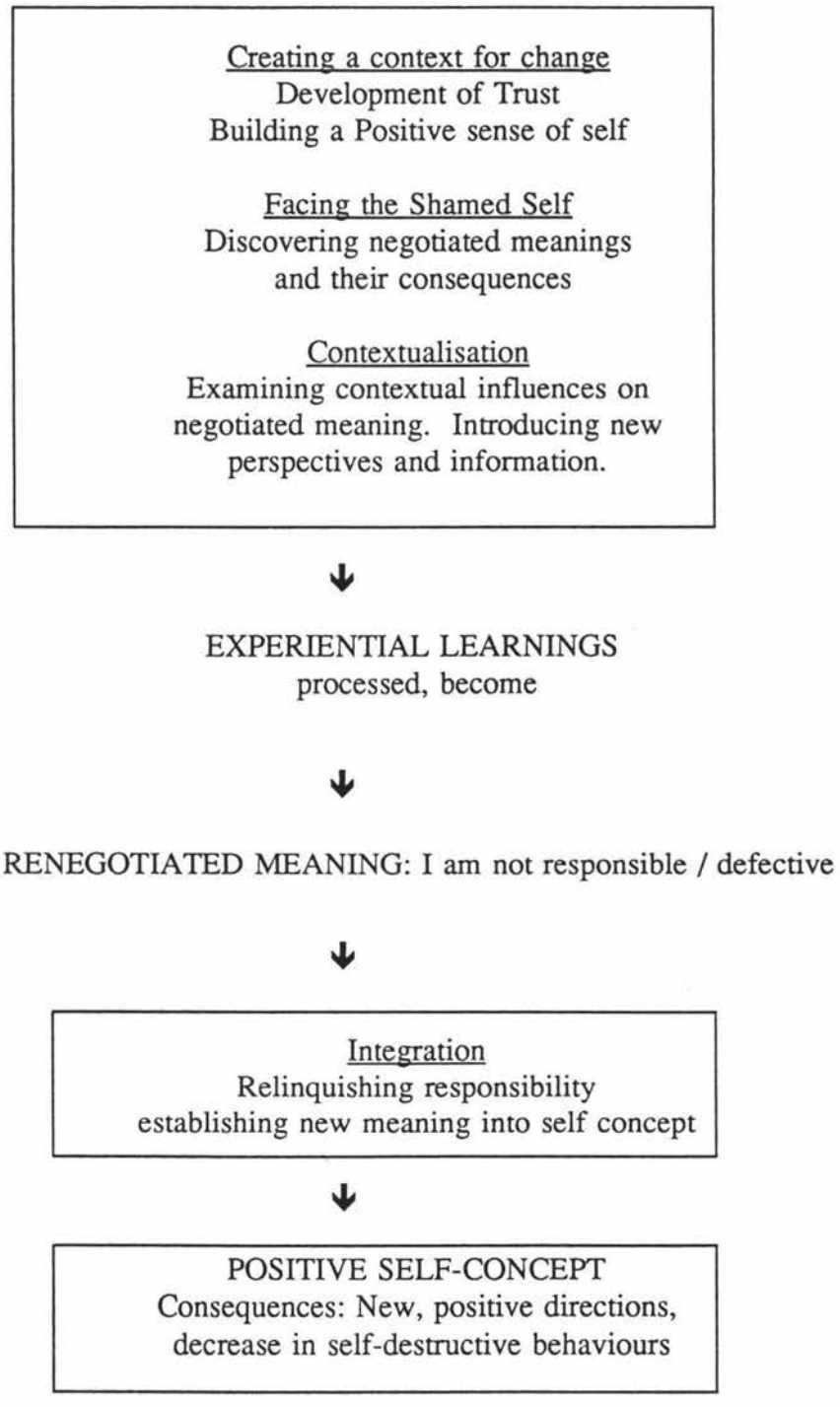

FIGURE 2: RENEGOTIATING MEANINGS: A GROUNDED THEORY OF HEALING SHAME IN ADULT SURVIVORS OF SEXUAL ABUSE

Chapter Six
The Role of Gender

Chapter Overview
Gender differences
Differences in therapy with males
Gender of the perpetrator
Therapist Gender
Summary

The present study gave attention to the role of gender in the healing process and in the development of shame, in order to contribute to understandings of the issues for men (an area often neglected within sexual abuse research) and of the process of healing from shame. During the interviews respondents were asked to comment on the differences and similarities in the issues male survivors and female survivors may bring to therapy, and on any differences or similarities in the ways they would work with males and females. The results obtained now follow;

Gender Differences

Primarily respondents saw the process of healing from shame for males and females as being very similar. They viewed the issues to be largely the same but acknowledged that the issues arising from sexual abuse may be reflected differently, due to the influence of gender identity.

> **Diane,** *"There are differences in terms of gender things...but the basic process I do not see as being substantially different at all, they are both human beings, both will take a meaning out of that which would be quite individual..."*

David, "[The issues are different] *but they are in the same categories, there's gender issues but they need to be explored from a different position. What impact has shame had on this mans' masculinity, how he believes others see him, how he sees others?...I would still say it was about exploration of gender."*

Generally-speaking respondents experienced males as being less expressive verbally and emotionally, maintaining stronger defenses of denial, anger and rationalisations to avoid experiencing the pain of the abuse experience and its consequences.

John, *"I wouldn't necessarily see things as different on the face of it, I think that being male may mean that John is less inclined to get help or to speak about his concerns. As a general finding, I am saying that as a male, men are less inclined either to seek help or maybe to talk about emotional happenings but I am also saying that it is important not to generalise...for males I've seen a tendency to...shut out and deny the abuse experience...becoming aggressive and detached, detached in relationships, aggressive in their relationships with others, very angry..."*

Grant, *"Women are much more prepared to enter the emotional side of things, much more quickly than males, many men are just absolutely, phobicly terrified of their own emotional experiences...Males don't tend to disclose about themselves as much. The perceived vulnerability with males is much greater than with females, these are huge generalisations I know, but they bear up in my professional experience."*

Diane, *"I would expect there to be more glossing over and more acting out, more denial and rationalisations, less emotional response, it would be more difficult, it would be hard work probably..."*

Theo, *"Men tend to act out more and women tend to internalise their anger more and he* [John] *might be starting to do that."*

Tony, *"There's the difficulty of getting men to talk about fantasies and feelings in general which women are more readily wanting to do, there's the difficulty of getting men to admit to fears and confusions which women are more readily wanting to do because of the stereotyped roles and the gender training that we all have I suppose. There is the added complication that when men are worried and scared and confused, generally they complicate the picture with physical violence, more readily used to substance abuse, more violent towards themselves and others, less likely to be affiliative and in seeking affiliation and will withdraw more, using anger as a shield...than with women. With women you can get straight to the point much more easily because there are not that many confounding variables there as a rule, sometimes there is..."*

The societal expectations that "women are victims" and "men are perpetrators" were thought to influence the shame issues males and females may struggle with.

Jenny, *"For boys I think 'can I still grow into an adequate man?', that's another shame hook-up"*

Theo, *"It would be a lot harder for John to come for counselling for sexual abuse because there is a lot more acceptance that women can come because women are victims...it's like there is some cultural, historical expectation..."*

Tony speaks of the difficulties for men who may be adversely affected by the feminist movement. He says;

"Because we all know now men are the complete villains of this world, they are held responsible for everything and women have no responsibility...he is going to surely feel much more afraid, because he is told left, right and centre from media publications, videos, that once he's been abused, he is going to be an abuser. He knows he can't be trusted...so shame is a slightly different problem for him"

Differences in Therapy with Males

Although respondents felt that they would address the same issues in the same way with clients of either gender, there were some differences in the strategies they may take in order to address some of the gender differences which could be present.

Diane, *"I would be more challenging...I would be looking to build up the awareness and the woundedness which might be less apparent in that one."*

Theo, *"I think the core issues are mostly the same, but if John was full of rage then I would have to have really clear boundaries,...that would have to happen with Jamie anyway, but there may be a need, given that he may be a big male, for me to be a bit clearer about that."*

Grant, *"Same issues...my responses to the person would be different. With males I am more open in terms of touch and physical support...I would check it out with them first and if they are open to it I will"*

Abusing Others

Respondents, in general, felt that there was a greater chance of a male survivor becoming sexually abusive to others, and therefore many stated they would be watching for this when working with a male client. Some respondents however, believed that there was just as much chance for females to become abusive.

Diane, *"The basic difference would be that I would be watching out for is that we know there is a different propensity for males to act out sexual abuse, I mean statistically speaking that's so, but I think we don't actually know the extent of female acting out of sexual abuse...it seems to me...that there's a lot more permission for men to act out sexual abuse..."*

Jenny, *"Both* [John and Jamie] *have the potential to have considered abusing children."*

Doug, *"My guess is that more males than females become perpetrators...I don't know if that's true...Its turned into some kind of maladaptive behaviour in both cases. Now men don't always become perpetrators of this, some do but some men never perpetrate, why?"*

Gender of the Perpetrator

Respondents were asked to comment on the outcomes for "John" and "Jamie" had their perpetrator been a woman. Results were varied, with most respondents viewing abuse by a perpetrator of the same gender as having a great impact on the identity of the survivor and on sexuality issues.

Doug, *"I think it does have a very powerful effect. It's so confusing in the sense that there is the need to trust, to find something out about who you are in terms of gender...[betrayal of that] sets up all kinds of conflicts later, in gender identity and relationship to children and sexuality. Who knows the depths to which it affects..."*

David, *"Some of the gender issues, the fundamental things of what it means to have damaged sexuality for men and for women, what happens at that fairly deep level (because I think that our sexuality is at the very core of us) and the anxiety that it gives rise to would almost definitely be influenced if the perpetrator was a different sex to the one you've got in your case study".*

Diane, *"Because Jamie is abused by somebody who is the same sex, the same gender to her then that is going to make quite a difference, I think that gives her the potential to become an abuser...because of the gender modelling basically...she's got a confusion between female nurturing and sexuality."*

Tony, *"In all the cases I have seen where a woman had been the perpetrator...there is a lot more molestation of a male victim to start off with in order to bring the male victim to enough sexual arousal so that she can interact with him sexually, whereas a male perpetrator does not require the female victim to be ready, he just uses her regardless...*

There is a lot more recruitment of their arousal and their fantasies [with female perpetrator] with heavy inducement of power, threats and so on...with female to male [victim] abuse...it may not always be experienced so violently...she may use different tactics than violence and scare tactics."

Grant, *"I've worked with many other males who have been sexually abused by their mother. Usually...the sexual abuse by women tends to have a different guise than males. There tends to be a whole lot more loving with it than with male sexual abuse with children...a lot of cuddling and support and caring and nurturing went on...it really screws up the boundaries, the differences between having a loving non-sexual relationship with people...they can't distinguish what is and what isn't appropriate"*

Some respondents expected there to be relational problems with persons of the perpetrators' gender, for victims of both genders.

John, *"Perhaps if [the abuser] was a female that might lead Jamie to have problems in relationship with females, in terms of trust and closeness and things like that...whereas if the abuser had been a male it's possible she would have difficulties in relationships [with men]".*

Diane, *"I invariably find in working with sexual abuse with females, it tends to come after, if the person has been sexually abused by both. It is a lot safer to talk about abuse by a male in this society that it is by a female."*

Theo, *"Women that I have worked with who have been abused by both sexes always leave approaching work around the female until last and it is always the most painful, most difficult to do and the hardest for them to be angry about..."*

Homosexuality

Uncertainty about their sexual orientation as a consequence of sexual abuse was something respondents raised when considering issues males might bring to therapy. They did not raise this issue when speaking about females. Confusion over sexual orientation was mentioned particularly in the case of male-to-male abuse.

> **Jenny**, *"I'd see [the issues for John] as being largely similar [to Jamie], but with the added hook of the threat of homosexuality and the humiliation and the low status that that has in our society, it makes you an outcast, a marginalised person..."*
>
> **Theo**, *"There could be some issues around his sexuality, you know, he may not know whether he is homosexual or heterosexual..."*
>
> **Doug**, *"the whole issue...of males being abused by males presents some key issues, I think. They have to deal with; developing their own sense of manhood, their sense of being of the male gender, the sense of what it is to be both a man and a father, in relationship issues of sexuality. There may be issues of sexual attractiveness to children."*
>
> **John**, *"It might not be just shame about past events but for males it might be having some sort of physical response to men as well as women, so does that mean they are gay or not, those sexual identity issues...it gets quite complicated to try and work out what belongs to the abuse or what might be a separate issue in itself."*

Tony infers the issue of homosexuality and talks about how the use of pornography might impinge on treatment,

> *"Pornography might be a different issue because males are probably more visually aroused on the whole than females...the more deviant the pornography is the more difficult it will be for him to orient himself toward his goal of heterosexual behaviour and intimacy..."*

In answering this line of inquiry some respondents indicated that the relationship to the abuser was of more relevance to outcomes than the sex of the perpetrator.

Jenny, *"Maybe the kind of relationship the person has generally with the victim is [what is] really relevant, if they are someone who has a lot of care responsibility for them in which there is more betrayal than if it's a babysitter or a stranger where it is less binding emotionally..."*

John, *"there could be differences partly with the gender but I suppose it comes down to exactly what was the relationship like with the abuser at the time, was this a distant remote figure...or someone that Jamie felt very close to and trusted."*

Diane considers it just as likely for John to become homosexual where the perpetrator is a female in a nurturing role**,**

"Unless he becomes homosexual, which would be very likely in my view, he's going to have incredible disturbance in his relationships with a partner, especially a female"

Therapist Gender

Therapist gender was seen to have implications for the therapeutic process. Because the issues involved in healing from shame address sexuality and identity, the gender of the therapist was important as a model to the client of their own gender identity, especially where their abuser was of the same sex. Therefore those therapists of the opposite gender believed that in order to fully address ones' gender identity, therapeutic contact with someone of the same sex was also beneficial, even necessary.

Theo, *"I really do not believe that I could fully help him to address his issues fully as a male, I'm sure I could be really good at helping him through his sexual abuse issues, maybe some stuff with his relationship with his mother but when it comes to his identity as a man I believe he would have to do some work with a strong male therapist..."*

David, *"I'd often be encouraging women, that no matter how much work they have done with me, to then be inviting them to work with other women...that doesn't necessarily mean finding them a therapist but what kind of women do they want to nurture their femininity and to help them to fulfill their potential. Against that I think that a man needs a continuing male influence, that may be provided in therapy and again it might be that he needs some sense of a woman to nurture his femininity..."*

With clients of the same sex, respondents were mindful of transference issues. Therapist gender was viewed as a significant issue for two respondents, who restricted their clients to those of the same sex.

Jenny, *"I don't deal with men...the reason for that is that certain aspects about how a man thinks and feels about their sexuality is mysterious to me and I don't even really want to learn about it, I think I probably couldn't, and also I'm not interested. I don't want to commit my life to that..."*

John, *"I haven't worked much with female survivors of sexual abuse...that's partly theoretical but it's also a personal choice because I feel uneasy about those dynamics"*

Summary

Respondents saw the process of healing from shame for males and females as being similar, with differences in specific issues raised by males and females being the result of gender identity differences. Males were considered to be less expressive verbally and emotionally, having stronger defenses of denial, anger and rationalisations which meant respondents may be more challenging and confrontational in therapy with males. Most respondents acknowledged the issue of victims becoming perpetrators. Respondents were divided as to whether they considered it more likely for a male to become an abuser, some felt the potential for victims of either sex to become abusers was equivalent, especially where their abusers had been of the same sex. This was thought to be the consequence of gender modelling. Perpetrator gender was felt to cause the victim to have relationship difficulties with those of that gender in the future. Confusion over sexual orientation for male survivors was associated with this factor of perpetrator gender. The issue of homosexuality was one respondents raised only in reference to males. Some respondents did however consider the perpetrators' relationship to the victim (close-distant) to be more important to outcomes than gender was. Therapist gender was thought to be significant to therapy, respondents were mindful of transference issues, some believing contact with therapists (or significant other) of both sexes to be beneficial to healing.

Chapter Seven
DISCUSSION

This chapter discusses the present findings, relating them to previous literature on shame and therapeutic intervention for sexual abuse survivors. The respondents' conceptualisations of the development of shame in adult survivors, the healing process and the role of gender are discussed. Following this, the implications of the present findings are discussed and suggestions for future research are made.

SHAME DEVELOPMENT

There is a strong element of cognitive theory evident in the present conceptualisation of shame development. However, in order to capture the complexity of the respondents' conceptualisations and to account for the different modalities they adopt, the present theory conceptualises these meanings as being stored holistically within the person, rather than just within the cognitions. This reflects a more holistic view of the person (as opposed to the mind/body split) similar to that of Maori mental health approaches (Durie, 1985; Durie, 1994). This conceptualisation is helpful to the analysis as it allows the different orientations to therapy to be located in the theory. For example those respondents operating from a cognitive viewpoint would see experiential learnings in terms of "schemata". Information from the abuse experience has to be assimilated (made meaningful) into existing schema (existing experiential learnings) which in turn affects the behaviour and experiences of the person. Respondents adopting the more experiential approaches to therapy may see experiential learnings in terms of feelings stored in the body, which in turn affects the behaviour and experiences of the person. Both views can be located within this theoretical model. Stone (1992) touches on shame development and meaning-making, stating,

"Once the [shame] response is made, associations and cognitions rush in, and in the hunger for meaning, the need to make sense of what is happening, previous experiences are compared and affect becomes emotion." p134.

Finkelhor & Browne (1985) also share a similar conceptualisation stating that the traumagenic dynamics of powerlessness, betrayal, traumatic sexualisation, and stigmatisation alter a childs' cognitive and emotional orientation to the world and create trauma by distorting the childs' self-concept, world-view and affective capacities.

The focus of the research questions in this project dealt largely with the core factors in the process of healing shame. Attention was given to the development of shame and the factors that influence it, in order to provide a context for the healing process theory. The findings presented were based on what the respondents viewed as pertinent to shame in adult survivors of sexual abuse. Certainly the factors respondents have cited as influencing shame (such as familial context, abuse context, nature of abuse and socialisation) are supported in the literature as being important dynamics. These findings and the theory of shame development presented here share a number of similarities to the Traumagenic Model of Sexual Abuse (Finkelhor & Browne, 1985). Conceptualising shame as a consequence of "messages" from the abuser and/or society is consistent with Finkelhor and Brownes' model and the dynamic of stigmatisation. This model holds that forms of stigma vary for males and females and links the same consequences (that is, self-destructive behaviour, low self-esteem, isolation and suicide attempts) to stigmatisation. Much of the phenomena and the relationships between phenomena found in this study that illustrate the process of shame development and the negotiating of meanings also occur in this Traumagenic model. For example, the trauma-causing dynamics of betrayal, stigmatisation and powerlessness outlined in the Traumagenic model were all seen to contribute significantly to the shame and the development of the shamed self and are incorporated into the present theoretical model.

The conceptualisation of shame development as a process, influenced by events in a number of contextual domains, enables sexual abuse and its' effects to be more accurately captured, than a view that allows the initial event only to explain sequelae (as in PTSD). This is also consistent with the type of model Finkelhor has developed in response to his

criticisms of the PTSD model.

The idea that self-concept influences behaviour is not a new concept but rather is one found in cognitive theory, educational and developmental theory. Combs (1989) outlines some current thinking regarding the "self" which is consistent with the present theory. These include notions of behaviour as the outward expression of the self-perception and the concept that once these behaviours are established, they are self-fulfilling. The notion that change in the self-concept is a deeply personal, subjective experience, not the result of intellectual self-analysis, not "thought up" but derived experientially is also consistent with present findings (Combs, 1989). Furthermore, the theory of negotiated meanings is found to be compatible with narrative and constructivist approaches to problems. Durrant & Kowalski (1990) outline their theoretical approach to sexual abuse, one which reflects much of the detail of the present theory. They state,

"We have a basic assumption that people are engaged in a constant process of making sense of their experience. The uniqueness of peoples' experience means that it is the sense they make of events that leads to their emotional and behavioural responses, not the events themselves. The individuals' self-perception provides a template against which experience and events are interpreted. The meanings ascribed to events and the experience of events operate to filter the available information about the self. The operation of such restraints or self-perception serves to perpetuate patterns of behaviour, or emotion, by not allowing the individual access to the possibility of alternatives. It follows that we may consider one of the main effects of sexual abuse to be the assault it makes on the persons' self-perception." (p76).

These ideas are consistent with cognitive theory, narrative approaches, gestalt and Rogerian theory.

HEALING FROM SHAME

Most of the respondents did not address shame as an individual issue in therapy. Although they believed it was necessary for shame to be addressed, they saw it as merely part of the whole process of healing from sexual abuse (which may include dealing with rage, anger, sexuality, interpersonal issues, parenting etc). For the sake of this research they kindly agreed to focus solely on shame.

Secondly, in order to gain information on the process of healing from shame, respondents were asked to identify the "tasks" or "phases" within this process. This tended not to be the way they looked at their work, seeing it as more of a whole than compartmentalising it. Once again they did accommodate my inquiries and identified the process of healing from shame. It is also important to bear in mind that the presentation of this process is constrained by the limits of the written form, which forces the work to be outlined in a linear way. This does not necessarily reflect the real-life process as therapy may not follow a linear format. For example, the process of therapy may involve returning to previous phases in any order or cover many phases simultaneously.

Current research supports the treatment themes evident in the respondents' accounts of their work. Hunter (1990) outlines a number of treatment themes in abuse counselling all of which are incorporated into the process of *re-negotiating meanings*. These themes include: integrating dissociated parts, empowering the survivor, increasing self-worth and competence, reducing isolation, developing new behaviour patterns and decreasing self-destructive ones, re-evaluating abuse experiences and meanings associated with them in a new context (Bruckner & Johnson, 1987), learning to identify and express emotions connected with the trauma, and eliminating irrational responsibility for abuse. It is interesting to note how many of these themes are linked to the issue, and treatment, of shame.

Inherent in this conceptualisation is the belief that the child has drawn conclusions that are incorrect and that, as an adult, these conclusions will be revealed as being flawed as

the healing process progresses and be replaced with more correct conclusions which will work to relieve the survivor of shame. The present findings suggest that the philosophy of the therapist impinges here. In respect to their philosophy of the person, there seems to be a great deal of similarity amongst these respondents. All emphasized a collaborative relationship in therapy. Respondents did not focus on personality factors or hereditary dispositions to explain the survivor who struggles with shame. Rather they saw the survivors issues as a natural response to a distressing event, an attempt to gain mastery and to cope with a number of significant external factors and dynamics. This view of the person is progressive and positive, not unlike Rogerian theory, and this view of the role of the therapist is supported in the literature (Schave, 1993). This view also fits the PTSD framework which sees symptoms as normal responses to abnormal events and is a welcome shift away from pathologizing the effects of sexual abuse, which tends toward blaming the victim. Therapists who hold a "deficit view" of the person may not be able to facilitate the healing of shame, at least not by the process of negotiating meanings.

Support for this conceptualisation of the process of re-negotiating meanings for the healing of shame is evident in the literature. Evans (1987) provides a Shame Recovery Model for chemically dependent, abusive and incestuous families, which proposes four key steps in the healing of shame. These include; 1) development of a caring relationship with someone trustable in which to explore "Who shamed them? How did they deal with it? What effect does it have on them now?" 2) recognition and labelling of shame, 3) stopping the inner abusive tapes, 4) affirming the self. Aspects of each of these steps are addressed and incorporated into the process of re-negotiating meanings. However, the process of re-negotiating meanings is more informative than the Shame Recovery model is about how shame develops and the specific areas in which a therapist might look for shame sources. It also enables the survivor to dismantle some of those shaming meanings through contextualisation rather than training the survivor to stop the shame response just on a

behavioural level. In line with this argument Shalev (1990 in Stone, 1992) suggests that once treatment has addressed psychophysiological reactions on a behavioural level, it may be broadened to include developmental, personality and relational aspects, questions of meaning and other existential concerns, all of which may be addressed in the process of contextualisation outlined in this theory. Evans (1987) does not mention contextualisation or any similar practice as part of healing shame. Re-negotiated meanings which are reinforced through logical appraisal of the context which supports them, through affirmation by a trusted therapist and by behavioural strategies would seem to be a more comprehensive strategy for the healing of shame. Evans (1987), like the present study, cites defenses as a barrier to the pain experienced in facing and healing shame. Eisens' work (1992) on guilt and shame in sexual abuse states the need for building ego-strength during therapy and implies the process of re-negotiating meaning, building a positive self and contextualising, illustrated by this quote:

"So, listening to the patients story becomes of central importance. It is not what happened but the *meaning* of what happened that determines the prognosis in each case. *Translating the traumatic memories into a cohesive narrative compatible with the individuals' self-image* may neutralise these memories so they can be integrated into the mental structure."[Italics mine]

(Eisen, 1992, p84)

COMPARISON TO PILOT STUDY

The current study confirmed many of the preliminary findings from the pilot study conducted in 1994. The conceptualisation of shame as a result of "messages" has carried through, and is elaborated on in the findings of present study. Respondents in the pilot study differed in that some addressed the building up of a positive sense of self after shame had been identified and explored; others addressed the building up of sense of self first as a primary form of intervention into shame. The findings from the present study support the building

up of a sense of self before the more painful exploratory work begins. Pilot study findings placed a great deal of emphasis on the therapeutic relationship, not unlike present findings, and aspects of the five categories (developing trust, building a positive sense of self, facing the shamed self contextualisation and integration) are all present in the work of the pilot study respondents'. The data analysis for the pilot study was not as rigorous, nor did it seek to develop an indepth theory. However, the theory of re-negotiating meanings is consistent with the themes and issues touched on in the pilot work.

THE ROLE OF GENDER

The pilot study did not examine issues for male survivors. However, comparisons can be made between present findings and current research. It is relevant to note that in order to respond to the issues of gender respondents had to make generalisations. These were often qualified by stating that it was possible for both males and females to fall outside of these generalisations. These results should be read with this in mind. The findings of this study certainly correspond with current literature trends, which view sexual abuse as being equally damaging to both male and female survivors, with differences largely being associated with cultural stereotypes and expectations of gender. The themes of males' being less expressive, verbally and emotionally, acting out anger and having stronger defenses are supported by current research findings (Hunter, 1990; Finkelhor, 1984) and respondents' acknowledged that males may have to overcome a number of cultural pressures in order to pursue healing. There is support in the literature for more active, more confrontative styles of therapy for male survivors, as expressed by a number of respondents in this study as well as the mentioning of issues such as sexuality confusion and homophobia in males (Boulton et al, 1989; Hunter, 1990). Respondents questioned the folklore that male victims will become abusers whereas female victims will not, and although the issue of victims becoming perpetrators was something that tended to be addressed when reviewing the male case study (and not the female), all respondents held the notion that women too, could become abusive and felt they

would be watching out for the signs of this in clients of both genders. These views illustrate the further development in the awareness of issues for both male and female survivors, which is reflected in current sexual abuse literature.

SUMMARY OF FINDINGS

The present study investigated shame in adult survivors of sexual abuse and the process of healing from shame. Interviewing eight therapists, who employ varied approaches to therapy, a grounded theory of core factors in the healing of shame was derived. That is, core factors were identified in the work of therapists despite differences in their approach to therapy. Similarities in the goals of therapy and in the stages of the therapeutic process were identified, although therapists may employ different strategies to achieve these similar ends. For example, cognitive-behavioural therapists stated that they would use relaxation techniques to assist the client to manage anxiety during therapy, whereas the therapists adopting a more experiential approach may use breathwork or meditative techniques to achieve the same end. Similarly, different therapists spoke about "building ego-strength", "building health in the client", "developing a healthy role", or "building self-efficacy", as a necessary part of the therapeutic process. These terms referred to similar phenomena and were therefore conceptualised as the core factor of "building a positive sense of self in the client".

The core factors in the process of healing shame were conceptualised as the process of re-negotiating meanings in the advanced stages of data analysis. Therapists from varied therapeutic orientations all understood shame to be a consequence of meanings negotiated by the child as a result of abuse and the context it occurred in. Two significant meanings were implicated in shame development; "I am responsible for the abuse" and "I am defective as a result of the abuse". Respondents also understood shame to be resolved through therapy which contained the following elements: trust was developed in the therapeutic relationship,

a positive sense of self was built in the client, the "shamed self" was acknowledged and explored, the abuse, and factors relating to it, were understood in regard to the context in which they had occurred and learnings from therapy were integrated into the life of the survivor. The outcome of which was that the client renegotiated the meanings they had once derived from their abuse experience and therefore developed a stronger, more positive self-concept. Attention was also given to the therapists' perceptions of the role of gender and the differences and similarities in the healing process for both males and females. Findings suggest that respondents saw the process of healing to be similar for both males and females, with differences in response and process being largely the result of socialisation practices.

LIMITATIONS OF THE STUDY

As is fitting for a qualitative method of analysis, such as the one employed in this study, the sample size for this project was small. As a consequence, therapies that lie outside the range of this sample have not been considered here, and the range of possible conceptualisations therapists within any given therapeutic viewpoint may hold, may not have been fully represented by those respondents participating in this study.

The current analysis represents the core factors in the process of healing shame in adult survivors, across therapeutic approaches. By virtue of this fact, much of the richness of concepts and theory that may occur within individual approaches, fails to be captured by this analysis. Another factor impinging on this analysis is the scope of this present study, which has not allowed for more in depth investigation and verification of findings. (It is hoped that future research may indeed achieve this). However the essence of the therapeutic approaches, as relevant to the healing of shame in the survivor of sexual abuse, has hopefully been retained.

Finally, although appropriate to qualitative research, using a one-off interview has amounted to a "snap-shot in time" of the ideas and conceptualisations held by respondents. Some respondents' stated that they were not used to talking about their work in this way. Their descriptions were therefore reliant on memory and upon their articulating these theoretical concepts "on the spot", which may or may not have limited their accounts. This potential limitation may be countered by the advantage of gaining the spontaneous responses of therapists to case study material.

IMPLICATIONS FOR FUTURE RESEARCH

Further investigation using both qualitative and quantitative methods, into the ways shame develops in the child victim of sexual abuse and the ways variables such as perpetrator characteristics and the nature of the abuse affect the development of shame, may provide important tools for parents and those working with children, as well as those working with adult survivors. This research has focused on looking at shame through the eyes of therapists, rather than the survivors themselves. Investigation into shame and the process of re-negotiating meanings could be furthered by comparing this model to the actual experiences of survivors who have gone through a process of healing.

Shame is an issue which is not limited to the experience of sexual abuse survivors. Investigation into the healing of shame as a feature in other counselling areas such as eating disorders, parenting and in marital counselling issues such as divorce, may clarify and verify the process of re-negotiating meanings.

Additional areas of future research could also look more indepth at the experience of therapy for males, increasing awareness of cultural pressures and of how males can overcome them, in order that males in the future be armed with some comeback against these societal pressures and obtain healing.

The holistic view of the person, which this theory holds, is helpful as a broad category which can locate and encompass many different emphases within therapeutic approaches. The Maori people also view the person holistically and there is a need for psychotherapy to be culturally sensitive and appropriate to the Maori (Durie, 1985; Durie, 1994). Future research could therefore investigate the application and relevance of the present theory in a bi-cultural setting.

Further investigation could be made into the implications of this model in order to enhance the scope of interventions for children. Designing developmentally appropriate

intervention strategies which could intervene in the process of shame development may assist in the prevention of self-destructive behaviour and other long term sequelae in teenage survivors.

IMPLICATIONS FOR CLINICIANS & SURVIVORS

The emphasis on the timing of aspects of the therapeutic work in the process of renegotiating meanings is a significant finding. The importance of building a positive sense of self in the survivor and the establishment of trust, before the work of revisiting the abuse experience occurs is clear, and this has implications for sexual abuse counselling theory and practice. For example, therapies which pay no regard to these aspects may be unhelpful, even dangerous for survivors. Now, more than ever, survivors (and their families?) need to be informed about what to look for in a therapist, especially with incidents of false memory syndrome and documented cases of survivors being retraumatised by therapy, which are some of the dangers, now highly publicised in the New Zealand media and abroad. Findings from this study would suggest that there are some criteria from which to judge potential therapists. This criteria might include the following points; a therapist who involves the client in a collaborative manner; is warm, trustworthy; does not push the client to face things too soon; does not use methods which rely on a great deal of catharsis or other altered states without integration of understandings; and who does not push for detailed memory recall to the neglect of other themes is more likely to be safe and effective. Survivors should be encouraged to feel stronger, more positive in themselves before addressing the more painful aspects of the work. Certainly the empowerment of survivors is important and something that the psychotherapeutic community must address to safeguard a population who has already been victimised, in order to prevent their further victimisation by ineffective, or even dangerous therapeutic practice.

CONCLUSION

Shame in adult survivors of sexual abuse is a vital aspect of sexual abuse counselling which has been often neglected in sexual abuse literature. Shame is a fundamental issue which strikes at the core of a person, at the very identity of the survivor. It is important for therapists to have an awareness of shame and the myriad of issues arising from it, so as not to neglect this important aspect of healing.

An increased understanding of the impact of shame is advantageous, not only to therapy outcomes with adult survivors, but also to the possible development of more effective interventions with child and teenage survivors, in order that the damaging effects of a shamed self-concept be avoided. The present study has investigated the process of shame development which occurs throughout the development of the child through to adulthood. Findings therefore have application to therapeutic work with adult, teenage and child survivors. The development of a body of knowledge which is applicable across therapeutic orientations and which has implications across the various developmental stages survivors may span, may allow for greater integration of knowledge, an increased awareness of problematic issues and increased effectiveness in the treatment of survivors of sexual abuse. The present study examined the therapeutic process of healing from shame across varied therapeutic orientations, developing a theory of core factors in this process. These core factors are encapsulated in the grounded theory of *re-negotiating meanings*.

REFERENCES

Algert, N.E. & Borman, C.A. (1992). "Survivors of sexual abuse: facts, effects & intervention". *T.A.C.D. Journal, Vol 20 (1), 3-10.*

Allison, J.A. & Wrightsman, L.S. (1993). *Rape - the misunderstood crime.* Newbury Park, California: Sage Publications, Inc.

Baker, A.W. & Duncan, S.P. (1985). "Child sexual abuse: a study of prevalence in Great Britain". *Child Abuse and Neglect, 9 (4), 457-467.* In Davenport, C., Browne, K. & Palmer, R. (1994). "Opinions on the traumatizing effects of child sexual abuse: evidence for consensus". *Child Abuse and Neglect, Vol 18 (9), 725-738.*

Basta, S. M. & Peterson, R.F. (1990). "Perpetrator status and the personality characteristics of molested children". *Child Abuse and Neglect, 14 (4), 555-566.*

Beck, A. & Weishaar, M. (1995). "Cognitive Therapy", [chapter] in Corsini, R.J. & Wedding, D. (Eds) (1995). *Current Psychotherapies (Fifth Edition).* Illinois: F.E. Peacock Publishers, Inc.

Becker, P.H. (1993). "Common pitfalls in published grounded theory research." *Qualitative Health Research, 3, 254-260.*

Blatner, A. (1995). "Psychodrama". [chapter] in Corsini, R.J. & Wedding, D. (Eds) (1995). *Current Psychotherapies (Fifth Edition).* Illinois: F.E. Peacock Publishers, Inc.

Blatner, A. & Blatner, A. (1988). *Foundations of psychodrama: history, theory & practice (3rd Ed).* New York: Springer Publishing Company.

Boulton, F.G., Morris, L.A. & MacEachron, A.E. (1989). *Males at risk: the other side of child sexual abuse.* California: Sage Publications Inc.

Bradshaw, J.E. (1988). *Healing the shame that binds you.* USA: Health Communications Inc.

Briere, J. & Runtz, M. (1988)."Post Sexual Abuse Trauma" [chapter] in Wyatt, G.E. & Powell, G.J. (eds). (1988). *Lasting effects of child sexual abuse.* New York: Sage Publications.

Bruckner, D.F. & Johnson, P.E. (1987). "Treatment for adult male victims of childhood sexual abuse". *Social Casework, 68, 81-87.*

Burgess, A. & Holmstrom, L. (1975). "Sexual trauma of children and adolescents: pressure, sex and secrecy". *Nursing Clinics of North America, 10, 551-563.*

Busby, D.M., Glenn, E., Steggell, G.L., & Adamson, D.W. (1993). "Treatment issues for survivors of physical and sexual abuse". *Journal of Marital and Family Therapy, 19(4), 377-392.*

Clarkson, P. (1989). *Gestalt counselling in action.* London: Sage Publications Ltd.

Clarkson, P. & Mackewn, J. (1993). *Fritz Perls.* London: Sage Publications Ltd.

Combs, A.W. (1989). *A theory of therapy: guidelines for counselling practice.* Newbury Park, CA: Sage Publications Inc.

Davenport, C., Browne, K. & Palmer, R. (1994). "Opinions on the traumatizing effects of child sexual abuse: evidence for consensus". *Child Abuse and Neglect, Vol 18 (9), 725-738.*

American Psychiatric Association, (1994). *Diagnostic and Statistical Manual of Mental Disorders: DSM- IV (4th Edition).* Washington D.C.: American Psychiatric Association.

Draucker, C. (1992). *Counselling survivors of childhood sexual abuse.* London: Sage Publications Ltd.

Durie, M. (1985). *Counselling Maori People*, Manuscript of a presentation to the New Zealand Counselling and Guidance Association Hui, Palmerston North, May 1985 (G. Hermansson, edit. & transcription) Massey University, Palmerston North, N.Z.

Durrant, M. & Kowalski, K. (1990). "Overcoming the effects of sexual abuse: developing a self-perception of competence", [chapter] in Durrant, M. & White, C. (1990). *Ideas for therapy with sexual abuse.* Adelaide, Sth Australia: Dulwhich Centre Publications.

Eisen, M.R. (1992). "The victims burden: guilt, shame and abuse" *Imagination, Cognition and Personality, Vol 12 (1), 69-88.*

Evans, S. (1987). "Shame, boundaries & dissociation in chemically dependent, abusive and incestuous families", *Alcoholism Treatment Quarterly, Vol 4 (2), 157-179.*

Erikson, E.H. (1964). *Childhood and society (2nd Edition).* New York: Norton.

Fagan, J. & Shepherd, I.L. (1970). *Gestalt therapy now.* USA: Science and Behaviour Books Inc.

Faria, G. & Belohlavek, N. (1984). "Treating female adult survivors of childhood incest." *Social Casework, 65, 465-471,* In Pearson, Q.M. (1994). "Treatment techniques for adult female survivors of childhood sexual abuse", *Journal of Counselling and Development, Vol 73, 32-37.*

Finkelhor, D. (1979). *Sexually victimised children.* New York: Free Press.

Finkelhor, D. (1984). *Child sexual abuse: new theory & research.* New York: The Free Press.

Finkelhor, D. (1988)."The trauma of child sexual abuse" [chapter] In Wyatt, G.E. & Powell, G.J. (Eds.) (1988). *Lasting effects of child sexual abuse.* New York: Sage Publications.

Finkelhor, D. & Browne, A. (1985). "The traumatic impact of child sexual abuse: a conceptualisation". *American Journal of Orthopsychiatry, 55 (4), 530-541.*

Flannery, R. B. (1987). "From victim to survivor: a stress-management approach to the treatment of learned helplessness" [chapter] In van der Kolk, B.A. (Ed.) (1987). *Psychological Trauma.* Washington D.C.: American Psychiatric Press Incorporated.

Fossum, M.A. & Mason, M.J. (1986). *Facing shame: families in recovery.* New York: W.W. Norton & Co.

Frankel, A.J. (1984). *Four therapies integrated.* New Jersey: Prentice-Hall Inc.

Gelinas, D.J. (1983). "The persisting negative effects of incest" *Psychiatry, 46, 312-332.*

Gergen, K.J. (1985). "The social constructionist movement in modern psychology." *American Psychologist, Vol 40 (3), 266-275.*

Glaser, B.G. (1992). *Basics of grounded theory analysis: emergence versus forcing.* Mill Valley, CA: Sociology Press.

Glaser, B.G. & Strauss, A. (1967). *The discovery of grounded theory.* Chicago: Aldine de Gruyter.

Gold, E.R. (1986). "Long-term effects of sexual victimization in childhood: an attributional approach" *Journal of Consulting & Clinical Psychology, Vol 54 (4), 471-475,* In Hunter, M. (Ed.) (1990). *The sexually abused male- volume two.* New York: Lexington Books.

Hammersley, M. (1989). *The Dilemma of Qualitative Method: Herbert Blumer & the Chicago tradition.* London: Routledge.

Hammid, J. (1995). *"Shaping up and fitting in: a grounded theory of womens body image"* (Masters Thesis) Palmerston North, N.Z.: Massey University, Department of Psychology.

Hazzard, A., Celano, M., Gould, J., Lawry, S. & Webb, C. (1995). "Predicting symptomatology & self-blame among child sex abuse victims". *Child Abuse and Neglect, Vol 19(6), 707-714.*

Holstein, J.A. & Gubrium, J.F. (1995). *The active interview.* California: Sage Publications, Inc.

Hunter, M. (Ed.) (1990). *The sexually abused male: volume one.* Lexington, Massachusetts: Lexington Books.

Hunter, M. (Ed.) (1990). *The sexually abused male: volume two.* New York: Lexington Books.

Janoff-Bulman, R. (1979). "Characterological versus behavioural self-blame: inquiries into depression and rape" *Journal of Personality & Social Psychology, 37 (10), 1798-1809.* In Allison, J.A. & Wrightsman, L.S. (1993). *Rape - the misunderstood crime* U.S.A: Sage Publications, Inc.

Joy, S. (1987). "Retrospective presentations of incest: treatment strategies for use with adult women. Journal of Counselling and Development, 65, 317-319 In Pearson, Q.M. (1994). "Treatment techniques for adult female survivors of childhood sexual abuse", *Journal of Counselling and Development, Vol 73, 32-37.*

Jumper, S.A. (1995). "A meta-analysis of the relationship of child sexual abuse to adult psychological adjustment". *Child Abuse and Neglect, Vol 19 (6), 715-728.*

Kaufman, G. (1985). *Shame: the power of caring. (Revised Edition)* Boston: Schenkman, In Nathanson, D.L. (1989). "Understanding what is hidden: shame in sexual abuse", *Psychiatric Clinics of North America, Volume 12 (2), 381-388.*

Kercher, G. and McShane, M. (1984). "Characterising child sexual abuse on the basis of a multi-agency sample" *Victimology, 9 (3-4), 364-382.*

Kinkl, J. & Biebl, W. (1992). "Long-term effects of incest: life events triggering mental disorders in female patients with sexual abuse in childhood" *Child Abuse and Neglect, Vol 16, 567-573.*

Kirschner, S. Kirschner, D. & Rappaport, R. (1993). *Working with adult incest survivors.* USA: Brunner/Mazel Inc.

Krieger, M.J. & Robbins, J. (1985). "The adolescent incest victim and the judicial system" *American Journal of orthopsychiatry, 55 (3), 419-425.*

Kritsberg, W. (1993). *The Invisible Wound.* USA: Bantam Books, Inc.

Kvale, S. (1988). "The 1000-page question". *Phenomenology & Pedagogy, 6 (2), 90-106.* In Miles, M.B. & Huberman, A.M. (1994). *Qualitative Data Analysis: an expanded source book.* California: Sage publications Inc.

Lazare, A. (1987). "Shame & humiliation in the medical encounter" *Archives of Internal Medicine, 147, 1653-1658.* In Stone, A. M. (1992). "The role of shame in Post-traumatic stress disorder" *American Journal of Orthopsychiatry, 62 (1), 131-136.*

Lowen, A. (1995). "Bioenergetic Analysis" [chapter] In Corsini, R.J. & Wedding, D. (Eds) (1995). *Current Psychotherapies (Fifth Edition).* Illinois: F.E. Peacock Publishers, Inc.

MacFarlane, K. & Korbin, J. (1983). "Confronting the incest secret long after the fact: a family study of multiple victimisation strategies for intervention" *Child Abuse and Neglect, Vol 7(2), 225-237.* In Hunter, M. (Ed.) (1990). *The sexually abused male: volume one.* Lexington, Massachusetts: Lexington Books.

MacKinnon, M. (Ed.). (1991). *Each small step.* London: Womens Post Treatment Centre Inc.

Meyer, C. & Taylor, S.E. (1986). "Adjustment to Rape" *Journal of Personality and Social Psychology, 50, 1226-1234.*

Miles, M.B. & Huberman, A.M. (1994). *Qualitative Data Analysis: an expanded source book.* California: Sage Publications Ltd.

Miller-Perrin, C.L. & Wurtele, S.K. (1990). "Reactions to childhood sexual abuse: implications for post traumatic stress disorder" [chapter] In Meek, C. (Ed) (1990). *Post traumatic stress disorder: assessment, differential diagnosis & forensic evaluation.* Florida: Professional Resource Exchange, Inc.

Nathanson, D.L. (1989). "Understanding what is hidden: shame in sexual abuse", *Psychiatric Clinics of North America, Volume 12 (2), 381-388.*

Nathanson, D.L. (1992). *Shame & pride: affect, sex and the birth of self.* New York: W.W. Norton & Co.

Nasjleti, M. (1980). "Suffering in silence: the male incest victim". *Child Welfare, 59 (5), 269-275.*

Oats, T. (1994). *Shame and the Adult Survivor of Sexual Abuse: A review of Gestalt, Rogerian & local counselling approaches to therapy.* Unpublished manuscript.

Olson, P.E. (1990). "The sexual abuse of boys: a study of the long-term psychological effects" [chapter] In Hunter, M. (ed.) (1990). *The sexually abused male: volume two.* New York: Lexington Books.

Packer, M.J. (1985). "Hermeneutic inquiry in the study of human contact", *American Psychologist, Vol 40 (10), 1081-1093.*

Patton, M.Q. (1990). *Qualitative evaluation and research methods.* Newbury Park, California: Sage.

Pearson, Q.M. (1994). "Treatment techniques for adult female survivors of childhood sexual abuse", *Journal of Counselling and Development, Vol 73, 32-37.*

Peterson, K.G., Prout, M.F. & Schwarz, R.A. (1991). *Post traumatic stress disorder: a clinicians guide.* New York: Plenum Press.

Pierce, R. & Pierce, L. (1985). "Analysis of sexual abuse hotline reports" *Child Abuse & Neglect, 9, 37-45.*

Rencken, R.H. (1989). *Intervention strategies for sexual abuse* (Report No CG022806). Alexandria, VA: American Association for Counselling and Development. (ERIC Document Reproduction Service No. ED 323 483) in Pearson, Q.M. (1994). "Treatment techniques for adult female survivors of childhood sexual abuse", *Journal of Counselling and Development, Vol 73, 32-37.*

Risin, L.I. & Koss, M.P. (1987). "The sexual abuse of boys", *Journal of Interpersonal Violence, 2 (3), 309-323.*

Rogers, C. (1961). *On Becoming a Person.* London: Constable & Company Ltd.

Rogers, C (1980). *A Way of Being.* USA: Houghton Mifflin Company.

Rogers, C. & Terry, T. (1984). "Clinical interventions with boy victims of sexual abuse" In Stewart, I. & Greer, J. (Eds.) (1984). *Victims of sexual aggression.* New York: Van Nostrand Reinhold.

Sanderson, C. (1990). *Counselling adult survivors of sexual abuse.* London: Jessica Kingsley Publishers.

Sanderson, C. (1995). *Counselling adult survivors of sexual abuse (2nd edition).* London: Jessica Kingsley Publishers.

Sanford, L. T. (1990). *Strong at the broken places.* New York: Random House.

Schave, B. (1993). *Forgotten memories: a journey out of the darkness of sexual abuse* Westport, London: Praeger.

Schiller, P. (1988). "Survey of the effects of incest on adult survivors" *Response, vol 11 (4), 16-18.*

Sgroi, S.M. (1982). *Handbook of clinical intervention in child sexual abuse.* Toronto: Lexington Books.

Shapiro, S. & Dominiak, G. (1990). "Common psychological defenses seen in the treatment of sexually abused adolescents" *American Journal of Psychotherapy, Vol 41 (1), 68-74.*

Stevens, S. (1992). *"The relationships between counsellor orientation, experiences and training and their conceptualisation of their tasks in the healing process in sexual abuse counselling: a qualitative analysis."* (Masters Thesis) Palmerston North, New Zealand: Massey University, Department of Psychology.

Stewart, I. & Greer, J. (Eds.) (1984). *Victims of sexual aggression.* New York: Van Nostrand Reinhold.

Stone, A. M. (1992). "The role of shame in Post-traumatic stress disorder" *American Journal of Orthopsychiatry, 62 (1), 131-136.*

Strauss, A. & Corbin, J. (1994.) "Grounded theory methodology: an overview" [chapter] In Denzin, N.K. & Lincoln, Y.S. (Eds) (1994). *Handbook of qualitative research.* Thousand Oaks, California: Sage Publications Inc.

Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: grounded theory procedures and techniques.* Newbury Park: Sage

Struve, J. (1990). "Dancing with the patriarchy: the politics of sexual abuse" [chapter] In Hunter, M.(Ed.) (1990). *The sexually abused male: volume one.* Lexington Massachusetts: Lexington Books.

Summit, R. (1983)."The childhood sexual abuse accommodation syndrome" *Child abuse & neglect 7 (2), 177-193.*

Summit, R. (1992)."Response to criticisms of CSAAS" Presentation to The Master Class Ninth International Congress of Child Abuse & Neglect 1992. Chicago.

Thorne, B. (1992). *Carl Rogers* London: Sage Publications Ltd.

Tsai, M. Feldman-Summers, S. & Edgar, M. (1979). "Childhood molestation: Variables related to differential impact on psychosexual functioning in adult women" *Journal of Abnormal Psychology, Vol 88 (11), 407-417* In Hunter, M. (Ed). (1990) *The sexually abused male- volume two.* New York: Lexington Books.

Van Belle, H. (1980). *Basic intent and therapeutic approach of Carl Rogers.* Toronto: Wedge Publishing Foundation, In Thorne, B. (1992). *Carl Rogers.* London: Sage Publications Ltd.

White, M. (1989). *Selected Papers.* Adelaide, South Australia: Dulwhich Centre Publications.

Wilson, G.T. (1995). "Behaviour Therapy" [chapter] In Corsini, R.J. & Wedding, D. (Eds.) (1995).*Current Psychotherapies (Fifth Edition).* Illinois: F.E. Peacock Publishers, Inc.

Wyatt, G.E. & Powell, G.J. (Eds.) (1988). *Lasting effects of child sexual abuse.* New York: Sage Publications.

APPENDIX

Case Study - Jamie
Case Study - John
Biographical Sheet
Interview Guide
Information Sheet
Letter to participants

CASE VIGNETTE- JAMIE

Jamie is 26 years old and has been referred by her G.P. who has been treating her for depression. Jamie recently ended a long-term relationship after fears that she could not remain faithful to her fiance. She also experienced ambivalence toward her fiancés children and anxiety at the thought of becoming committed to them.

Brought up in the sole care of her mother, Jamies' childhood was lonely and isolated. Her mother worked two jobs and had a string of short-term relationships. Jamie had few friends due to moving frequently. The only other contact with family were the visits to Jamies grandparents for holidays. During these visits Jamie was abused by her grandfather and remembers this abuse starting as early as 4 years old. Attempts to disclose the abuse to Jamies mother were not successful. Jamie suspects her mother may have also been abused by the grandfather.

During her teenage years Jamie was depressed, self-mutilating at times and once attempted suicide. She recalls being molested on two occasions by her mothers boyfriend. She describes her failure to form good relationships with peers and was involved in numerous short-term sexual relationships which were "turbulent, angry and based on sex". Upon leaving school Jamie became involved in prostitution and stripping but stopped after being beaten up. She now works as an artist in a graphic design firm.

Jamie describes herself as having two distinct "sides": one who desires to have a stable relationship, a family of her own, and a successful career as an artist, and the other who is secretive, angry and "dirty", seeking sexual encounters with strangers and drawn compulsively to pornography. Jamie describes feelings of hatred and anger toward her grandfather but adds that her grandfather came from a physically and emotionally abusive background far worse than her own.

CASE VIGNETTE- JOHN

John is 26 years old and has been referred by his G.P. who has been treating him for depression. John recently ended a long-term relationship after fears that he could not remain faithful to his fiance. He also experienced ambivalence toward his fiancés children and anxiety at the thought of becoming committed to them.

Brought up in the sole care of his mother, Johns' childhood was lonely and isolated. His mother worked two jobs and had a string of short-term relationships. John had few friends due to moving frequently. The only other contact with family were the visits to Jamies grandparents for holidays. During these visits John was abused by his grandfather and remembers this abuse staring as early as 4 years old. Attempts to disclose the abuse to Johns mother were not successful. John suspects his mother may have also been abused by the grandfather.

During his teenage years John was depressed, self-mutilating at times and once attempted suicide. He recalls being molested on two occasions by his mothers boyfriend. He describes his failure to form good relationships with peers and was involved in numerous short-term sexual relationships which were "turbulent, angry and based on sex". Upon leaving school John became involved in prostitution and stripping but stopped after being beaten up. He now works as an artist in a graphic design firm.

John describes himself as having two distinct "sides": one who desires to have a stable relationship, a family of his own, and a successful career as an artist, and the other who is secretive, angry and "dirty", seeking sexual encounters with strangers and drawn compulsively to pornography. John describes feelings of hatred and anger toward his grandfather but adds that his grandfather came from a physically and emotionally abusive background far worse than his own.

BIOGRAPHICAL SHEET

What age group are you in? (20-29) (30-39) (40-49) (50-59) (60-69)

What is your cultural background?

What educational qualifications do you hold?

What training have you undertaken relevant to your sexual abuse counselling?

Other counselling experience?

What therapeutic school(s) do you identify most with?

Which theories or beliefs about the dynamics and effects of sexual abuse inform your

work?

Do you mainly work with males? females? Mainly males/females? Adults? Children? Adolescents?

What authors, books, workshops etc. have informed your work or have been helpful to

you?

INTERVIEW GUIDE

This study is looking at shame in sexual abuse survivors. Related terms are: self-blame, self-hatred, low self-esteem, guilt, negative self-image, "damaged goods".

What term would you give to this phenomena? Are there any other terms you would add to this list?

How do you explain the presence of shame in the sexually abused in general? How do you understand it? What is happening for the client that causes it?

*What are the sorts of issues you may expect Jamie/John will bring to therapy?

*In what order would you address them? How much of your counselling process is lead by a theory or model? By intuition? Other?

*Where in the therapeutic process would you expect to address shame issues.

*What events/factors in Jamies/Johns life history would you consider likely to have contributed to the development of shame?

What are some of the tasks specifically related to shame that may need to be addressed by therapy? (ie:breaking substance abuse shame cycle, building self-concept etc.)

*What sorts of obstacles are there to resolving shame that may be encountered by Jamie/John.(ie: reactions of family, denial etc.)

*What therapeutic approaches and interventions would you use? Are there any you would not recommend? What therapeutic approaches and interventions would you use, would they be the same?, any differences?

In your opinion, how do these interventions work to resolve shame issues. What do they aim to do, how do they work therapeutically?

*Would you expect anything to be different had John or Jamie been abused by a female? *What could have been gained had Jamie or John entered counselling at 10 years of age?

*In your experience what sorts of things have your clients said they found most helpful during the counselling process? What about least helpful?

*What do you see as some of the key differences, if any, in the types of issues brought to counselling for males and female survivors? What are the similarities?

*Is there anything I haven't asked you about with respect to either of the cases that you feel is important or relevant?

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FACULTY OF
SOCIAL SCIENCES

DEPARTMENT OF
PSYCHOLOGY

AN INVESTIGATION OF COUNSELLORS CONCEPTUALISATIONS OF SHAME AND ITS IMPACT ON MALE AND FEMALE ADULT SURVIVORS OF SEXUAL ABUSE.

INFORMATION SHEET FOR COUNSELLORS

BACKGROUND INFORMATION

My name is Tracey-Lynne Oats and I am completing an M.A. in Psychology. My thesis topic involves looking into the ways counsellors conceptualise and work with the issue of shame in adult survivors of sexual abuse (males and females). I am working under the supervision of Cheryl Woolley, a senior lecturer from Massey University's Psychology Department. Potential participants have been chosen from the ACC list of approved counsellors in the Palmerston North area. I am hoping to interview a number of ACC approved counsellors who work in the area. If you agree to participate in my study the following explains some relevant details.

WHAT IS THE STUDY ABOUT?

In this study I am interested in the issue of shame in adult survivors of sexual abuse and in the theories and therapies that inform counselling practice. I hope that from this exploration a greater awareness of the issue of shame and its impact on the sexually-abused will be gained as well as a greater understanding of what theories and therapies inform the work of counsellors who work with these clients. As a large amount of the research in this area has focused on the experiences of women, it is also hoped that this research will contribute to knowledge of the effects of abuse for males and females comparatively and the sorts of issues males come into counselling with.

HOW MUCH TIME IS INVOLVED AND WHAT WILL YOU HAVE TO DO?

After having sent this information sheet to you I will contact you by phone in the next few days to discuss the possibility of your participation and to answer any further questions you may have. If you are interested in contributing to this research and can afford the time involved I will arrange an interview time with you then. You may complete the enclosed consent form which I will collect from you at the time of your interview.

Participation will involve an interview in which you will be asked to complete a short biographical sheet and to respond to two case studies (case studies are used as an aid for you to help you recall issues and relevant counselling practice). The interview will be loosely structured (a few guiding questions) and will probably take between one to two hours. Following this a copy of the transcript from our interview will be sent to you for you to check and amend where you see fit or to add any other thoughts for further clarification, which you will then return to me.

If you agree the interview will be audiotaped, but you have the right to ask for the audio tape to be turned off at anytime during the interview. The audiotape(s) will be transcribed by me personally, alone. No one else will have access to the tapes, they will be stored and coded in a safe place. At the end of the study the transcripts and tapes will be returned to you.

Should you agree to take part in this study your participation will be anonymous, your identity and that of your employing agency will remain confidential to myself and my supervisor and it will not be possible to identify you or your agency in any reports that are prepared from the study. It is your right as a participant to refuse to answer any questions and to withdraw from the study at any time. The information gathered will only be used in publications relating to the research.

WHAT CAN YOU EXPECT FROM ME?

If you take part in the study you have the right to:

*refuse to answer any particular question, and to withdraw from the study at any time;

* ask any further questions about the study that occur to you during your participation;

* agree/disagree to the interview being audio taped;

* request that the taping be stopped at any time during the interview.

* provide information on the understanding that it is completely confidential to the researcher. All information is collected anonymously, and it will not be possible to identify you in any reports that are prepared from the study;

* be given access to a summary of the findings from that study when it is concluded.

You are welcome to contact me by leaving a message for me at the Psychology Department, Ph: 356-9099. My supervisor is Cheryl Woolley, a senior child and family psychologist from Massey University Psychology Department. Cheryl can be contacted at the Psychology Clinic, Ph: 350-4142.

If you have any further enquiries please don't hesitate to call me or my supervisor. Thank you very much in anticipation.

Yours sincerely

Tracey-Lynne Oats

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CONSENT FORM

I have read the information sheet for this study and have had the details of the study explained to me and I understand that I may ask further questions at anytime.

I also understand that I have the right to withdraw from the study at anytime and that I have the right to decline to answer any particular questions in the study. I agree to provide information to researchers on the understanding that my identity and that of my agency are completely confidential.

I agree/do not agree to the interview being audio-taped.

I also understand that I have the right to ask for the audiotape to be turned off at anytime during the interview.
I wish to participate in this study under the conditions set out on the information sheet.

SIGNED:_____

NAME:_____

DATE:_____