

Childhood Psychological Maltreatment and Perception of Self,
Others, and Relationships: A Phenomenological Exploration

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Abstract

Using a qualitative approach this thesis aimed to investigate perception of self, others, and relationships in individuals with a history of chronic, childhood, parental, childhood, psychological maltreatment. Six participants (3 staff; 3 clients) from low-cost counselling agency completed a semi-structured interview designed to assess perceptions of self, others, and relationships. Interpretative Phenomenological Analysis yielded four superordinate themes: shame-based perception of self; self-protection from emotional pain; egocentric perception of others; and shame-based roles in relationships. The results of this study were compared with current literature on childhood maltreatment, including psychological maltreatment, and perception of self, others, and relationships, and significant similarities were found between research to date and the findings of this study. Theoretical links were then made to Bowlby's (1969) attachment theory. The findings of this study suggest that psychological maltreatment has significant, pervasive, deleterious consequences for the individual's perception of self-worth, awareness of others, and interpersonal functioning, and implies that childhood psychological maltreatment merits greater attention and investigation, especially the issue of perception of others.

Childhood Psychological Maltreatment and Perception of Self, Others, and Relationships: A Phenomenological Exploration

Chronic, childhood maltreatment has long been associated with a number of widely recognised detrimental, pervasive long-terms posttraumatic psychopathologies including posttraumatic stress disorder (Muller, Sicoli, & Lemieux, 2000; Roche, Runtz, & Hunter, 1999), anxiety and depression (Wright, Crawford, & Del Castillo, 2009). Chronic, parental, childhood *psychological* maltreatment, a neglected field of study relative to other forms of childhood maltreatment, has been associated with a number of similar adverse outcomes as other forms of childhood maltreatment, including emotional distress (Grassi-Oliveira & Stein, 2008), and interpersonal problems (Mullen, Martin, Anderson, Romans, & Herbison, 1996).

The thesis begins with a clarification of terminology, followed by a discussion of the difficulties inherent in defining psychological maltreatment. Then the prevalence of childhood psychological maltreatment, as well as its coexistence with other forms of childhood maltreatment is presented. This will be followed by evidence of the posttraumatic symptomatology, and related diagnostic issues associated with chronic, parental, childhood, psychological maltreatment.

Focus will then turn to the impact of chronic, parental, childhood psychological maltreatment perception of self, others, and relationships. Attention will be given to how chronically negative interactions with parents can result in the child forming negative perceptions or sets of beliefs about the self. Specifically this section will describe how parents set standards and expectations which are internalised by the child (Bowlby, 1988). The child monitors the parent for feedback on the child's success in meeting those standards. If the parent's feedback is chronically negative the child's creates an explanation for this, commonly that the child is inferior, unlovable and rotten which leads to a sense of shame and continued attempts to gain approval and avoid abuse (Harter, 1999).

I will then discuss the relationship between psychological maltreatment and the negative perception of others. This will include a discussion of the impact of a negative perception of others on adult functioning, especially difficulties in interpersonal relationship (Bartholomew & Horowitz, 1991). I hope to contribute to the significant gap in the literature of perception of others by using a broad open-ended measure that encourages participants to talk openly and fully about their perceptions of others, with the possibility of providing new concepts, beyond the established issues of trust, for further future exploration

Finally perceptions of relationships will be explored. Perceptions about self and others impact the individual's perceptions of oneself in relations to others, the nature of relationships and ones role in relationships, including expectations of further maltreatment. These beliefs endure into adulthood and the child develops a set of coping techniques such as inhibiting displays of emotions, developing and maintain a public façade, and putting others desires, needs and feeling before their own (Herman, 1992). These coping techniques are designed for appeasing others and reducing maltreatment in childhood but inhibit the development and maintenance of healthy relationships in adulthood (Bowlby, 1988).

This study seeks to add to the limited research and literature on the impact of chronic, parental, childhood psychological maltreatment on perception of self, others, and relationships by utilising a qualitative methodology, interpretative phenomenological analysis (IPA) to identity and describe relevant themes that emerge. The vast majority of previous research has used quantitative methodology to test pre-determined hypotheses derived largely from studies of other forms of childhood maltreatment.

Psychological Maltreatment

Terminology

Several terms have been employed to describe the topic under investigation, including emotional abuse and emotional neglect (Brock, Pearlman, & Varra, 2006; Spertus, Yehuda, Wong, Halligan, & Seremetis, 2003), psychological maltreatment (Crawford & Wright, 2007; DeRobertis, 2004), verbal aggression (Vissing, Straus, Gelles, & Harrop, 1991), psychological abuse (Ferguson & Dacey, 1997), and emotional maltreatment (Wright et al., 2009). Psychological maltreatment and emotional abuse appear to be the most commonly used terms.

While there is no consensus, a strong argument has been made for the term psychological maltreatment. The word psychological encompasses both emotional and cognitive aspects of childhood maltreatment, and the word maltreatment includes both acts of commission (abuse) and omission (neglect) (Hart & Brassard, 1987; Hart, Brassard, Binggeli, & Davidson, 2002). The term psychological maltreatment has been selected and refers to chronic, parental, childhood psychological maltreatment. The term parent is used to refer to the child primary caregiver (e.g., step-parents, grandparents, foster parents).

Definitional Issues

Relative to other forms of abuse, psychological maltreatment has been subject to little attention, research and intervention (Behl, Conyngham, & May, 2003). This may in part be due to a lack of recognition by both researchers and the public about the existence and consequences of psychological maltreatment. This is also largely due to the difficulties inherent in defining a concept with which, unlike physical abuse for example, has no immediate or observable consequences. Further impeding the creation of a clear, widely accepted definition is the matter of creating a threshold that delineates when certain behaviours are determined to be detrimental to the child's wellbeing. Many of the behaviours that are deemed to be emotionally abusive (e.g., name calling, humiliation) are common occurrences in many households. This study however, focuses only on individuals with a

history of chronic psychological maltreatment. Creating an operational definition that specifies a threshold to determine the presence of psychological maltreatment is extremely difficult. Furthermore any definition must take into account different cultural contexts. A great deal of debate and discussion has gone into devising a legal, conceptual, and operational definition of psychological maltreatment and yet, to date, there is no consensus among researchers, protective services, and legal agencies on a definition (Baker, 2009).

Psychological maltreatment is not as widely recognised as sexual abuse or physical abuse by researchers, policy-makers, clinicians, or the general public, as a valid form of trauma with a significant, potentially lifelong, detrimental impact on development and functioning. The creation of a widely accepted, fully inclusive definition is a necessary step in redressing this situation.

In their practice guidelines, the American Professional Society on the Abuse of Children (APSAC, 1995) state “Psychological maltreatment means a repeated pattern of caregiver behaviour or extreme incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or of value only in meeting another’s needs.” (Glaser, 2004, p.2). The guidelines describe six forms of psychological maltreatment: spurning, terrorising, exploiting/corrupting, denying emotional responsiveness, isolating and mental, health, medical, or educational neglect. While this definition is useful, it is by no means complete or widely agreed upon.

Baker (2009), in a review of key legal and conceptual definitions of psychological maltreatment, found that conceptual definitions fall into one of two categories: (a) the definition employs an approach that focuses on the parents’ behaviour, to the exclusion of consideration of outcomes to the child; and (b) the definition employs an approach that focuses exclusively on the outcome to the child, and believes the specific behaviour of the parent is irrelevant or too varied to enumerate. Baker (2009) provided a list of parental

behaviours included in the first category of conceptual definitions, as presented in Appendix A. Baker (2009) pointed out that “with only minimal fine-tuning” (p. 207) all of the parental behaviours can be fitted into one of the six categories of psychological maltreatment described by the APSAC above (i.e., spurning, terrorising, exploiting/corrupting, denying emotional responsiveness, isolating and mental, health, medical or educational neglect).

Baker (2009) concluded that the second category of conceptual definitions (focusing exclusively on the consideration of child outcomes) comprises three relevant child outcomes that define psychological maltreatment as something that: (1) is psychologically damaging or harmful to the child; (2) that harms the child’s developmental functioning in one or more domains (e.g., social, cognitive, emotional); and (3) affects the child’s self-perception and perception of the world as a safe place (see Baker, 2009 for a comprehensive summary of legal and conceptual definitions of psychological maltreatment and a review of current definitional challenges). In short, psychological maltreatment should be understood as constituting an amalgam of both categories, such that a caregiver’s behaviour has a detrimental and potentially lasting impact on the child’s psychological well-being. Thus, in this thesis, psychological maltreatment is defined as a chronic pattern of caregiver behaviour that encompasses the six categories of described by the APSAC above, and comprises the three relevant child outcomes described above.

Prevalence

A number of studies investigating the impact of chronic, childhood psychological maltreatment on adults have accumulated retrospective data regarding childhood prevalence. In a sample of primary care patients Spertus et al. (2003) found that forty three percent of participants reported a history of emotional neglect, and 42% reported a history of emotional abuse. Martsolf, Draucker, and Chapman,(2004) found lower, but still significant, rates of psychological maltreatment, with 24% reporting a history of emotional neglect and 20%

reporting a history of emotional abuse. Grassi-Oliveira and Stein (2008) produced a cross-sectional study of 115 participants utilising paediatric and gynaecology services at a public general hospital frequented primarily by the low social and economic status population. A history of childhood emotional abuse was reported by 36.5% of participants, and 35.7% reported a history of childhood emotional neglect. The prevalence rates in the above studies average at just over one third of the samples. In a clinical sample of outpatient psychotherapy clients 88% and 81% reported emotional neglect and emotional abuse histories, respectively (Brock et al., 2006).

Studies which have utilised both female and male samples have reported that, despite apparent gender differences in the prevalence of sexual and physical abuse (Brock et al., 2006; Gibb, Alloy, Abramson, Rose, Whitehouse, & Hogan, 2001; Higgins & McCabe, 2003), no significant gender differences are evident for psychological maltreatment (e.g. Grassi-Oliveira & Stein, 2008; Wright et al., 2009). Prevalence literature on abuse suggests psychological maltreatment, whether co-occurring with other forms of maltreatment, or as a stand-alone form of maltreatment, appears to be the most prevalent form of childhood maltreatment experienced by a significant portion of the population, yet despite this, the long-term effects of childhood psychological maltreatment are relatively under-studied.

Psychological Maltreatment as a Core Component of Child Maltreatment.

Hart and Brassard (1987) refer to psychological maltreatment as “potentially more destructive” (p. 160) than other forms of childhood maltreatment. Wright et al. (2009) claim psychological maltreatment may be “one of the most destructive (and pervasive) forms of maltreatment” (p. 2). Others have taken a different approach. Rather than pitting one form of maltreatment against another, many researchers (Goldsmith & Freyd, 2005; Spertus et al., 2003; Wright et al., 2009; Yates, 2007) support a proposition by Hart and Brassard (1987) that psychological maltreatment is inherent in all others forms of childhood maltreatment;

specifically that psychological maltreatment, as well as being a stand-alone form of maltreatment, is also the core component of all forms of childhood maltreatment. Hart and Brassard (1987) base this proposition on:

the widely supported assumptions that a) psychological maltreatment is inherent in all forms of childhood maltreatment; b) the major negative effects of childhood maltreatment are generally psychological in nature, affecting the victims view of self, others, human relationships, goals, and strategies for living; and c) the concept clarifies and unifies the dynamics that underlie the destructive power of all forms of child abuse and neglect (Hart & Brassard, 1987, p. 161)

In either case, it is an untenable situation that psychological maltreatment is subject to so little investigation.

Posttraumatic Symptomatology Associated with Childhood Psychological Maltreatment.

Despite limited research on psychological maltreatment relative to other forms of abuse, several studies have provided empirical support for the long-term, profound, and devastating outcomes of childhood psychological maltreatment on adult psychological functioning. Outcomes include anxiety and depression (Ferguson & Dacey, 1997; Hund & Espelage, 2006; Spertus et al., 2003; Wright et al., 2009), dissociation (Ferguson & Dacey, 1997), alexithymia (Goldsmith & Freyd, 2005; Hund & Espelage, 2006), emotional distress (Grassi-Oliveira & Stein, 2008), low self-worth (Brock et al., 2006), suicidal ideation and hopelessness (Gibb et al., 2001), increased posttraumatic stress symptomatology. (Grassi-Oliveira & Stein, 2006; Spertus et al., 2003), physical health problems (Martsolf et al., 2004), and disordered eating (Hund & Espelage, 2006).

Some researchers have suggested that psychological maltreatment may be more detrimental to healthy development than physical or sexual abuse (Ney, Moore, McPhee, &

Trought, 1986; Vissing et al., 1991). Psychological maltreatment has been demonstrated to be the strongest predictor of anxiety (Higgins & McCabe, 2003; Martsolf et al., 2004; Spertus et al., 2003), depression (Higgins & McCabe, 2003; Martsolf et al., 2004; Spertus et al., 2003), negative health outcomes (e.g., bodily pain, physical functioning impairment), and perpetration and victimisation of adult interpersonal aggression (Crawford & Wright, 2007), after controlling for other forms of childhood maltreatment.

Diagnostic Issues

Researchers and clinicians working with individuals with a history of complex trauma, including psychological maltreatment, assert that current diagnostic criteria in the Diagnostic and Statistical Manual of Mental disorders – Fourth Edition – text revised (DSM-IV-TR; APA, 2000) do not adequately capture the full range of posttraumatic symptomatology observed in survivors of complex trauma, and have proposed that a new diagnostic construct be created and included in the DSM to account for the complex reactions to chronic and complex trauma. Currently the risk exists that by relegating posttraumatic outcomes to comorbid conditions beyond PTSD, fundamental posttraumatic disturbances may not be thoroughly investigated and ineffective treatment approaches may be applied (Spinazzola, Blaustein, & Van der Kolk, 2007). Herman (1992), based on a review of existing literature on chronic trauma survivors, developed a diagnostic construct, Complex Posttraumatic Stress Disorder (CPTSD), to capture the full range of posttraumatic symptomatology for individuals with a history of complex trauma. The following list of symptom was developed, based on literature on the long-term impact of complex trauma (Table 1). Studies focusing on psychological maltreatment show posttraumatic symptomatology consistent with Herman's (1992) diagnostic construct of CPTSD including alteration in the regulation of affect and impulses (e.g., suicidal ideation) (Gibb et al., 2001), alterations in attention or consciousness (e.g., episodes of dissociation) (Ferguson & Dacey, 1997; Wright et al., 2009), somatization

(e.g., physical pain) (Spertus et al., 2003), alterations in self-perception (e.g., defectiveness/shame) (Wright et al., 2009), alterations in relations with others (e.g., mistrust) (Crawford & Wright, 2007), and alterations in systems of meaning (e.g., hopelessness) (Gibb et al. 2001). This compilation of studies provides support for the idea that psychological maltreatment is associated with the significant, pervasive, and detrimental complex outcomes captured under Herman's diagnostic construct of CPTSD.

Table 1

CPTSD Symptom Clusters and Subcategories (Herman, 1992).

I. Alteration in regulation of affect and impulses

- A. Affect regulation
- B. Modulation of anger
- C. Self-destructive
- D. Suicidal preoccupation
- E. Difficulty modulating sexual involvement
- F. Excessive risktaking

II. Alterations in attention or consciousness

- A. Amnesia
- B. Transient dissociative episodes and depersonalisation

III. Somatisation

- A. Digestive pain
- B. Chronic pain
- C. Cardiopulmonary symptoms
- D. Conversion symptoms
- E. Sexual symptoms

IV. Alterations in self-perception

- A. Ineffectiveness
- B. Permanent damage
- C. Guilt and responsibility
- D. Shame
- E. Nobody can understand
- F. Minimising

V. Alterations in perception of the perpetrator

- A. Adopting distorted beliefs
- B. Idealisation of the perpetrator
- C. Preoccupation with hurting perpetrator

VI. Alterations in relations with others

- A. Inability to trust
- B. Revictimisation
- C. Victimising others

VII. Alteration in system of meaning

- A. Despair and hopelessness
 - B. Loss of previously sustaining beliefs
-

The Long-term Impact of Psychological Maltreatment on Perception of Self, Others and Relationships

Perception of self. Studies specifically exploring the impact of psychological maltreatment on perception of self found it to have a stronger association with negative perception of self than other forms of childhood maltreatment (McLewin & Muller, 2006; Muller et al., 2000). A child's experiences with his or her parents are the primary source for the acculturation of the rules and norms for the socialisation of emotions (Eisenberg,

Cumberland, & Spinrad, 1998; Shipman, Zeman, Nesin, & Fitzgerald, 2003). The parent provides guidelines, expectations and standards to guide or control the child's behaviour (Bowlby, 1988), both directly (e.g., verbal direction: e.g., "say please", "take that look off your face"), and indirectly (e.g., modelling). The parent also provides evaluative feedback to the child about the extent to which the child is meeting those expectations and standards (e.g., verbal feedback: e.g., "it's not ok to hit the dog", "you are useless"). When feedback from the parents is chronically negative, and fits the criteria for psychological maltreatment (e.g., degrading, belittling, spurning), the child internalises these messages, and incorporates them into his or her perception of self. These internalised negative self-concepts become global and stable, and lead to a low sense of self-worth and self-esteem (Harter, 1999).

A number of studies have demonstrated that individuals with a history of psychological maltreatment manifest low self-esteem and perceptions of low self-worth (Brock et al., 2006; Herman, 1992; Mullen, Martin et al., 1996), which are possibly the most commonly recognised outcomes of psychological maltreatment (Mullen et al., 1996; Varia, Abidin, & Dass 1996). This global sense of low self-worth often extends to a sense of "inner-badness", that the core-self is somehow rotten (Harter, 1999). The egocentrism of young children, with the child's developmental sense of being the centre of the universe, leads the child to blame themselves for events they are not responsible for, and that are beyond the child's control (Harter, 1999; Herman, 1992). Many abused children blame themselves for the behaviours inflicted upon them by parents.

The child's internalisation of the parents messages of contempt, rejection, and disapproval results in intense self-derogatory ideations (Harter, 1999). Furthermore the child will deliver these messages to themselves in absentia of the parent, when the child believes that he or she has failed to live up to those internalised expectations – in a sense the child will assume the parent's role as the abuser of the self. Sachs-Ericsson, Verona, Joiner, and

Preacher (2006) found that parental verbal abuse significantly predicted a negative, global, stable cognitive style of constant self-critical judgments.

The incorporated damaging messages from parents into the child's evaluation of his or her worth as a person (Harter, 1999) can directly contribute to global, stable, internal, negative self-attributions (Crawford & Wright, 2007). Such attributions can convey the message that the child is not living up to expectations, that the child's core self falls short of certain standards, is a disappointment to the parent, and is therefore not worthy of love (Feiring, 2005). Psychological maltreatment can invalidate the child's own thoughts and feelings (e.g., "don't cry", "you don't really think that", "you shouldn't be angry"). Emotions and emotional expressions deemed undesirable or inappropriate by the parent may be perceived to be displays of bad personal characteristics of the child and relayed thus to the child (Goldsmith & Freyd, 2007). The child may come to believe that his or her own assessments of experiences, thoughts, or feelings are wrong, and cannot be valid or correct (Linehan 1993) contributing to the child's sense of being somehow innately flawed or damaged. The blame, condemnation, and criticism of psychological maltreatment will be incorporated by the child into representations of self-blame that contribute to an overall sense of low self-worth and self-esteem. Shame is often accompanied by body language displays, such as shrinking posture and averting the gaze, possibly serving the adaptive function of a signal of submission, to stop the abusive behaviour (Feiring, 2005).

Paradoxically, this self-blame may serve an adaptive function. If the child perceives the primary caregiver as inherently bad or unloving, this threatens the caregiving relationship that the child is instinctively, physiologically and psychologically driven to maintain for survival purposes. Furthermore, if the child perceives the primary caregiver to be the blame, the situation is then perceived as beyond the child's control and the child is overwhelmed with feelings of helplessness. Psychological maltreatment has been associated with the belief that

the individual is vulnerable to harm, and is unable to prevent harm (Lumley & Harkness, 2007; Wright et al., 2009). This sense of vulnerability may underlie the individual's sense of helplessness (Gibb, 2002; Hankin, 2005).

Psychological maltreatment directly devalues the child as an individual, undermining any sense of power or self-efficacy (Mash & Wolfe, 2005). Survivors of childhood maltreatment often report an overwhelming sense of powerlessness (Herman, 1992). However, if the child develops a representation of self-blame, this offers some hope to the child that the child has the ability to control the situation by changing his or her own behaviour (Herman, 1992).

Psychological maltreatment such as rejection, degradation, and criticism may lead the child to believe they are somehow unacceptable, inferior (Harter, 1999), or a failure (Lumley & Harkness, 2007). These perceptions are commonly associated with shame (Harter, 1999). Individuals with shame-based representations can perceive themselves as chronically helpless, powerless, worthless, and incompetent (Harper, Austin, Cercone, & Arias, 2005). The feeling of powerlessness can become a salient part of the individual's self-identity (Wolfe, Jaffe, & Jette, 2003). Shame has a debilitating impact on self-worth and can motivate the individual to avoid others or hide the true self (Harter, 1999). Wright et al. (2009) assessed a group of 301 college students and found that psychological maltreatment such as chronic contempt, put-downs, rejection, criticism, disapproval, and being ignored, was significantly related to internal, global, stable, self-representations of shame and defectiveness. Verbal disapproval, hostility, and contempt convey the message that the child's core-self is a disappointment, and therefore unlovable, as the child has failed to live up to the parent's expectations (Feiring, 2005).

The child believes that by trying to live up to the parents, often unrealistic, expectations, they will eventually be able to appease the parents (Harter, 1999; Herman, 1992), and gain the love, support and approval the child desperately longs for. This sense of inner-badness,

combined with the belief that one must alter one's own behaviours to appease others, and to prevent abuse, leads to a series of beliefs about oneself in relation to others, and about the appropriate role to adopt to appease others or to avoid abuse.

Perception of others. The impact of childhood maltreatment, including psychological maltreatment, on perception of others is relatively poorly investigated. Bowlby (1988) theorised that chronic, childhood maltreatment by primary caregivers results in the internalising of stable, global, internal, negative representations or perception of others, significantly impacting subsequent relationships. Bowlby (1988) uses a number of terms to describe the way the child comes to perceive the caregiver (and subsequently all others) including unloving, rejecting, unresponsive, unreliable, unpredictable, untrustworthy, or even dangerous, and yet research on a negative perception of others is mainly limited to the view that others are untrustworthy. The concept of CPTSD, for example, includes mistrust as the only marker on perception of others (Herman, 1992).

As with perception of self, studies have found a stronger association between psychological maltreatment and a negative perception of others than other forms of childhood maltreatment but this association is weaker than the association between psychological maltreatment and a negative perception of self (McLewin & Muller, 2006). Prior research examining the impact of a negative perception of others (as untrustworthy, unsupportive) on adult functioning has produced mixed results. Some studies have associated a negative perception of others with difficulties in interpersonal functioning (Bartholomew & Horowitz, 1991), and posttraumatic symptoms including anxiety, depression, dissociation, and sleep disturbances (McLewin & Muller, 2006), while other studies have found no significant association between a negative perception of others and adult posttraumatic symptomatology (Muller et al., 2000). Evidence suggests that having both a negative perception of self and a negative perception of others is more predictive of adult posttraumatic symptomatology than

negative perception of self alone. (Muller et al., 2000; Roche et al., 1999). Roche et al. (1999) proposed that a negative perception of self combined with a negative perception of others leads to significant interpersonal problems in adulthood.

Pearlman and Courtois (2005) assert that survivors of complex trauma develop both a negative perception of self and a negative perception of others and experience a lack of trust, revictimisation, affect dysregulation, hopelessness, and low self esteem. Other studies have found associations between negative perceptions of others and posttraumatic symptomatology (e.g., depression, anxiety, dissociation) (McLewin & Muller, 2006; Roche et al., 1999), and difficulties in interpersonal functioning (Bartholomew & Horowitz, 1991).

As perceptions of others, that develop as a result of psychological maltreatment, have been subject to limited exploration and are poorly defined, negative perceptions of others may go beyond issues of trust that dominate research to date. A phenomenological methodology such as IPA allows an examination of the 'lived experience' of perception of others for individuals with a history of psychological maltreatment (Smith & Osborn, 2003). This methodology may open the door to representations of others that exist for maltreated individuals, that go beyond the established issues of trust, to improve awareness, understanding and treatment of this issue.

Perception of Relationships. A significant amount of literature testifies to the pervasive, deleterious, long-term impact in adulthood of chronic, parental, childhood maltreatment including significant interpersonal problems (Mullen et al., 1996). Various forms of childhood maltreatment have been associated with less intimacy in close relationships (Ducharme , Kervarola & Battle 1997), poor interpersonal coping skills including casual sex and avoidance of intimacy (Polusny & Follette, 1995), increase in interpersonal problems and sexual difficulties (Mullen et al., 1996), feeling less secure in intimate relationships and utilising maladaptive conflict resolution skills (Styron & Janoff-Bulman,1997), experiencing

a risk of revictimisation including date rape and domestic violence (Briere & Runtz, 1990), increased sexual dysfunction (e.g. Fromuth, 1986), increased risk sexual activities, including increased frequency of sexual encounters, increased number of partners, and decreased use of contraceptives (Gold, 1986; Tsai, Feldman-Summers & Edgar, 1979). These individuals are more likely to have a history of prior divorce, to have never married, to marry younger, to have increased marriage disruption, decreased satisfaction with intimate relationships, to be more withdrawn and lead more isolated lifestyles (Bagley & Ramsay, 1986; Finkelhor, Hotaling, Lewis & Smith, 1989; Mullen, Romans-Clarkson, Walton & Herbison, 1988). Difficulties with interpersonal functioning may be one of the primary reasons individuals with this history seek therapeutic assistance (Cloitre, Koenan, Coehen, & Han, 2002).

Unlike the traumatisation of an adult, chronic traumatisation during childhood will disrupt the child's normal developmental processes including identity formation, affect regulation, communication, boundary setting, conflict resolution, and coping strategies (Courtois, 2004). The traumatisation of a child, especially when it occurs in the context of the child's primary attachment relationships, distorts the child's view of themselves and others (Bowlby, 1982). All of the above developmental processes have a long-term pervasive and often debilitating impact on the individual's adult intimate relationships. Survivors of childhood trauma have great difficulty trusting and developing and maintaining healthy secure adult intimate relationships and many may become isolated from people to varying degrees to avoid the risk of further loss, betrayal and rejection (Pearlman & Courtois, 2005). Although less attention has been paid to the association between childhood psychological maltreatment and relationships the following section lays out research to date.

Krause, Mendelson, and Lynch (2003) found that a history of childhood emotional invalidation was strongly related to adult chronic emotional inhibition. Crawford and Wright (2007) found that psychological maltreatment predicted emotional inhibition. A stable, global

sense of shame has also been associated with emotional inhibition (Harper et al., 2005). The child may learn that it is unacceptable, or perhaps even threatening, to display emotion, especially negative emotions. The child may inhibit or repress emotional displays to appease the caregiver or avoid maltreatment (Goldsmith & Freyd, 2005).

While emotional inhibition may be an adaptive strategy for survival, or to minimise maltreatment in childhood, chronic emotional inhibition in adulthood can have detrimental long-term consequences. Emotional inhibition impedes the ability to express emotion in healthy ways, which may contribute to difficulties in establishing and maintaining healthy relationships. For example, the ability to express one's emotions, desires, and needs is important in avoiding conflict (Crawford & Wright, 2007). A pattern of chronic emotional inhibition can lead to adult psychological distress (i.e., depression and anxiety) (Crawford & Wright, 2007), and may also mediate the relationship between psychological maltreatment and psychological distress (Krause et al, 2003) and the relationship between psychological maltreatment and the individual's subsequent victimisation or perpetration of adult intimate relationship aggression (Crawford & Wright, 2007). For some individuals, the frustration that results from constantly suppressing emotional expression can lead to episodes of explosive anger (Crawford & Wright, 2007).

Another maladaptive coping technique adopted by individuals with a history of chronic childhood maltreatment is the development of a false external self that one can display to the world, to hide one's feelings of inner badness (Herman, 1992). When parents' approval and support is conditional (i.e., contingent on the child meeting certain, often unattainable standards) the child is motivated to attempt to meet those standards to gain love and approval (Harter, 1999). The more conditionality evident in the parent-child relationship the lower the child's perception of self-worth (Harter, 1999). Instead of receiving love and approval simply for who they are, the child must hide the true self and adopt a false-self based

on the parent's needs and desires, forcing the individual to ignore or push away his or her own thoughts, feelings, and desires (Harter, 1999).

Maltreatment that constitutes conditionality enhances the likelihood of the formation of a false-self (Harter, Marold, Whitesell, & Cobbs, 1996; Herman, 1992). When the child is unable to meet others' standards, they may attribute this failure to their innate badness. Herman (1992) suggests child then attempts to create a façade, a false-self, that will hide self-perceived flaws, avoiding contempt and derision, to appease others, gain their approval, and reduce incidents of maltreatment. It may be that those individuals who resort to the tactic of creating a false-self feel hopeless about the inner self ever being able to please others (Harter, 1999).

As with emotional inhibition, the development of a false-self may have served an adaptive function as a child, but has deleterious long-term consequences for the individual, as suppression of the true self is associated with depressive symptoms, low self-worth (Harter et al., 1996), and conflict in relationships (Harter, 1999). The individual with a history of chronic, psychological maltreatment that encompasses rejection, derision, scorn, conditionality, and invalidation believes that, in order to please others, to gain love, approval, and support from others (especially in the context of intimate relationships), and avoid maltreatment and conflict, they must hide their inner "rotten" selves and constantly present a false-self to the world (Harter, 1999). To do this requires the suppression of one's own feelings, thoughts, and behaviours.

This ingrained belief that one must suppress one's own needs and desires in order to accommodate others' needs, desires, and feelings, to appease others, and to avoid maltreatment and conflict, and the belief that the desires of others take precedence over ones own desires, have both been associated with a history of childhood psychological maltreatment (Crawford & Wright, 2007; Lumley & Harkness, 2007; Wright, 2009).

Accommodating others needs may serve to appease the perpetrator but has been associated with long-term psychological distress (e.g., depression and anxiety) (Wright, 2009) and victimisation in intimate relationships (Crawford & Wright, 2007).

Some individuals, who believe others are abusive and untrustworthy, and believe they do not have the ability to avoid conflict, may simply choose to withdraw from relations with others, rather than face the constant expectations of maltreatment (Crawford & Wright, 2007). Drapeau and Perry (2004) found that individuals with a history of childhood verbal abuse were more likely to express a desire for distance in relationships. Unfortunately withdrawal from relationships and interpersonal interactions will limit the number of socialisation experiences the individual has, which may otherwise serve to revise inner representations of self and others to something more positive (McLewin & Muller, 2006).

If the core of childhood maltreatment is psychological and the core of psychological development is relational it is easy to see the rationale for gaining a better understanding of perception of self, others, and relationships in individuals with a history of chronic, parental, childhood psychological maltreatment. Exploring the individuals lived experience to obtain a deeper account of perception in those with a history of psychological maltreatment reflects an important step in further understanding this area.

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) is an idiographic case based research method, as opposed to the predominant nomothetic mode of inquiry in psychology that focuses on large groups and populations (Smith & Osborn, 2003). IPA often goes beyond a purely idiographic approach, utilising a small number of case studies to examine any convergences and divergences between individual cases (Brocki & Weardon, 2006). Unlike quantitative methodology, IPA does not attempt to test any predetermined hypothesis, but

rather, is a flexible approach to allow in-depth exploration of the topic (Smith & Osborn, 2003).

IPA assumes that individuals seek to make sense of experiences, events and actions in their lives, and do so by assigning meanings to those experiences (Brocki & Weardon, 2006). The aim of IPA is to explore, represent, and interpret the means by which the individual makes sense of their personal and social world (Larkin, Watts, & Clifton, 2006). IPA goes beyond simply generating an account of the insider's perspective of the individual's experience, but also requires the researcher to draw out and disclose these meanings through an interpretative process.

Smith and Osborn (2003) deem IPA particularly suitable when the topic under study is complex, contextual, novel, dynamic, relatively under-studied, and concerned with processes, especially regarding issues of identity, self, and making sense of their personal and social world. Chapman and Smith (2002) suggest that IPA's flexibility and detailed analysis are useful when the topic being studied is relatively unexplored, and may be sensitive and emotional for the participant. The study of chronic, intrafamilial, childhood psychological maltreatment is the investigation of complex, dynamic, interpersonal processes that has been under-studied. In addition this study concerns potentially emotional and sensitive issues, including issues relating to the self, and issues of sense-making processes. Therefore IPA was selected as an appropriate methodology to meet the aims of this study.

Another benefit of using IPA was that the method engages the narrative of the individual deeply, without preconceived notions or theoretical constructs. This allows the possibility of fresh avenues of exploration to arise. However IPA is limited by both the participants ability to articulate his or her lived experience (Baillie, Smith, Hewison, & Mason, 2000) and the researchers ability to analyse and interpret the participants account (Brocki & Weardon, 2006). Furthermore, no two analyses will be exactly the same, creating concerns regarding

validity and reliability (Golsworthy & Coyle, 2001). Reliability will be discussed further in the analysis section. Another limitation of IPA is that, given the small sample size, data gathered may not be fully representational of all individuals with a history of chronic childhood psychological maltreatment. However, according to Smith and Osborn, (2003) IPA is not averse to making generalisations about a wider population but rather seeks to undertake a more in-depth focussed analysis of the accounts of a small sample of individuals that may lead to subsequent explorations. This study does not seek to make any claims about generalisability of the results but rather hopes that some fresh insight may be garnered about a topic that has received insufficient attention to date.

Smith and Osborn (2003) describe the semi-structured interview method utilised in this study as the exemplary and most commonly used method of data generation for IPA. They propose that this method facilitates the establishment of empathy and support during the interview process, and tends to produce richer, more elaborate accounts. The semi-structured interview consists of a schedule of questions that are designed to guide rather than dictate the interview direction. This flexibility creates the opportunity for the interviewer and participant to engage in a dialogue, and allows the participant the maximum opportunity to give a full, rich account of their own perceptions and sense-making processes (Smith & Osborn, 2003). Research questions are usually framed broadly and openly to avoid guiding the participant.

Initial questions can be modified in light of the participant's responses, and a researcher has the opportunity to focus on any areas that seem important, interesting or perhaps even novel as they arise (Chapman & Smith, 2003). The dialogue may therefore diverge considerably from its initial direction at the interviewer's discretion. Smith and Osborn (2003) recommend that the interviewer monitors how far the dialogue diverges, and attempts to maintain a balance between staying on topic and allowing the possibility of fresh insight to be gained from novel avenues of investigation, which is a key aim of this study.

The Present Study

As mentioned above, consistent with IPA methodology (Smith & Osborn, 2003), there was no predetermined hypothesis for this study. This study aims to investigate perception of self, perception of others, and perception of relationships in individuals with a history of chronic, parental, childhood, psychological maltreatment by utilising a phenomenological approach that allows the participant to speak broadly and openly about his or her lived experience. The primary objective was to explore, in-depth, the personal account of perception of self, others, and relationships of a small number of individuals with a history of chronic, parental, childhood psychological maltreatment. By utilising IPA this study aimed to analyse and compare accounts and interpret themes that arise, and to produce a complete, coherent narrative that represents the lived experience of the individuals. The evidence and theories which are emerging suggest that psychological maltreatment is the most prevalent form of childhood maltreatment, has perhaps a more pervasive significant detrimental impact on long-term adult functioning than any other form of childhood maltreatment and may be the core component of all forms of childhood maltreatment. These factors indicate the importance of further understanding this topic.

Method

Participants

. Case study methodologies such as IPA seek to examine the perceptions and understandings of a distinct, closely defined, group. IPA utilises a single sample of participants, carefully selected to represent the phenomena being studied. In this case, individuals with a history of chronic, parental, childhood psychological maltreatment (Smith & Osborn, 2003) were recruited. Participants were deliberately sampled from current clients and counsellors of Petersgate Counselling Agency, a low-cost counselling agency in Christchurch, New Zealand.

Individuals deemed by their individual counsellors to have a history of psychological maltreatment were invited to participate. The counsellors at Petersgate were given a brief presentation on the nature of the study and the interview process and were presented with a list of inclusion and exclusion criteria for participants (see Appendix B). Any clients who met the criteria were invited by their counsellors to participate in the study and were given a letter detailing the nature of the study and inviting them to volunteer to participate as presented in Appendix C. During the presentation to counsellors, several felt they met the criteria and were continuing to work on the emotional impact of their histories. Counsellors who met the criteria and wanted to volunteer were invited to contact the researchers directly.

Smith & Osborn (2003) recommend five or 6 as a reasonable sample size. Six individuals agreed to participate in the study, three were clients and three were counsellors. The ages, and gender of the participants are provided in Table 2. The names given are pseudonyms created to preserve the anonymity of participants. Participants received no financial remuneration for taking part in this study.

Table 2

Summary of Participants Interviewed.

Pseudonyms	Age	Gender	Status
Kate	68	Female	Client
Jack	57	Male	Client
Anna	34	Female	Client
Jane	53	Female	Counsellor
Tara	57	Female	Counsellor
Anya	43	Female	Counsellor

Measure.

Development of the interview schedule for this study followed Smith and Osborn's (2003) recommended four steps for designing an interview schedule:

Step 1.) Begin by considering the broad issues of the study. For this study the broad issues are the participant's current perception of self, perception of others, and perception of relationships. Questions were designed to enquire broadly about these three topics.

Step 2.) Smith and Osborn (2003) recommend sequencing the topics depending on the nature of the study (e.g., in the most logical or sensitive order). For study it was deemed logical to tackle the issue of perception of self and perception of others before perception of relationships. The question of perception of self was ordered first as it seemed that it may be easier for individuals in general to access this information than perception of others, and discussing a more familiar topic may put participants at ease before moving on to the slightly more difficult question of perception of others.

Step 3.) The third step recommended by Smith & Osborn (2003) is the creation of the questions. The schedule of questions for this study was designed based on guidelines outlined in Smith and Osborn (2003) as follows: Questions should be open ended rather than closed to encourage participants to give full answers; questions should be neutral, rather than value-laden, to avoid influencing participant's responses; there should be no jargon or technical terms to ensure the questions are as clear and accessible as possible; questions should be designed to encourage the participants to talk freely about the topic, ideally with minimal prompting. An initial question was designed for demographic purposes and to provide an opportunity to build a rapport with participants and put them at ease. The other questions were designed to encourage participants to engage in a full and rich dialogue about their perception of self, others, and relationships. The questions are broad to allow the participants to direct the dialogue in terms of areas of importance and relevance to them. Questions were reassessed a number of times by the research team and any question that was too closed,

leading, complicated, or derived from preconceived notions was altered or deleted. All three researchers were involved in the question design process and with the above guidelines in mind, the questions were eventually selected on consensus. (See Appendix D).

Step 4.) Finally Smith & Osborn (2003) detail the development of prompts and probes to be more explicit if required, dependant on the specific study or individual participant, or to encourage further discussion about any area of interest to the researcher. Prompts were also designed collaboratively by the research team. General prompts were created as a reference to allow the interviewer to probe areas of interest or importance, however the exact wording of prompts were guides only which could be used or adapted at the interviewers discretion (See Appendix D).

Procedure.

The participants were invited to attend an interview with one researcher, who conducted all the interviews. Before the interview started, participants were briefed about the nature of the interview process, were asked to read and complete the information and consent forms (Appendix E), and were given a chance to ask questions. The participants were then asked a series of prewritten interview questions utilising a semi-structured interview process. Each session lasted one hour, and an audio recording was made of each interview. At the end of the interview each participant was debriefed, given the chance to ask questions, and thanked for participating. The audio recordings were then transcribed and analysed.

Given the nature of the subject matter it was possible that participants may have become emotionally distressed during the interview process. The possibility was mitigated to some extent by recruiting participants who were in an ongoing counselling relationship. The benefits of this were twofold. First, the counsellors were asked to only invite individuals to participate that would be suitable for this type of interview process and discussing matters of a personal nature. Secondly, each individual had the support mechanism available to them of

their own counsellor who was aware of the nature of the individual's participation in this study. During the interview process Martin Dorahy, clinical psychologist, was available to assist should any problem, queries, or concerns have arisen. Furthermore participants were encouraged to discuss with their counsellor any distressing thoughts or feelings that should arise at any time during the study. The nature of the interview process was fully explained before the interview, and the participant was informed that they can withdraw from the study at any time. After the interview process the participants were debriefed and again given the opportunity to ask any questions or address any concerns.

The participants were also invited to a second voluntary meeting approximately six weeks later, at which they were given a summary of the analysis of their transcript, and asked if they thought that the outcomes from the whole analysis captured their experience. The participants were given the chance to provide any feedback, and ask any questions. The interviews were held at the Petersgate Counselling Agency. This study was granted ethical approval by the University of Canterbury's Human Ethics Committee.

Analysis.

Smith and Osborn (2003) specifically state that IPA is not a prescriptive methodology but rather a set of flexible guidelines to be adapted by the individual researcher to their specific research aims. This study is based on guidelines for analysis described by Smith and Osborn (2003). The analysis process involves reading each transcript several times. IPA requires the researcher to engage in an intensive and detailed immersion in each transcript. This involves multiple readings of each account, often with the discovery of fresh insight with each reading. This close interaction between the researcher and the text requires the researcher to draw upon his or her resources to understand and interpret what emerges (Brocki & Weardon, 2006). This is a 'double hermeneutic' – a two stage interpretation process where "the participants are trying to make sense of their world; the researcher is trying to make sense of the participants

trying to make sense of their world” (Smith & Osborn, 2003, p. 51). Any analysis will be filtered through the researchers own interpretations, perceptions, and biases. Thus IPA is a dynamic process, in that it involves both the individual’s personal perception and has an active interpretative role for the researcher (Smith & Osborn, 2003). Every effort was made to avoid the bias of any theoretical or personal knowledge in the analysis or interpretation phase.

Each transcript was read several times and initial reactions, thoughts, or comments elicited during these initial readings were noted in the left hand margin of the transcript. These initial notations were then transformed and coalesced into emerging themes or phrases and noted in the right hand margin of the transcript. The same detailed analysis was performed on each individual’s transcript producing a set of subthemes for each participant. A spreadsheet was then created of all participants and subthemes. Any subthemes that were relevant for five or 6 participants were included in the next stage of analysis. The subthemes were then clustered appropriately. “Imagine a magnet, with some of the themes pulling others in and helping to make sense of them” (Smith & Osborn, 2003, p.71).. At this time the original accounts were consistently referred to, to ensure that the analyst’s interpretation had not strayed from the participant’s original account.

Finally each cluster is given a name representing superordinate themes and a table of superordinate and subthemes was then produced

In accordance with the iterative process of IPA (Smith & Osborn, 2003), each transcript was reviewed several times, in light of any new superordinate themes, to ensure that any emerging themes were supported by the initial data (i.e, the transcripts). This analysis process continued throughout the IPA process, including the writing phase (Smith & Osborn, 2003). In an effort to assess the reliability of the analysis a randomly selected transcript was separately analysed by another researcher. It is the nature of IPA that every analyst will

produce different results, however it was determined that the results produced by each analyst in this study were similar enough to be deemed reliable. Furthermore participants were invited to give feedback on the analysis, specifically the extent to which the themes that emerged from the analysis were an accurate reflection of their lived experience.

Researcher Bias

It is impossible for the researcher to completely avoid bias in the analysis. For virtually every researcher who selects a topic to study, that selection will be based on some prior knowledge of the topic at hand or related topics (Smith & Osborn, 2003). For those researching topics related to parents an additional opportunity for bias is present, given the best any child can get is ‘good enough parenting’. Thus, every researcher has childhood hurts that have their origin in the way they were parented. It is the responsibility of the analyst to minimise the amount of bias brought to bear during the analysis as much as he or she is able. For this study every effort was made to reduce bias, including the analyst remaining consistently conscious of any possibility of bias of previous personal or academic experience, learning, or knowledge during the analysis. The potential for bias was also mitigated by ensuring that every theme selected was relatable to the narrative from the individual’s transcripts, as well as by reliability checks discussed above.

Results

Each of the participants, without prompting, wove two separate times frames through their narratives; perceptions as an adult prior to therapy and their, more positive, perceptions now after a period of self growth. Because this study focuses on the long-term perception of adults with a history of childhood psychological maltreatment, and because an analysis of the impact or effectiveness of therapy is not an aim of this study, the results presented focus on each participant’s pre-therapeutic adult perceptions. A benefit of recruiting participants who have

experienced some effective therapy or self growth is that the participant will ideally have increased insight which will enable the participant to retrospectively recognise their previous perceptions in a way they would not have been able to do previously.

Table 3

Master Table of Themes

1. Shame-based perception of self

Shame

Self-blame

2. Self-protection from emotional pain

Desire to please others

Development of a false-self

Self-inhibition

Withdrawal or avoidance of interpersonal contexts

3. Egocentric perception of others

Egocentrism

Mistrust

Projection of parents

Dichotomising others

4. Shame-based role in relationships

Loneliness

Difficulty forming and maintaining relationships

Difficulties with emotional intimacy

Internalisation of parent's relationships

Shame-Based Perception of Self.

Shame. Each participant spoke of low self-confidence, low self-esteem, or a low sense of self worth. These issues seemed to coalesce around the self-conscious emotion of shame. For each participant shame about themselves manifested a significant number of times during their accounts. For these participants their shame was global, stable, and all-encompassing. Most had developed a shame-based perception of themselves as inferior to virtually all others. For example, Jack noted,:

I was my world I was at the bottom of the list and all the people that I knew were stacked like that [above]...better than me.

This shame-based perception of self seems to have resulted largely from the internalisation of negative messages from their parents about their self-worth that were critical, demeaning, invalidating, or rejecting. In the following passage Jane reflects on her mothers influence on her self-perception:

I don't think I had a lot of confidence and self belief because there were a lot of comparisons growing up with other people. 'You're not as good as this person down the road, or you've failed at that, you're hopeless'.

Often shame was associated with the feeling of being exposed as inferior in other people's eyes:

[I'm afraid of] making a dick of myself, not being capable enough, not being bright enough, feeling stupid if I said something, going over what I said, bashing myself around after I've “...” presented something or been out socially and felt like a bit of a klutz, you know, if I'd said the wrong thing (Jane).

Self-blame. For most of these participants the sense of shame was so pervasive that they blamed themselves for things beyond their control, including events over which they had no possible influence. Kate sacrificed many opportunities she was enthusiastic about by blaming herself for her family's physical health, and resultantly returning home and caring for them:

I had a chance to go to bible college. I went up there for six months to study and I wanted to take on social work but then my mother and grandmother both became ill because I had left home. Nobody could cope with me leaving (Kate)

Kate went on to blame herself for leaving bible college:

I ‘knocked myself up’ because I came home in the August holidays and looked after mum...and I ‘cracked’ myself and had to get out due to all the pressure going on [at home].

This self-blame was especially evident in the interpersonal context with participants feeling responsible for others’ feelings, thoughts, and behaviours, especially towards them:

Everything bad that happens to me is because I’ve been bad, so I deserve it. It’s probably why I didn’t leave my husband, coz he was hitting me. I felt I was deserving of it...its always my fault. I blame myself first (Anya).

Self-Protection from Emotional Pain

A key superordinate theme that emerged from the analysis was that of the participants concern with the need for self-protection from emotional pain. The participants utilised a variety of coping strategies were evident to protect from emotional pain in primarily interpersonal contexts.

Desire to please others. The subtheme of pleasing or appeasing others, as a means of self-protection, was evident in the accounts of most participants. Here Anna is clearly aware of a drive to ‘be nice to’ or please others as a self-protective measure against emotional pain:

I think I’m always incredibly, incredibly nice to people all the time, and I think it’s a defence, like I’m frightened all the time, and I’m really, really, nice....I find it really hard to say how I felt because I was scared of personal attack.

Participants had developed a strong aversion to displeasing others, as they had learned to expect painful feedback from others, as a result of the behaviour modelled by, or messages

from, their parent(s). In the following passages Kate and Anna both speak of severe consequences of displeasing their parents:

I accidentally burnt his [stepfather] saucepan once...He had a go at me the way he used to...and this is no exaggeration, for two hours he would go on about your faults, almost from the time you were born right up to the age you were when you were living with him (Kate).

I was irresponsible, I didn't shut the door properly...I came back home the next day and all my stuff was out, um, on the pavement, and she just said 'get out. I don't want anything to do with you anymore' and she was just screaming at me (Anna)

Participants commonly reported a need to avoid conflict. In this excerpt Anna explains the need to avoid conflict to avoid shame-based emotional pain:

I think if I confront people they are really going to come down on me in a really, really, awful way.

Development of a false-self. Each participant expressed the need to constantly present a false façade to others, to behave in a way that is deemed by the participant to be more acceptable to others. By adopting a false-self the participant felt they were able to avoid expected emotional pain from their others, often in the form of judgment, invalidation, betrayal, or rejection:

With my mother I always had to say yes and no and hope I said it in the right place, but I could never express how I felt, I could never be honest. If I didn't like anything I couldn't dare say I didn't like it...if I knew it was going to displease somebody else (Kate).

Self-inhibition. Another strategy for self-protection from emotional pain developed by these participants was the complete inhibition of any expression of their inner experience, or inner self; including any thoughts, feelings, desires, opinions, or dreams of any emotional

significance to the individual, as exposure of the inner self created a sense of vulnerability to others. Jane speaks here about the effect her history with her mother had on her ability to be 'open' in relationships:

...it made me a bit of a closed book, so I found it really difficult relating to others, or having close sort of relationships...coz I'd hold back.

Most participants opined that this intense need for personal privacy developed after having their parents ridicule, ignore, invalidate, or reject previous attempts at communicating issues of importance to the participant. Anna expresses here the experience of having her opinions and feelings invalidated by both her parents:

We're never allowed to express an opinion...my mum was always second guessing me, and nothing that I felt was really important. It was like it didn't matter how I felt, or who I was.

Avoidance or withdrawal from interpersonal contexts. Another mechanism commonly utilised by participants to protect themselves from emotional pain was to avoid, or completely withdraw from, the interpersonal contexts that provided the (expectation of) emotional pain. For some this meant withdrawing from jobs, social activities, or relationships:

You'd be going and meeting mothers at playgroup and at school, and I think those were particularly difficult times because, you know, you'd have to talk to people and sometimes it was easier for me to avoid those things (Jane).

For Anna her withdrawal from interpersonal context is so extensive she is left feeling isolated:

I'm just incredibly socially isolated. I haven't got any friends at all. I've got no relationships with anyone...I'm still terrified of people...I don't ask people around to the house. I don't go out...All I have in my life right now is just people in the mental health arena and that you know isn't that healthy or well balanced either.

It is worth noting that withdrawing from, avoiding, or distancing oneself in relationships may not necessarily be a maladaptive coping strategy. Anya found that distancing herself from her friends and family, especially her mother and father, had given her the opportunity for self-growth and recovery she may not have otherwise had:

It gave me permission to not have to fit in a box because there was a new box. So for me it's like a blank page. I could do what I wanted to do, and no one could see me, my family, my friends. Nobody could see what I was doing.

Interestingly each participant also evidenced some form of distancing themselves from relationships, events, or feelings in their accounts, all of which encompasses emotional pain, by suddenly switching the grammar of their narrative. For instance possessive pronouns (i.e., ‘my parents’ ‘our relationship’) were momentarily replaced by ‘the parents’, ‘the stepmother’, or ‘that relationship’. In this passage Kate switches from the first to second person when recalling a painful emotional experience:

...I found that after he'd spent all that time with me I'd feel awful. I couldn't work. I'd go to work and I just felt lousy, you know...you felt as if you had your whole life knocked out of you. That's how bad that you felt.

Egocentric Perception of Others

Egocentrism. When asked what each participants thought of themselves they answered by providing a list of personal characteristics and personality traits. When asked the question “how would describe your thoughts and feelings about people outside your family?” each participant answered the question by referencing others in terms of themselves. In other words each participant answered by saying something about themselves: “I was probably quite judgmental” (Tara); “I wouldn’t have been that trusting” (Jane); “I felt... completely alien” (Anya).

It seems that, for these participants, the sense of shame, self-blame, and the need for self-protection created an introverted perspective so pervasive that the perception of others seemed limited to egocentric appraisals. Tara reflected retrospectively on how, when feelings hurt by others she rarely gave any consideration to the thoughts, feelings, motivations, and so forth, of the other person beyond the belief that the person was deliberately trying to hurt her:

I ask them ‘where were you coming from when you said that’, and it might be that I hardly gave them that way of thought before. Ok, I see, that I can see where you’re coming from now.

Mistrust. One key theme or expectation of others that emerged for each participant was the issue of mistrust. Jane relates how she internalised her mother’s mistrust of people:

I wouldn’t have been that trusting. We lived in a community where we kept ourselves to ourselves. My mother used to snipe about other people.

For these participants mistrust was often associated with self-protection from emotional pain, based on the belief that others are going to hurt, betray, or reject them including in the context of intimate relationships:

I always felt they [boyfriends] were going to leave me, so I would leave first. I couldn’t trust them and I couldn’t believe that they actually really loved me (Anna).

Projection of Parents. For these participants it seems that shame and self-blame, for the thoughts, feelings, and behaviour of others, led participants to believe that others would think and feel about them, and behave towards them, the same way their parents did (i.e., verbal abuse, betrayal, invalidation, rejection). Jane describes how in retrospect she was able to appreciate that others do not all view her the way her parents did:

I suppose that I started to see that I could relate to others, and others could see something different in me.

The participants perceived their parent's hurtful behaviour towards them as 'normal', and developed expectations and standards about acceptable and common interactions with others expecting others to judge them harshly, and even treat them poorly. Jane talks about how her husband's behaviour exceeded her expectations of affection, based on her parent's behaviour towards her:

I would say, perhaps at times, in the early days it was lonely being in that relationship because my expectation wasn't particularly [affectionate]. From where I'd come from, with my primary caregiver not being a particularly demonstrative person, he [husband] was 100% better.

Dichotomising others This theme of dichotomising people into two different groups or types become apparent for most participants in a number of ways. Jack describes perceiving others in a 'black and white' way:

Prior to me counselling it was all pretty black and white and now, because you just don't like one-sided people, you know, there's other sides.

Other participants dichotomised others in terms of an 'underdog versus top-dog' mentality. Participants described empathy for, and affiliation with individuals who they deemed to be struggling in some sense:

I'm very caring of other people. If I see people struggling I want to be there as perhaps a bit of a rescuer at times, but just being able to have perhaps heard someone (Tara).

Tara discussed how the impact of being emotionally hurt by her parents affected her perception of others. For Tara, not being heard was a big source of loss and pain and here she clearly shows empathy for individuals she feels may be struggling, and reaches out to provide the support she was not given.

For some participants the distortions were split along gender lines with perceptions of males and/or females being largely based on the behaviour of, or messages from, the parents. Gender differences in participant's accounts were often expressed as dominance versus submission, with control being a key feature in relationship beliefs and expectations. These expectations were based largely on behaviours modelled within the parental relationships, or were directly verbalised to the child:

Men are there to humiliate woman and use them. So... the world is really hostile and especially...men and woman...are enemies (Anya)

Shame-based Role in Relationships

Loneliness. Each participant desired more and healthier relationships. This desire was largely driven by feelings of isolation, loneliness, being unloved and unsupported:

I'm sort of in limbo at the moment without any friends...its hard to strike up something new, especially at this age (Kate)

A lack of love and support commonly characterised participant's relationships with their parents. This was felt strongly by the participants and strongly impacted subsequent relationships. Here Tara describes how her feelings of having never been loved impacted her relationships with her husband and children:

We got on pretty well but again, a lot of the sort of things I really craved for, like being loved, by being cuddled, all the things I hadn't had as a kid. He [husband] wasn't really that sort of person...I was able to pour all my love into, and cuddle, the kids.

Difficulty forming and maintaining relationships. Participants expressed difficulty in forming new friendships and, for most participants, intimate (romantic) relationships. This seems to be largely due to shame-based social anxiety which participants all experienced but to different degrees. For Anna her social anxiety became quite debilitating and isolating, and was associated with her eating disorder:

I always feel like I'm not as good as other people, and I always feel like I often embarrass myself, and sometimes I don't want people to look at me. I get that bad that I just can't be in rooms with people. I can't eat in front of people ever. I always eat by myself.

Most participants also expressed doubts about their ability to maintain a healthy relationship:

I tell you there would be nothing I'd like better than to be married, to be in a happy marriage, but whether I could maintain that I don't know (Jack)

Difficulties with emotional intimacy. Each participant described previous relationships that, in retrospect, they perceived as unhealthy for a variety of reasons including volatility, co-dependence, and physical abuse. The one factor common to each of these relationships was a lack of emotional intimacy. Like many others Anya describes feeling a lack of connection or 'meaning' in previous relationships:

I didn't care about who the person was. I don't even know what I was doing. I don't actually think I was in the relationship. I don't think I was really there...It wasn't meaningful.

For each of these participants a lack of emotional intimacy characterised their relationships with their parents. Communications with their parents was limited, and participants felt a lack of emotional closeness with their parent, and a definite lack of intimate exchanges of thoughts feelings, desires, dreams, and so forth. Jane described her mother as emotionally cold, and described the lessons she learnt from her mother about (giving) or disclosing oneself to others, that doing so leaves one open and vulnerable to harm:

It was a mean way of seeing the world, you know. It was sort of them against us sort of thing. So, you know, you didn't give [disclose] anything to anyone else or give of yourself particularly because if you did you'd expect a [negative] return in life.

Internalisation of parents relationships. Most of these participants described their parent's relationships as characterised by the interaction between dominant and submissive roles with control being an important theme:

[My mother] held all the purse strings. She had complete control over the family and that is how she parented. It was sort of her, then him [father], then us. I guess I could have seen him as a weak link, but I don't anymore. She was very controlling of everything (Jane).

Participants seemed to internalise these models of relationships and developed expectations about control characterising their own relationships, with themselves as naturally inclined to assume the submissive role due to their shame-based perception of self:

It's definitely had an affect on my opinion on marriage. A couple of guys that I was with wanted to get married, but my parents had quite a volatile marriage. They used to fight quite physically in front of us, and I think mum was so devastated when my parents got divorced, and she ended up going out with another guy that beat her up, and then she was with somebody else. It made me feel like you couldn't have a positive productive relationship with a guy. That it wouldn't last (Anna).

Furthermore most participants felt they had a lack of control in their relationships with their parents and in their lives in general:

All this stuff had been put on me, and there was no control in my life. I couldn't control the pain. I couldn't control anything (Tara).

Jane describes herself as feeling constrained by the strict expectations and standards of behaviour set for her by her mother:

...being sort of straight-jacketed into having to believe in certain things and behave in certain ways... (Jane)

This also contributed to the expectation of future relationships characterised by issues of dominance and control with the participants assuming, and fearing, that they will adopt the submissive role. Jack describes concerns with being controlled in any future intimate relationship with a partner being ‘like my mother’:

It might be quite easily that you could get very much into your wife telling you to clean your things up, like your mother, and how much I’d handle that I don’t know (Jack).

Discussion

The aim of this study was to provide insight into the lived experience of perception of self, others and relationships in individuals with a history of chronic, parental, childhood psychological maltreatment. Four superordinate themes were identified as shared experiences of the participants, shame-based perception of self, self-protection from emotional pain, egocentric perception of others, and shame-based role in relationships. These superordinate themes are compared to previous research, and theoretical links are made to attachment theory (Bowlby, 1969). Following that counsellors accounts are compared to clients accounts and limitations of this study are discussed.

Shame-based Perception of Self.

This study found that shame was a key theme for these participants. Shame is an emotion where the individuals negative perception of themselves is global (i.e., encompasses all that is me and all that I do), stable (e.g., ‘this is how I have always been and always will be’), and uncontrollable (e.g., ‘there’s nothing I can do to change what they think of me’) (Abramson, Seligman, & Teasdale, 1978). The participants viewed themselves as inferior and unworthy of love.

This fits with Bowlbys attachment theory which states that, through the internalisation of repeated interactions with the caregiver, a child will begin to form an internal representation

of self and others. Bowlby (1969) labelled these internal representations of the self and others Internal Working Models (IWMs) and asserted that these IWMs are incorporated into the child's personality and form a basis for their behaviour. In other words, ones perception of self refers to the extent to which one believes one is worthy of love and support and ones perception of others refers to what extent one believes that others will provide that attention and support when needed. If the caregivers interactions with the child are chronically inconsistent, insensitive, unsupportive, cold, unavailable, and/or unresponsive the child will perceive themselves as unworthy of love and incapable of generating support, and will view others as unpredictable and a source of threat. Bowlby believed that, as IWMs strengthened with each caregiver-child interaction, they became relatively stable and continued to influence interpersonal relationships throughout the lifespan. Children who feel ridiculed, unworthy and inferior in the eyes of their parents are likely to internalise shame-based perceptions of themselves.

The emergence of this theme is consistent with previous findings that childhood psychological maltreatment is associated with shame (Wright et al., 2009). Shame can occur when an individual perceives they have failed to live up to their own or others expectations (Van Vliet, 2009). For these participants the shame occurred as a result of internalising parents chronic critical statements about themselves. Parents provided rigid, often unrealistic, standards and expectations regarding the participant's behaviour but also often had rigid beliefs about what the participant should or does think, feel, desire, and so forth. Failure to achieve standards produced feedback from parents that was chronically negative and fit the criteria for psychological maltreatment, (e.g., degrading, belittling and spurning). Such experiences may stifle the development of a positive coherent sense of self and instead result in a low sense of self worth and self esteem, and ultimately a deep-seated stable, global sense of shame. Furthermore the participants internalised their parent's beliefs standards and

expectations for themselves which continue to contribute to the stability and longevity of the sense of shame. For most, this sense of shame was so all encompassing that participants blamed their own perceived inadequacies or faults for events beyond their control.

Self-protection from Emotional Pain

. For these participants the experience of emotional pain was a significant factor in their childhood and each was strongly influenced to minimise interpersonally contextualised emotional pain. Several of the participants described themselves as especially ‘sensitive’ to emotional pain. Each participant had adopted strategies to attempt to protect themselves from interactions with their parents that could cause emotional pain. These strategies were subsequently extended to relations with others.

These strategies may have been adaptive in childhood in that they limited the amount or severity of emotionally painful interactions with their parents, or at the very least gave the individual a sense of hope or control (Harter, 1999) but become maladaptive in adulthood as it limited both the frequency and quality of interpersonal interactions that would serve to increase the individuals awareness of self, others and relationships (This will be discussed further below).

Participants felt driven to attempt to please people to avoid conflict, embarrassment, shame and rejection. Participants developed a false-self to present to others to please or appease them and prevent anticipated experiences of emotionally painful interactions. Participants also developed a very strong need for privacy, putting strong boundaries around their own thoughts, feelings, and beliefs, seldom expressing themselves openly to others. In anticipation of emotionally painful personal interactions participants sometimes chose to avoid or withdraw from interpersonal contexts. These maladaptive coping strategies have been explored in previous literature.

Herman (1992) suggests that persistent attempts to please and appease the primary caregiver, along with the desire to hide the rotten inner-self, leads to the development of a stable pattern of false-self behaviour. This false-self behaviour can extend to encompass a range of different false-selves for different contexts (e.g., parents, friends, work colleagues) (Harter, 1999). The need to please others and the possibility of simply choosing to withdraw from relationships rather than face further anticipated maltreatment or emotional pain have both been associated with psychological maltreatment (Crawford & Wright, 2007). An association has also been found between childhood psychological maltreatment and inhibition of emotional displays to avoid displeasing others (Crawford & Wright, 2007). However for these participants their need for self inhibition extended beyond emotional expression to the need to keep private any thoughts, feelings and so on, of emotional significance. In the past their inner experiences had been belittled, invalidated, or rejected by their parents enhancing their sense of shame and expectation of the same reaction from other people. This led participants to develop a strong wall or boundary around their inner selves “giving” or disclosing very little to others. This coping strategy impeded the person developing emotional intimacy in relationships, limiting their ability to develop an increased awareness of others that will be discussed in the next section.

As the effects are clearly similar in terms of strategies for self protection in interpersonal contexts between psychological maltreatment and other forms of childhood maltreatment. More qualitative and quantitative investigation is needed to not only examine the results of this study for generalisability but the issue of protection from emotional pain for survivors of other forms of childhood maltreatment

Egocentric Perception of Others.

For participants in this study, their egocentrism was very evidently shame-based. Mistrust was a theme that emerged for these participants. Because of the strong sense of shame and

their ensuing intense self-blame participants expected the same treatment from others they had experienced with their parents (i.e., a lack of love and support, invalidation, betrayal, rejection). The development of a negative view of others as untrustworthy as mentioned above was theorised by Bowlby (1969) as a consequence of chronic childhood maltreatment by the primary caregiver. Childhood psychological maltreatment has been associated with a mistrust of others (Crawford & Wright, 2007).

IWMs developed out of child-parent interactions come to provide a template for later relationships. This appears to be true of the current participants, who developed expectations of thoughts, feelings and behaviours towards others based on interactions with their parents. Bowlby (1969) believed that the repeated caregiver-infant interactions are internalised by the child who, over time, develops mental representations of how the caregiver is likely to respond to the infant's behaviour – in other words expectations about the caregiver's behaviour. Bowlby believed that these expectations are then extended beyond the primary caregiver to encompass expectations of other people in general and then extended these expectations to encompass all others.

Participants spoke of dichotomising people into opposing groups; healthy and unhealthy, dominant and submissive, caring and uncaring, weak and strong. Participants primarily characterised themselves as unhealthy, submissive, and weak, but caring. Given the participants preoccupation with self protection from emotional pain, it may be that dichotomising others was originally an adaptive mechanism of quickly identifying who one does and does not have to be wary of.

The way participants referenced the actions of others in their narratives was relatively egocentric. For instance participants were unaware of the possibility of alternate motivations for the behaviour of others towards them beyond their own perceived shameful influence. In this sense perception of others was very limited. Perhaps to create a sense of safety and

comprehensibility in an unpredictable and potential threatening world, participants seemed to reduced to complexities of human interactions and relationship down into a more simplified, egocentric view, where others were seen in more categorical (e.g., black and white) ways and their behaviour was largely influenced by, and the responsibility of, the participant.

Shame-based Role in Relationships

Each of the participants had experienced a sense of loneliness and expressed the desire for more friendships, healthier relationships or for the four single participants, a loving healthy intimate relationship. This is despite having a largely negative perception of others and relationships, and particularly of their role in relationships. However participants expressed difficulty in developing and maintaining relationships as well as difficulty with emotional intimacy. Bartholomew (1991) theorised that individuals with a history of childhood maltreatment would develop a negative perception of self and others which would impact on adult interpersonal functioning. For these participants another factor that impinged on their adult interpersonal functioning was their internalisation of the relationship between their parents and their own relationships with their parents, creating a sense of continuity of ones role in relationships. For these participants there was a shame-based sense of being submissive or controlled in that role.

Bartholomew (1991), a strong proponent of Bowlbys theory of IWMs developed an adult attachment model with four dimensions, based on four categories derived from a dichotomised view of self with positive and negative poles and a dichotomised view of others with positive and negative poles (i.e., the self is viewed as worthy of love or not and others are viewed as available and trustworthy or unreliable and rejecting). Bartholomew proposed that individuals with both a negative perception of themselves as unworthy and a negative view of others as untrustworthy and rejecting would desire relationships with others as they require the external validation to gain or maintain a positive self-perception, however these

individuals also avoid relationships with others to avoid the expected pain of rejection and loss, and seek to protect themselves by developing a strong sense of independence.

Results on this study would seem to suggest that is also true of individuals with a history of psychological maltreatment A negative perception of self combined with a negative perception of others has been associated with increased interpersonal problems in adulthood (Roche et al., 1999). This seems true for these participants. As mentioned above these participants demonstrated a negative shame-based perception of self and a negative, although, egocentric perception of others.

Comparing Counsellors Accounts to Clients Accounts.

The counsellors in the sample were less enmeshed in the emerging themes than the clients, though the themes were still relevant for them. For instance the counsellors were less emotional during their interviews than the clients, and showed more retrospective awareness of their experience than clients, as if they had moved to a psychological space where they had a greater ability to stand back from their history and observe and narrate it. They occasionally referenced theoretical terms or constructs that they had learned as part of their training that had given them insight into their previous perceptions and assisted their perspective. However, like the clients, each counsellor considers themselves still ‘a work in progress’ with the potential for continued growth. Each counsellor felt that their history had, at least in part, increased their empathy for, and desire to work with, people in the counselling setting.

Limitations.

The limitations of IPA as a methodology have been discussed above. One of the potential limitations discussed above is reliability. To mitigate this possibility, participants were invited to provide feedback on the themes that emerged from the analysis process. Four participants volunteered to provide feedback on the analysis and were provided with a statement and explanation of the superordinate themes. All four participants reported that they

felt that, overall, the four superordinate themes, accurately represented their lived experience. The following are the limitations of this study. The participants were predominantly female. There were some differences between the accounts of Jack and the female participants. For example Jacks' presentation style was more reticent than the female participants. It is beyond the scope of this study to explore gender differences and as mentioned above IPA makes no claims about the generalisability of results, but instead aims to explore the lived experience of the participants.

Another limitation is, because all participants have had the benefit of some therapy and self-growth, and were therefore deemed 'stable' enough to cope with the potentially emotionally rigorous demands of the study, we may not have captured the lived experience of the individuals for whom this is still a current raw experience. Perhaps the perceptions described by the participants have been tainted by hindsight as much as they may have been made clearer by it.

As mentioned in the method section, key themes were extracted during the analysis if they were relevant for five or 6 participants. Several things prevalent to the literature (e.g. self-sacrifice) were present for one or two participants so were not eligible for inclusion as a central theme. However such issues may be present for other individuals with a history of childhood psychological maltreatment.

Conclusion.

The primary aim of this study was to explore the impact of chronic, parental, childhood psychological maltreatment as opposed to the well-studied impact of physical or sexual abuse. The results of this study suggest that the impact, in terms of the themes generated in the analysis is very similar to the findings of research on the impact of childhood maltreatment in general. Further investigation of these themes will assist in the development of a greater understanding of the psychological impact of psychological maltreatment.

It is clear from this study that participants were strongly affected into adulthood by the emotional pain suffered during their childhood as a result of interactions with their parents. Furthermore, their subsequent perception of themselves, others and relationships, and subsequent adult interpersonal functioning were compromised by this early relational experience. Given the prevalence of childhood psychological maltreatment and the impact of psychological maltreatment described in literature and that emerged from this study further investigation of the impact of childhood psychological maltreatment is warranted.

References

- Abramson, L. Y., Seligman, E. P., & Teasdale, J. D. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87*, 49-74.
- American Psychiatric Association. (1994). Diagnostic and statistical manual of mental health disorders (4th ed.) Washington DC: Author.
- Bagley, C., & Ramsay, R. (1986). Sexual abuse in childhood: Psychosocial outcomes and implications for social work practice. *Journal of Social Work and Human Sexuality, 5*, 33-47.
- Baillie, C., Smith, J., Hewison, J., Mason, G. (2000). Ultrasound screening for chromosomal abnormality: Women's reactions to false positive results. *British Journal of Health Psychology, 5*, 377-394.
- Baker, A. (2009). Adult recall of childhood psychological maltreatment: Definitional strategies and challenges. *Children and Youth Services Review, 31*, 703-714.
- Bartholomew, K., & Horowitz, L.M. (1991) Attachment styles among young adults: A test of a four category model. *Journal of Personality and Social Psychology, 61*, 226-244.
- Behl, L. E., Conyngham, H. A., & May, P. F. (2003). Trends in child maltreatment literature. *Child Abuse and Neglect, 27*, 215-229.
- Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books.
- Bowlby, J. (1982). *Parent-child attachment and healthy human development*. New York: Basic Books.
- Bowlby, J. (1988). *Parent-child attachment and healthy human development*. New York: Basic Books.
- Briere, J., & Runtz, L. Y. (1990). Differential adult symptomatology associated with three types of child abuse histories. *Child Abuse and Neglect, 14*, (3), 357-364.

- Briere, J., & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress, 18*, 401-412.
- Brock, K. J., Pearlman, L. A., & Varra, E. M. (2006). Child maltreatment, self capacities, and trauma symptoms: Psychometric properties of the inner experience questionnaire. *Journal of Emotional Abuse, 6*, 103-125.
- Brocki, J. M., & Wearden, A. M., (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health, 21*, 87-108.
- Brown, J., & Beail, N. (2009). Self-harm among people with intellectual disabilities living in secure service provision: A qualitative exploration. *Journal of Applied Research in Intellectual Disabilities, 22*, 503-513.
- Chapman, E., & Smith, J. A. (2009). Interpretative phenomenological analysis and the new genetics. *Journal of Health Psychology, 7*, 125-130.
- Cloitre, M., Koenen, K. C., Cohen, L. R., & Han. (2002). Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to childhood abuse. *Journal of Consulting and Clinical Psychology, 70*, 1067-1074.
- Courtois, C. A. (2004) Complex trauma, complex reactions: assessment and treatment. *Psychotherapy: Theory, research, practice, training, 41*, 412-425.
- Crawford, E., & Wright, M. O. (2007). The impact of childhood psychological maltreatment on interpersonal schema and subsequent experiences of relationship aggression, *Journal of Emotional Abuse, 7*, 93-116.
- Derobertis, E. M. (2004). The impact of long-term psychological maltreatment by ones maternal figure. *Journal of Emotional Abuse, 4*, 27-51.

- Drapeau, M. & Perry, J. C. (2004). Childhood trauma and adult interpersonal functioning: a study using the core conflictual relationship theme method (CCRT). *Child Abuse and Neglect*, 28, 1049-1066.
- Ducharme, J., Kerverola, C., & Battle, P. (1997). Intimacy development: The influence of abuse and gender. *Journal of Interpersonal Violence*, 12, 590-599.
- Eisenberg, N., Cumberland, A., & Spinrad, T. L. (1998). Parental socialisation of emotion. *Psychological Inquiry*, 9, 241-273.
- Feiring, C. (2005). Emotional development, shame and adaptation to child maltreatment. *Child Maltreatment*, 10, 307-310.
- Ferguson, K. S., & Dacey, C. M. (1997). Anxiety, Depression, and dissociation in women health care providers reporting a history of childhood psychological abuse. *Child Abuse and Neglect*, 21 941-952.
- Finkelhor, D., Hotaling, G. T., Lewis, I. A., & Smith, C. (1989). Sexual abuse and its relationship to later sexual satisfaction, marital status, religion and attitudes. *Journal of Interpersonal Violence*, 4, 379-399.
- Fromuth, M. E. (1986) The relationship of childhood sexual abuse with later psychological and sexual adjustment in a sample of college women. *Child Abuse and Neglect*, 10, 5-15.
- Gibb, B. E. (2002). Childhood maltreatment and negative cognitive styles: A quantitative and qualitative review. *Clinical Psychology Review*, 22, 223-246.
- Gibb, B. E., & Abela, J. R. Z. (2008). Emotional abuse, verbal victimization, and the development of children's negative inferential styles and depressive symptoms. *Cognitive Therapy and Research*, 32, 161-176.

- Gibb, B. E., Alloy, L. B., Abramson, L. Y., Rose, D. T., Whitehouse, W. G., & Hogan, M. E. (2001). Childhood maltreatment and college students' current suicidal ideation: A test of the hopelessness theory. *Suicide and Life-threatening Behavior, 31*, 405-415.
- Gillespie, M., & Flowers, P. (2009). From the old to the new: is forensic mental health nursing in transition? *Journal of Forensic Nursing, 5*, 212-219.
- Glaser, D. (2002). Emotional abuse and neglect (psychological maltreatment): a conceptual framework. *Child Abuse and Neglect, 26*, 697-714.
- Gold, E. R. (1986). Long-term effects of sexual victimisation in childhood: An attributional approach. *Journal of Consulting and Clinical Psychiatry, 54*, 471-475.
- Goldsmith, R. E., & Freyd, J. J. (2005). Awareness for emotional abuse. *Journal of Emotional Abuse, 5*, 95-123.
- Golsworthy, R., & Coyle, A. (2001). Practitioner's accounts of religious and spiritual dimensions in bereavement therapy. *Counselling Psychology Quarterly, 14*, 183-202.
- Grassi-Oliveira, R., & Stein, L. M. (2008). Childhood maltreatment associated with PTSD and emotional distress in low-income adults: The burden of neglect. *Child Abuse and Neglect, 32*, 1089-1094.
- Hankin, B. L. (2006). Childhood maltreatment and psychopathology: Prospective tests of attachment, cognitive vulnerability, and stress as mediating processes. *Cognitive Therapy and Research, 29*, 645-671.
- Harper, F. W. K., Austin, A. G. A., Cercone, J. J., & Arias, I. (2005). The role of shame, anger, and affect regulation in men's perpetration of psychological abuse in dating relationships. *Journal of Interpersonal Violence, 20*, 1648-1662.
- Hart, S. N., & Brassard, M. R. (1987). A major threat to children's mental health. *American Psychologist, 42*, 160-165.

- Hart, S. N., Brassard, M. R., Binggeli, N. J., & Davidson, H. A. (2002). Psychological maltreatment. In J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. A. Reid (Eds.), *The APSAC handbook on child maltreatment* (pp. 79-103). Thousand Oak: Sage.
- Harter, S. (1999). *The construction of the self: A developmental perspective*. New York: Guildford Press.
- Harter, S., Marold, D. B., Whitesell, N. R., & Cobbs, G. (1996). A model of the effects of perceived parent and peer support on adolescent false self behaviour. *Child Development*, 67, 360-374.
- Henderson, A. J. Z., Bartholomew, K., Trinke, S. J., & Kwong, M. J. (2005). When loving means hurting: An exploration of attachment and intimate abuse in a community sample. *Journal of Family Violence*, 20, 219-230.
- Herman, J.L. (1992). *Trauma and recovery: The aftermath of violence from domestic to political terror*. New York: Basic Books
- Higgins, D. L., & McCabe, M. P. (2003). Maltreatment and family dysfunction in childhood and the subsequent adjustment of children and adults. *Journal of Family Violence*, 18, 107-120.
- Hund, A. R., & Espelage, D. L. (2006). Childhood emotional abuse and disordered eating among undergraduate females: Mediating influence of alexithymia and distress. *Child Abuse and Neglect*, 30, 393-407.
- Krause, E. D., Mendelson, T., & Lynch, T. R. (2003) Childhood emotional invalidation and adult psychological distress: the mediating role of emotional inhibition. *Child Abuse and Neglect*, 27, 199-213.
- Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3, 102-120.

- Linehan, M. M., Tutek, D., Heard, H., & Armstrong, H. (1994). Interpersonal outcome of cognitive behavioural treatment for chronically suicidal borderline patients. *American Journal of Psychiatry, 151*, 1771-1776.
- Lumley, M. N., & Harkness, K. L. (2007). Specificity in the relations among childhood adversity, early maladaptive schemas, and symptom profiles in adolescent depression. *Cognitive Therapy and Research, 31*, 639-657.
- Martsoff, D. S., Draucker, C. B., & Chapman, T. R. (2004). The physical health of women in primary care who were maltreated as children. *Journal of Emotional Abuse, 4*, 39-59.
- Mash, E. J., & Wolfe, D. A. (2005). *Abnormal child psychology*. California: Thomson Wadsworth
- McLewin, L. A., & Muller, R. T. (2006). Attachment and social support in the prediction of psychopathology among young adults with and without a history of physical maltreatment. *Child Abuse and Neglect, 30*, 171-191.
- Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, G. P. (1996) The long-term impact of the physical, emotional and sexual abuse of children: A community study. *Child Abuse and Negelct, 20*, 7-21.
- Mullen, P. E., Romans-Clarkson, S. E., Walton, V. A., & Herbison, G. P. (1988). Impact of sexual and physical abuse on women's mental health. *The Lancet, April 16*, 841-845.
- Muller, R. T., Sicoli, L. A., & Lemieux, K. E. (2000) Relationship between attachment style and posttraumatic stress symptomatology among adults who report the experience of childhood abuse. *Journal of Traumatic Stress, 13*, 321-332.
- Ney, P. G., Moore, C. M., McPhee, J., & Trought, B. A. (1986). Child abuse: A study of the child's perspective. *Child Abuse and Neglect, 10*, 511-518.

- Pearlman, L. A., & Courtois, C. A. (2005) Clinical applications of the attachment framework: Relational treatment of complex trauma. *Journal of Traumatic Stress, 18*, 449-459.
- Petalas, M A., Hastings, R. P., Nash, S., Dowey, A., & Reilly, D. (2009). "I like that he always shows who he is": The perceptions and experiences of siblings with a brother with autism spectrum disorder. *International Journal of Disability, Development and Education, 56*, 381-399.
- Polusny, M. M., & Follette, V. M. (1995). Long-term correlates of childhood sexual abuse: theory and empirical findings. *Applied and Preventive Psychology, 4*, 143-166.
- Prior, J., & O'Dell, L. (2009). 'Coping quite well with a few difficult bits': Living with disfigurement in early adolescence. *Journal of Health Psychology, 14*, 731-740.
- Roche, D. N., Runtz, M. G., & Hunter, M. A. (1999). Adult attachment: A mediator between child sexual abuse and later psychological adjustment. *Journal of Interpersonal Violence, 14*, 184-207.
- Sachs-Ericsson, N., Verona, E., Joiner, T., & Preacher, K. J. (2006). Parental verbal abuse and the mediating role of self-criticism in adult internalising disorders. *Journal of Affective Disorders, 93*, 71-78.
- Shipman, K. L., Zeman, J., Nesin, A. E., & Fitzgerald, M. (2003). Children's strategies for displaying anger and sadness: What works with whom? *Merrill-Palmer Quarterly, 49*, 100-122.
- Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 51-80). Thousand Oaks: Sage.

- Smith, J. A., & Osborn, M. (2007). Pain as an assault on the self: An interpretative phenomenological analysis of the psychosocial impact of chronic benign low back pain. *Psychology and Health, 22*, 517-534.
- Spertus, I. L., Yehuda, R., Wong, C. M., Halligan, S., & Seremetis, S V. (2003). Childhood emotional abuse and neglect as predictors of psychological and physical symptoms in women presenting to a primary care practice. *Child Abuse and Neglect, 27*, 1247-1258.
- Spinazzola, J., Blaustein, M., & Van der Kolk, B.A. Posttraumatic stress disorder treatment outcome research: The study of unrepresentative samples? *Journal of Traumatic Stress, 18*, 425-436.
- Stovall-McClough, K. & Cloitre, M. (2006) Unresolved attachment, PTSD, and dissociation in women with childhood abuse histories. *Journal of Consulting and Clinical Psychology, 74*, 219-228.
- Styron, T. & Janoff-Bulman, R. (1997). Childhood attachment and abuse: Long-term effects on adult attachment, depression, and conflict resolution. *Child Abuse & Neglect, 21*, 1015-1023.kl
- Tsai, M., Feldman-Summers, S., & Edgar, M. (1979) Childhood molestation: Variables related to differential impacts on psychosexual functioning in adult women. *Journal of Abnormal Psychology, 88*, 407-417.
- Van Vliet, K. J., (2009). The role of attributions in the process of overcoming shame: A qualitative analysis. *Psychology and Psychotherapy: Therapy, Research, and Practice, 82*, 137-152
- Varia, R., Abidin, R. R., & Dass, P. (1996). Perceptions of abuse: Effects on adult psychological and social adjustment. *Child Abuse and Neglect, 20*, 511-526.

Vissing, Y. M., Straus, M. A., Gelles, R. J., & Harrop, J. W. (1991). Verbal aggression by parents and psychosocial problems of children. *Child Abuse and Neglect, 15*, 223-238.

Wright, M. O. (2007). The long-term impact of emotional abuse in childhood. *Journal of Emotional Abuse, 7*, 1-8.

Wright, M. O., Crawford, E., & Del Castillo, D. (2009). Childhood emotional maltreatment and later psychological distress among college students: the mediating role of maladaptive schemas. *Child Abuse and Neglect, 33*, 59-68.

Yates, T. M. (2007). The developmental consequences of child emotional abuse. *Journal of Emotional Abuse, 7*, 9-34.

Appendix A

Parental behaviours defined as psychological maltreatment by Baker (2009 p. 707)

Berating/disparaging

Cruelty

Denying emotional responsiveness/ignoring

Developmentally inappropriate or inconsistent interactions with the child

Developmentally inappropriate expectations of the child

Exploiting/corrupting

Failing to recognise or acknowledge the child's individuality, and psychological boundary

Failing to promote the child's social adaptation

Hostility

Inadequate nurturance/affection

Inappropriate emotional responses to the child's emotional expressions

Isolating/close confinement

Mental health/medical/educational neglect

Mis-socialising

Negative attributions and misattributions to the child

Over-pressuring

Punishing an infants operant social behaviour

Punishing a child's manifestations of self esteem

Rejecting

Spurning

Terrorising

Threatening harm

Verbally assaulting

Appendix B

Research Aims

The aim of our study is to analyse the long-term effects of emotional parental abuse into adulthood, specifically the effects on the individuals view of self, view of others and on their adult relationships.

Emotional Abuse

Being told your emotions are wrong or inappropriate
Being constantly criticised, degraded, belittled
Withholding love
Threats of violence or separation from family
Being made fun of in front of others
Being given the “silent treatment”
Inconsistent demands and rules
Unpredictable moods and behaviour
Expecting child to be caregiver for parent
Placing unreasonable or age inappropriate demands on the child
with anger at failure to perform
Being encouraged to do things that are illegal or harmful to themselves
Failure to protect/rescue the child
Emotional abandonment in time of need
Continued lack of attention
Isolating child from friends, family etc.
Constant demeaning jokes

Participants

To be eligible for this study participants must meet the following criteria:

- Adult
- In current ongoing counselling
- History of emotional abuse form parent(s) or primary caregiver(s)
- Their reason for seeking treatment appears related to their experiences of emotional abuse as a child.
- No history of sexual abuse.
- No significant history of physical abuse

Contacts

Shannon Harvey

Smh148@student.canterbury.ac.nz
0274792548

Martin Dorahy

Martin.dorahy@canterbury.ac.nz
3643416

Appendix C

We are researchers at the University of Canterbury looking for volunteers to participate in a study investigating the long term effects on adults of having a childhood where they regularly felt emotionally hurt by their parent(s).

This form has been given to clients at Petersgate who may have experienced emotional distress from their parents or caregivers in childhood.

If you are interested in participating in this study you will complete a short series of questions about how you view yourself, the view you have of other people, and the nature of your relationships with other people (for example partners, family, friends, workmates etc).

The interview will be conducted between yourself and one of the researchers at the University of Canterbury in Ilam (see map attached), at a times that suits you. There will be no-one else present and all of your information will be strictly confidential. There will be no cost to you to participate and we are able to reimburse volunteers for petrol or public transport costs.

If you are interested in participating in this study please complete the reply slip below and hand to your counsellor at Petersgate:

Shannon Harvey, MSc student

Martin Dorahy, PhD, Clinical Psychologist, Senior Lecturer, University of Canterbury.

Fran Vertue, PhD, Clinical Psychologist, Senior Lecturer, University of Canterbury

I am interested in participating in this study:

Name: _____

Preferred contact

Home phone: _____

Mobile phone: _____

(Text)

Email: _____

Appendix DInterview proforma

1. Could you tell me a little about yourself?
Prompt: interests, family makeup
 - 1a. Are you currently in a romantic relationship?
 - 1b. Do you have children?
 - 1c. Do you have any brothers or sisters?
 - 1d. Who were the main people involved in raising you?
Prompt: main caregivers
2. How would you describe yourself as an individual?
Prompt: Can you tell me about your personality and characteristics?
Tell me how you usually feel and think about yourself?
In what ways do you feel unique?
3. How would you describe your relationship with your main caregivers now?
Prompt: How would you describe your degree of closeness to your caregiver(s)?
In what ways now do you feel supported by your caregiver(s)?
How do you feel about your caregiver(s) now?
4. How would you describe your past romantic relationships?
Prompt: How would you describe the quality of your past relationships?
Can you tell me a little about what your past relationships were like for you?
How does this compare to your current relationship (if applicable)?
5. How would you describe your thoughts and feelings about people outside your family now?
Prompt: friends, colleagues etc.
How do you feel about people other than your caregiver(s)?
Based on your past experiences with people what are your thoughts on people in general?

We have discussed the present. Now I would now like to move the discussion to your childhood.

6. Looking back now how would you describe your childhood?

Prompt: What can you tell me about your childhood?

Looking back now how do you feel about your childhood?

7. What was it like for you as a child with your main caregivers?

Prompt: Can you describe what you were like around your caregivers?

What were your caregivers like with you?

Looking back now what can you tell me about your experiences of being emotionally hurt by your caregivers?

When you think back on your experiences of being emotionally hurt as a child by your main caregivers; based on those experiences I am interested in your thoughts about whether or not they had a long term effects on you

8. For starters what are your thoughts on whether or not those experiences had any long term effects on your view of yourself?

Prompt: Can you tell me your thoughts about the relationships between your experiences of being emotionally hurt by your caregivers and the way you think and feel about yourself now?

What impact did these experiences have on your view of yourself?

9. What are your thoughts on whether or not those experiences of being emotionally hurt as a child had any long term effects on your view of people in general?

Prompt: Can you tell me your thoughts about the relationships between your experiences of being emotionally hurt by your caregivers and your view of other people?

What impact did these experiences have on your view of other people?

10. What are your thoughts on whether or not those experiences of being emotionally hurt as a child had any long term effects on your romantic relationships?

Prompt: Can you tell me your thoughts about the relationships between your experiences of being emotionally hurt by your caregivers and your romantic relationships?

What impact did these experiences have on your romantic relationships?

Appendix E

Participant Information sheet

Title: How the feelings and thoughts people have about their past affects how they see themselves, others and their relationships

You are invited to take part in a research study. Your participation is completely voluntary and you are free to withdraw your participation from this study at any time without having to give any reason. Choosing not to take part or withdrawing at anytime will in no way affect your ongoing counselling or your relationship with Petersgate counselling agency. Before you decide it is important to read the following information to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Ask us if there is anything that is not clear or if you would like more information (our contact details are below).

Aim of study

To understand how individuals who were emotionally hurt as children view themselves, other people and their relationships.

What will happen to me if I take part?

Shannon Harvey (Masters Student in Psychology) will sit down with you one-on-one and ask you some questions about your view of yourself, your views on others and about your relationships (partners, family, friends etc.). It is our goal to make you as comfortable as possible during the session therefore you will not be required to discuss anything you are uncomfortable with. With your permission the session will be taped. The session will last no longer than 75 minutes and you will be given time to ask any questions, both before and after the session. You are free to withdraw your participation and your information from the study at any time, without having to give any reason.

You will be invited back to attend a voluntary second meeting approximately 6 weeks later. At this meeting you will be given a summary of our analysis of your input. You will then have the opportunity to provide any feedback or ask any questions should you want to. It is your choice whether you would like to attend this second meeting.

Are there any risks?

In discussing matters of a personal nature there may be a risk of becoming emotional distressed. Should this occur the researcher will gladly pause or stop the discussion at any stage if you would like. Participants are encouraged to contact their counsellor to discuss any distressing thoughts or feelings that come up after the study or contact the researchers. Martin Dorahy (Clinical Psychologist) will also be available during the session if you feel additional support would be helpful.

Confidentiality policy for Research

Whilst the information received from you during this research study will remain confidential we will be required to seek extra support for you if it becomes apparent during the research that you have serious intentions to hurt yourself or someone else.

The results of this study may be published but you may be assured of the complete confidentiality of data gathered in this investigation: the identity of participants will not be made public. To ensure anonymity and confidentiality the only record of each participants name will be on the consent form. These records will be stored securely in Martin Dorahy's office.

Names of researchers

This project is being carried out as a requirement for a Masters degree by Shannon Harvey (Masters Student, University of Canterbury) under the supervision of Martin Dorahy (Clinical Psychologist, Senior Lecturer, University of Canterbury) and Fran Vertue (Clinical Psychologist, Lecturer, University of Canterbury), and in collaboration with Struan Duthie (Petersgate Director, Counsellor)

Contact Details:

If you have any further questions or wish to contact someone either before or after the study, please contact:

Dr Martin Dorahy (Clinical Psychologist)
Phone: (03) 3643416
Email: martin.dorahy@canterbury.ac.nz
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University of Canterbury
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CHRISTCHURCH 8140
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Postal: Psychology Department
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CHRISTCHURCH 8140
New Zealand

Human Ethics Committee
Postal: Human Ethics Committee
University of Canterbury
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CHRISTCHURCH
New Zealand

You will have the opportunity to discuss your experience of participating at the end. If you would like a copy of the final results, please contact Martin Dorahy.

Consent form

Title of Study: How the feelings and thoughts people have about their past affects how they see themselves, others and their relationships

Names of researchers

Shannon Harvey (Masters student, University of Canterbury), Martin Dorahy (Clinical Psychologist, Senior Lecturer, University of Canterbury), Fran Virtue (Clinical Psychologist, Lecturer, University of Canterbury), Struan Duthie (Petersgate Director, Counsellor)

Please initial box

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. On this basis I agree to participate as a subject in this study and I consent to publication of the results of the study with the understanding that anonymity will be preserved.
3. I understand that my participation is voluntary and that I am free to withdraw at any time, including withdrawal of any information I have provided; without giving any reason, without my care or legal rights being affected.
4. I agree that the researcher can tape the session
5. I understand that the data collected during the study may be looked at by responsible individuals from the research team
6. I understand that if the researcher becomes aware that I have serious intentions to hurt myself or someone else, they will contact the relevant people.
7. I note that the study has been reviewed and approved by the University of Canterbury Human Ethics Committee.
8. I would like my data to be passed onto my counsellor

Name of Participant

Signature