Imagination, Power and Resilience in Psychotherapists/Counsellors Who Have Overcome Childhood *Abuse: A quantitative and* qualitative study

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In

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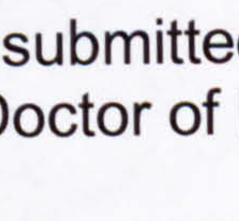
-ScHARR-



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ABSTRACT

Aims: To investigate any possible relationship between the power and resilience of British psychotherapists and counsellors, and the possibility of their having been abused as children.

Main research question: What elements contribute to recovery from childhood abuse?

Methods: This three-part study used a mixed-methods approach.

Results: (1) The *Systematic Review* of reliable questionnaires resulted in the design of a final instrument with eight sections including the following five measurements: the 'GHQ-12', the 'List of Threatening Experiences', the 'Ways of Coping Questionnaire-R', 'The Empowerment Scale' and the 'TSC–40'.

(2) A S*urvey* of results of 103 completed questionnaires indicated that the prevalence of childhood abuse was 57% with a higher proportion (64%) in women. The occurrence of symptoms of trauma was found to be significantly different between the abused and non-abused groups. However, the results suggested that psychotherapy was beneficial because the abused group did not reflect significant trauma. A complex interaction was discovered between coping styles, power, life events, trauma and emotional health. Regression analysis demonstrated that Self-Esteem-Self-Efficacy was a subscale of empowerment that mediated trauma.

(3) Interpretative Phenomenological Analysis of seven *Interviews* showed different usages of power: Dominance Power, Powerlessness/Disempowerment, Inner Power and Empowerment. It also showed that 'Imagination' in childhood and 'Active Imagination' in adulthood were faculties of Inner Power. Psychotherapists reported that their experience of childhood abuse led to an open understanding of trauma, and of its emotional effects in clients who had suffered childhood abuse. They believed that psychotherapy was important for empowerment and recovery.

Conclusions: Triangulation of results strongly suggests that imagination is a fundamental component of inner power, and that play, creativity and sports are crucial elements in the construction of empowerment. These results highlight the importance of play, arts and sports in psychotherapy methods, education programmes, and everyday life.

To my parents:

Profra. Bertha Aguilar Sánchez and M.Sc. Luis Pimentel Bribiesca

With all my love

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1. INTRODUCTION

This thesis presents research that examines childhood abuse, resilience, power and imagination. It has been conducted in three phases: a questionnaire design, a survey and an interview study.

This first chapter introduces the reader to the research by firstly giving the context of the study. It then describes the general aims, approach and variables of the research and presents the problem statement. This is followed by establishing the general prescription of the procedures of the research with an overview of the methodology including the scope and limitations of the study. Finally, the organization of the dissertation is described.

1.1 Context of the study

The concept of power in feminist studies is here defined as a category that involves a subject exercising control over others (Elworthy, 1996). In feminists' studies, social scientists have studied power under the paradigm of the control of women by men. This position of power has been called "patriarchal power". Few studies have been focussed on the power of women. I am interested not only in the power of women, but also the power within women. The research questions thus include a number of issues: the factors which enable people to overcome trauma, and the factors which provide inner strength to children. This can enable victims to continue with their lives and finally become positive and successful adults despite having suffered abuse. It is also important to determine the source of such power, and whether the use of imagination can generate it. Pertinent to these issues is the necessity of achieving a valid (or consistent) definition of this inner power.

The feminist movement and feminist research in particular has had an impact on theory and therapy for child abuse, particularly in child sexual abuse (Enns

et al., 1995). The feminist approach looks at ways of conducting research in which the key aim is to place the diverse experiences of women at the centre of the social investigation. The proponents of this argument consider that feminist research must be "by women, on women, for women" (Webb, 2000). This approach encourages researchers to examine women's daily experiences, written from the point of view of women and analysed through the sociologically constructed paradigm of women.

Issues of power and inequality will be investigated and also their impact on psychotherapy practice. Historically women have played a role which is often the product of male domination-patriarchal control, and which supports the prevailing stereotypes of weakness and intellectual inferiority. Therefore the kind of domination power involved in the different types of childhood abuse will be examined. In recent years, a rapid growth in therapy and advances in research for child sexual abuse survivors have increased knowledge in the field. There exists a range of important and controversial issues relating to childhood abuse. Feminist research perspectives have made significant contributions to the concepts of power and gender. The present study attempts to explain different types of power, including inner power, that have not yet been fully explained as a category in the research literature.

1.2 Statement of the problem

Phenomenological inquiry endeavours to discover how people can describe their experience of the structures that lie beneath their levels of consciousness. It also attempts to understand the essential nature of ideas (Rudestam and Newton, 2001). The causes of child abuse may be as a result of exercising control from an adult to a child. It can exist where power and equality play a role that supports domination from adults to children, from men to women, from teachers to students. The interest of this research is to understand the nature of ideas that psychotherapists and counsellors experienced in their childhood, and to understand the inner child in them.

The effects of childhood abuse in children vary from behaviour and relational problems to severe mental health problems. All of these could be extended up to adulthood as a trauma (depression and anxiety) to extreme cases of severe psychiatric damage. This research considers different types of childhood abuse as: sexual, physical, emotional, neglect and witness domestic violence. The trauma caused by the abuse may vary depending on the severity, the period of time, the age at the onset and personal psychological resources that may lead to resilience.

Within these personal psychological resources, I suggest that 'power' may intervene and be one of the key psychological resources. The category of power has been extensively studied in feminist and gender studies. However, the concept has been mainly studied as a form of control or as empowerment (the process to acquire power). Furthermore, the concept of power has been scarcely studied in the field of psychology and even less studied in psychotherapy.

Therefore, the justification for this research is based on the following reasoning: knowledge of the factors that increase resilience may contribute to improving the work of psychotherapists and psychotherapeutic strategies. The application of this knowledge could help childhood abuse survivors to achieve psychological health and improve their quality of life. Knowing how power works in the process of building resilience would be valuable in helping survivors of child abuse, as well as adding to current theory. The knowledge obtained by this research therefore has both theoretical and practical applications – it can be used in both academic research, and in childhood abuse treatment education and therapy.

Childhood abuse has already been studied in health professionals. Several studies have been carried out investigating the prevalence of childhood abuse in health professionals and in mental health professionals (Pope, and Feldman-Summers, 1992; Nuttall and Jackson, 1994; Howe, *et al.*, 1988; Follette, *et al.*, 1994). Van Deurzen and Tantam (2000), produced a protocol suggesting a study with psychotherapists and counsellors, which was agreed I could use as a

base for my own project. My own ideas on power, empowerment and imagination (which come from my background as Latin-American feminist in rural development as well as my folk dance training) modified significantly the original conception of such a protocol, as well as the inclusion of a wider range of child abuse, and methods of qualitative analysis. The sponsorship I received from the Mexican government, allowed me to put this research into practice. My original input to this research is (1) to investigate the relationship of resilience and childhood abuse within the context of a feminist perspective, (2) to investigate different aspects of power and resilience, (3) to explore power and imagination to overcome trauma. This knowledge could help to facilitate recovery from childhood trauma, but its originality also lies in (4) the investigation of what inner power might be and (5) how it is developed and constructed, and also (6) whether or not inner power is related to imagination.

The survey examines the relationship between the general health of the sample and traumatic childhood abuse symptoms, as well as coping strategies and overcoming trauma. In addition, it uncovers the prevalence of childhood abuse trauma in a sample of psychotherapists and counsellors in the United Kingdom, which could be compared to other international studies.

The interview study investigates in depth the participants' general accounts and identifies the different types of power within their discourse using interpretative phenomenological analysis (IPA)[1]. This was done using a technique that has not been applied before using IPA analysis. Two researchers collaborated for validating the 'meaning units' for the category of 'inner power'. Furthermore, this study specifically addresses topics such as empowerment, inner power, dominance power, powerlessness/disempowerment, imagination, active imagination and psychotherapy. To date, these related areas have not been studied together in any depth.

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[1] *Interpretative phenomenological analysis explores in depth how individuals perceive their personal and social experience and the researcher try to make sense of the individual's personal perception of their experience. (Rudestam and Newton, 2001; Moustakas, 1994; Polkinghorne, 1989; Smith and Osborn, 2004).*

1.3 Positionality[2] and reflexivity[3]

As a brief comment of the positionality of the researcher it is basic to explain that my position as a researcher reflects (a) my personal experience as a daughter, granddaughter, sister, wife and mother, (b) my perspective as folk dancer and (c) my orientation as a Latin American woman who has been trained in the fields of psychology, psycho-oncology and rural development. My position as a Mexican folk dancer, teacher and choreographer has provided me with a deep interest in archetypes, movement, kinaesthesia, body, childhood, creativity and imagination.

Being the daughter of a fantastic woman, who is a great educator and herself brave against illness and adversity, who has survived breast cancer for more than 25 years is very much an inspiration to me. But also, as a woman, being part of a family where being a woman is not seen as an obstacle in life. Bartky (1990:11) states that "*to be a feminist, one has first to become one*"; as a granddaughter of two great grandmothers (both successful school teachers), I became a feminist at a very early age led literally by the hand of my maternal grandmother. I remember exactly the day that I became a 'feminist'. It was a sunny Sunday morning when for the first time my grandmother did not cover my head and hers with a veil to go to hear a church mass (catholic). I remember the feeling of butterflies in my stomach; as far I was concerned that was a sin. But my grandmother explained to me that the Pope had abolished the rule which required women to wear the veil at church, because women wanted to be liberated and be equal to men, and that was a step forward for women, not only in the catholic world but for other women too. She said to me that someone needed to lead by example, so we went in to hear our usual Sunday mass without a veil on our heads. And that was what we did. I tried to persuade her at

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[2] *Positionality is a term used in Geography that looks for greater reflexivity in terms of the relative "position" of individual researcher. The position of the researcher in respect of value/power/knowledge as an outsider and as an insider (Sideway, 2000). It "reflects critically on the academic competition and marketization" of the relative position of power of the researcher in contemporary science (Sideway,2000). Cox (2001:1) states that "academic and other knowledge are always situated, always produced by positioned actors working in/between all kinds of locations" working on all kinds of research.*

[3] *Reflexivity "means sensitivity to the ways in which the researcher and the research process have shaped the data collected, including the role prior assumptions and experience, which can influence even the most avowedly inductive enquiries" (Mays and Pope,2006:89).*

the last minute before entering the cathedral, and she said to me, 'we need to be brave, Silvia, we need to liberate ourselves'. She gave me her hand, and we entered the church through the central aisle to the first block of pews to listen to the mass, under the inquisitive sights of some. However, I felt safe and proud of the braveness of my grandmother. It took a couple of weeks, but, little by little, other women took their veil down. I also remember that, weeks after, a group of women were talking with my grandmother about how difficult it was for them to stop using the veil, and how encouraging it was to see her example. For other women, it was a focus of critical comments. It took a few years to see all women without veils, and even now, there is still someone who covers her hair to go to church. To break tradition and habit is not an easy task.

1.4 General aims, approach and variables of the research

The general topic of this research is overcoming childhood abuse. This is a mixed methods research which has the general aims (a) to investigate how power and resilience are involved in overcoming childhood abuse trauma, and (b) to discover whether imagination brings empowerment to achieve resilience. To investigate these issues, this study undertakes quantitative and qualitative approaches through (1) the design of a questionnaire, (2) a questionnaire survey of the prevalence of child abuse suffered by psychotherapists, and (3) an interview study that uses a purposive stratified sample. The data analysis is carried out using statistical analysis and a feminist interpretative phenomenological analysis (IPA).

The outcome of this research has been analysed both quantitatively and qualitatively, and the discussions integrate both approaches. The quantitative approach was applied by a survey using an instrument composed of five questionnaires (validity and reliability already proven) and specific questions about power and resilience designed by the researcher and her supervisors at that time. The results of the survey were processed in SPSS and analysed. The qualitative approach was conducted using semi-structured interviews with subjects willing to participate in that stage of the research. The results were

analysed using interpretative phenomenological analysis. In the conclusion, the results from these two methods were triangulated; with (1) the findings obtained from the questionnaire study, contrasted with (2) the accounts of the interview study and (3) the knowledge gained from the literature review and a second focusing set of questions with the interviewees.

The key variables of this research are: child abuse, trauma, coping, power, empowerment, inner power, imagination, and resilience. The definitions of each variable are as follows: *"Power is the ability to get what we want"* (Boulding, 1999). Empowerment is a process of transferring power. Empowerment in this study will be considered as the process focused on women's' ability to reclaim power from abuses to change their own lives in order to stop and overcome childhood abuse. Imagination is *'the faculty which envisages possibilities, which works them out in detail, which formulates them in such ways as to make them viable and available options'* (Oksenberg, 1983:811). *'The move from identifying power as the means to obtaining what a person desires directly leads to seeing that the imagination is among the greatest of these powers, and the control of the imagination gives the greatest control over power'* (Oksenberg, 1983:813).

The description of inner power will be based on Elworthy (1996) who states that inner power is the power 'within' (:80). It will be described in this thesis as '*power over*' (:79, 180) the self, but also will consider the findings of Valentine and Feinauer (1993), who described inner power as an *"inner direct locus of control"*. Inner locus of control was also described in the same study as a sense of inner self and that *'this sense of control and power seemed to enable these participants to do well in school, to overcome fears, and to have small successes along the way'* (:222) they found in their participants *'the ability to reframe situations'* (:223). Taking into account the Oxford English Dictionary definitions of the words "inner" which is described as "inside; towards or close to a centre of a place (...) not expressed or shown to other people" (2000:669) and "power" which is described as control, ability, authority, influence, energy and good/evil spirit[4].

[4] *Power: "the ability to control people or things" (...) "the ability or opportunity to do something" (...) the right or authority of a person or group to do something" (...) "a country with a lot of influence in world affairs" (...) strength or influence in a particular area of activity" (...) the strength or energy*

This study will take the definition of imagination as the faculty of inner power, where imagination *'is not one single faculty; its exercise involves many different sorts of skills, many of them acquired through practice and imitation. It involves separating variables, recombining them, defining and re-describing situations, tracing possible consequences, drawing inferences from hypothetical considerations, constructing ramified counterfactual alternatives'* (Oksenberg, 1983:811).

With reference to resilience, it will be considered as *'the power or ability to return to original form or position after being bent, compressed, or stretched'* (Valentine and Feinauer, 1993:222). Masten, Best and Garmezy (1990:426) consider resilience as *"the process of, capacity for, or outcome of, successful adaptation despite challenging or threatening circumstances"*. And the term of powerless defined as *'without power to control or to influence somebody/something'* (Oxford Dictionary 2000).

Table 1.1 Parts comprising this thesis

Thesis research	Objective
Part one	To design a suitable and reliable questionnaire
Part two	To do a survey
Part three	To do in depth interviews

The research examines what factors have influenced psychotherapists in their ability to overcome their own childhood abuse. It explores connections between power, imagination and resilience. Table 1.1 shows the different studies that compose this thesis. Part one was the design of a questionnaire through a systematic review[5] study with the aim to select different questionnaires and to design a suitable and reliable core questionnaire[6]. Part two uses a self selected sample and a questionnaire. Part three is an interview study that uses a stratified purposive sample. The key research question for the qualitative study

contained in something (...) the public supply of electricity (...) "a good or evil spirit that controls the lives of others" (Oxford English Dictionary, 2000:988-989).

[5] Systematic review: *"reviews of the empirical literature concerning the efficacy or effectiveness of an intervention* –in this case a questionnaire- *that considers all of the relevant studies taking account of quality criteria"* (Marks et al. 2002).

[6] *A core questionnaire in this case is a set of questionnaires selected in order to measure different aspects of interest in this thesis around the child abuse situation.*

can be stated as follows: 'Is imagination involved in the process of overcoming childhood abuse?'

Table 1.2. General aims and objectives of this research

General purpose of the research	General research question	Aims	Objectives	Methods
To contribute to knowledge about the relationship between power of different types and resilience in overcoming childhood abuse by examining a sample of psychotherapists and counsellors based in the United Kingdom.	What helps people to overcome childhood abuse?	To find out the prevalence of childhood abuse among psychotherapists	To design a questionnaire that includes the different factors that may result from childhood abuse or that may cause a change in emotional health	A selection of questionnaires that may accurately reflect the different factors and the possible relationships between them.
		To find out what has influenced psychotherapists in their ability to overcome child abuse	To describe the factors that are involved in overcoming childhood abuse through both quantitative analysis and qualitative analysis	An analysis of the different factors presented in the questionnaire
		To investigate if psychotherapy helps participants to overcome the trauma caused by childhood abuse	To explain the findings in feminist terms, particularly in relation to power and imagination	To interview women that had the experience of child abuse and have a particularly high score of power
		To examine whether or not there are connections between power, imagination and resilience	To attempt to define 'inner power'	To examine whether the interviews' accounts shows characteristics that may reflect the definition of inner power
		To ascertain what factors intervene to build inner power		
		To uncover whether childhood abuse is a factor why some people choose to became therapists.		
		To investigate whether the practice of psychotherapy is a factor in resilience.		

Table1.2 illustrates the aims and methods of this research. The general research question of the whole thesis is 'what helps people to overcome

childhood abuse?' The aims of the systematic literature review are (i) to find reliable and valid questionnaires in the topics of: general emotional health, recent life events, coping strategies, power and symptoms of trauma. (ii) to design a suitable and reliable questionnaire applicable to adults, and professionals that may help to uncover the purposes of the survey.

The aims of the survey are: (a) To find out the prevalence of childhood abuse among psychotherapists. (b) To find out what has influenced psychotherapists in their ability to overcome child abuse. (c) To investigate if psychotherapy helps to overcome the trauma caused by childhood abuse. (d) To examine whether or not there are connections between power and resilience. (e) To ascertain what factors contribute to build empowerment. (f) To uncover whether childhood abuse is a factor why some people choose to became psychotherapists or counsellors. (g) To investigate whether the practice of psychotherapy is a factor in resilience. The aims of the interview study are: (a) To examine whether or not there are connections between power, imagination and resilience. (b) To ascertain what factors intervene to build inner power

1.5 General description of the procedures of the research

To achieve the aims of this thesis, different projects were required: (a) a general protocol design, (b) ethical procedure, (c) questionnaire design, (d) pilot study, (e) survey, (f) interview study design and (g) interview study.

Table 1.3 Procedures of the research

Projects	stages
General protocol design	
Ethical procedure	Stage 1 For the approval of the whole research questionnaire study Stage 2 For the approval of the interview study
Questionnaire design	
Pilot study	Pre-pilot Pilot
Survey	
Interview study design	
Interview study	Main interview Follow up interview

a) A general protocol design was structured at the beginning of my studies to plan and create an idea of the project. Initially, a comparison with another country –Mexico- was included; however after three years and a few months, this option was discarded because it was very difficult to find an organization in Mexico that agreed to participate in the research. Acceptance of this proposal was received after three and a half years of continuous effort. For these reasons, the research only concentrates on United Kingdom psychotherapists and counsellors.

b) The ethical procedure was a very important part of the investigation. A constant communication with the ScHARR Research Ethics Committee (SREC) was sustained during the whole process of this research. To ensure the protection of participants, the procedures were submitted and approved by the ethics committee of the School of Health and related Research (ScHARR) of the University of Sheffield. The studies of this research observe the ethical principles and rules of confidentiality, anonymity and autonomy. A number was designated to research respondents and anonymised personal data was kept secure in a locked cabinet at the work place. Similarly, research participants were treated fairly and they had the right to leave the research at any time they wished. People who helped with the transcription of the interviews were unaware of the participant's real identity and kept confidentiality about any information disclosed in the interview.

The questionnaire procedure advised by SREC was to send out initial contact letters seeking consent for completion of the research questionnaires. These initial contact letters were sent through the Universities Psychotherapy and Counselling Association (UPCA), which assisted me in contacting its members for their participation in this research[7]. Each pack contained an initial contact letter, an information research letter, a consent form and a pre-paid envelope. Informed Consent was received in the pre-paid envelope by the researcher. After receiving the consent form stating their willingness to participate in the study, a set containing the questionnaire was sent to participants who still had

[7] *Many thanks to Diana Lohman for assisted me with the mailing of the initial contact letter.*

the option of not filling in the questionnaires if they changed their mind. This procedure affected the time and response rate to the questionnaire study.

c) The questionnaire was designed after completing a systematic review. A core instrument was designed from a selection of questionnaires that had already been tested and selected for reliability and validity. The questionnaires were selected through a systematic review of databases, mainly the PsycINFO and Medline databases. The following were considered: (i) validity and reliability, (ii) suitability for adults (iii) whether the questionnaires had been verified with samples of survivors of childhood abuse trauma. After a careful search of the literature, questionnaires were found with demonstrated reliability and validity for the assessment of childhood trauma, methods of coping, general health, power and recent life events.

d) The questionnaire was pre-piloted and then piloted. Firstly a pre-pilot study was conducted with five psychotherapists. Based on their feedback, the instrument was refined. Secondly, a pilot study with ten members of the association was carried out to assess how the instrument design functioned. Physical abuse, emotional abuse, sexual abuse, neglect and witnessing domestic violence were considered. After some final minor amendments and corrections were made to the designed instrument, a survey was then carried out with a self-selected sample of psychotherapists. The final instrument has eight sections: section one has questions about socio-demographic details such as: age, gender, marital status and childrearing. Section two is from Goldberg's General Health Questionnaire (GHQ-12). Section three consists of a questionnaire to measure recent life events from the "The List of Threatening Experiences" (Brugha, T. S. and Cragg, D., 1990). Section four is the "Ways of Coping Questionnaire" (WAYS-R). Section five looks at the personal history of childhood abuse trauma with the "Trauma Symptom Checklist-40" (Briere and Runtz, 1988) Section six is a questionnaire about power and empowerment named "The Empowerment Scale" (Rogers, Chamberlin, Ellison, Langer, Crean.1977). Sections seven and eight include a "Power and resilience section" designed to both measure power in the resilience process and present personal

power; these questions were designed by the main researcher and her supervisors at that time.

e) The survey was conducted by questionnaire. It was designed (i) to determine the prevalence of childhood abuse among psychotherapists, (ii) to detect the emotional state of the subjects through the general health questionnaire, (iii) to find out if there was a recent life experience which could alter the actual emotional state of the practitioners or if there was a trauma as a result of childhood abuse, (iv) to find which ways of coping used by subjects who had suffered child abuse lead to resilience, (v) to find out whether or not power was related to resilience, and if it was, what kind of power facilitated resilience.

The methodology of this approach included: a protocol design, the Ethical approval by the Ethics Committee of the School of Health and related Research (ScHARR) of the University of Sheffield, the questionnaire design, the pre-pilot and pilot studies and the survey.

Three hundred and ninety psychotherapist and counsellor members of the Universities of Psychotherapy and Counselling Association (UPCA) were sent a consent letter and information research letter via UPCA in which they were asked to complete a questionnaire. The interested participants then mailed the answer to the researcher (137 subjects). Questionnaires were then sent out to members willing to receive such a questionnaire (124 participants). The questionnaire included a section that asked participants to indicate whether or not they would be willing to be contacted for subsequent interview (62 respondents).

(f) The interview study was based on a semi-structured interview 'created to construct meaning' from the subjects and to learn in greater detail about the factors they perceived as important to surmount childhood abuse. Such interviews enabled an exploration of individual constructions of resilience to child abuse, in order to understand further the relationships between empowerment, imagination and resilience in child abuse. Also, to clarify what kind of power helps individuals to overcome trauma and on what such power is

based. The research questions ask whether or not imagination and creativity of female psychotherapists/counsellors can help to build power and help to develop personal capabilities to find options to overcome child abuse. The aim is to understand the individual perspective and how creativity and imagination helped the interviewee to develop personal capabilities. This enables them to make creative and conscious use of the experience of child abuse in their clinical work, their empowerment process and what they needed to do in order to overcome child abuse.

g) Initially, the interview study considered interviewing twelve female questionnaire respondents. Instead, it was decided to interview one participant for the pilot interview plus six participants in the first instance with the option to study more if a participant should withdraw from the study. In terms of time and costs, it was a better option to start with a small sample because it involved travelling across the United Kingdom. The method of selection of the sample was 'stratified purposeful sampling'. This is based on 'Patton's Sampling strategies' where participants "illustrate the characteristics of particular subgroups of interests" (Wengraf, 2001). In this research, participants were selected according to the categories used in Great Britain, derived from Department of Health guidelines (Department of Health (2000), where in 1988 five categories of child abuse were considered. These categories are: physical abuse, neglect, emotional abuse, sexual abuse and witnessing domestic violence.

The sample was obtained from questionnaire respondents who previously gave consent to participate in the interview study. The procedure proposed for conducting the qualitative study was to initially conduct one pilot interview, followed by a main study in which there was a sample of five cases. The interviews were planned with open-ended questions.

In this thesis the purpose is to examine the different factors that intervene in overcoming psychological trauma. This research investigated two main aspects. These were firstly, which elements contribute to power and resilience in childhood abuse trauma and secondly, whether or not imagination contributes

to empowerment leading towards resilience. This thesis is organised into seven chapters.

1.6 Outline of the research

Seven chapters that are illustrated in table 1.4 comprise the thesis. The introduction provides a general overview of the thesis, aims and structure of the thesis.

Chapter two explains the literature review. The main aspects of the topics of child abuse, trauma, life events, resilience and power will be outlined. It will look at definitions, the latest classifications and prevalence of child abuse, explanatory theories and theoretical position of the researcher.

Table 1.4 Structure of the thesis

Chapter 1	Chapter 2	Chapter 3	Chapter 4	Chapter 5	Chapter 6	Chapter 7
Introduction	Literature review	Methodology	**Results of the systematic review for the questionnaire design**	**Results of the Survey**	**Results of the interview study**	**Discussion and conclusions**
General overview Key themes Research questions	Literature review	Research questions Methodology and questionnaire design	Systematic review	Questionnaire survey	Interview study	Summary of the research and Triangulation

Chapter three proceeds to specify the methodology followed in the research. It will be explained in three different phases: the questionnaire design, the quantitative study and the qualitative study as interpreted in feminist methodology.

The fourth chapter discusses the results of the phase one of the study: the systematic review and it explains the design of the questionnaire that was applied after in the survey

Chapter Five examines the survey. It shows how the questionnaire study was applied. It reports the analysis of the results under these headings: emotional health, child abuse, life events, coping skills and power. Integration of the

results and comparison with other studies are explained in the discussions at the end of this chapter.

The Interview study will constitute Chapter six. Its purpose is to explore in more detail the strategies that the interviewees used to gain resilience. It explores the different categories of power, namely: empowerment, inner power powerless/disempowerment, and dominance power that intervene in their experiences of childhood abuse. Moreover, it aims to determine if there are any relationships between either imagination or creativity and empowerment or/and inner power that result in greater resilience.

Chapter seven is the discussion and conclusions provided by the research, in this chapter an integration of the theoretical position of the researcher –'feminist phenomenological'- and the findings will be conducted around three axes: psychology, feminist and phenomenological. This chapter provides a summary of the methods of the research. It integrates and discusses the findings of the three phases of the research, discusses the results, present conclusions and offer suggestions for applications of the findings and for future research.

To provide a context for this research, the next chapter will review the literature selected to give an overview of the terms and issues involved in childhood abuse and the perspectives around it. This will help to develop an understanding of the theory and methods used in this research.

CHAPTER 2

Literature Review

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2. LITERATURE REVIEW

In this chapter, the key concepts underpinning the research will be presented: child abuse, trauma, life events, resilience, aspects of power, and feminist and phenomenological psychology. The scope of this chapter is to arrive at satisfactory definitions of the concepts and variables relevant to this thesis, as well as to understand the concepts to be deployed in the research questions of the different research studies of this thesis. This Chapter will present definitions of those concepts and the various terms and categories pertinent to this research. The literature review has been conducted by searching in (a) databases such as Psycinfo and Medline, (b) the Cochrane library, (c) through the British Library, (d) using the Internet and (e) also travelling to the British Library located in Bath SPA. The systematic literature review used as a methodology to find suitable questionnaires for the quantitative approach is reviewed in the methodology chapter.

2.1. Introduction

The theoretical position of this study is feminist phenomenological. The rationale of this decision is that the researcher situates her thinking within the discursive frameworks of postmodernism and post-structuralism, and more specifically within the field of interpretative phenomenological analysis. This in turn is situated within the broader field of hermeneutical phenomenological research that derives understanding from the context of the experience of the participant. In other words, this research is situated within the feminist phenomenological perspective because it gives women an autonomous voice, which honours women's meaning making structures and the feminist aim of to listening to women. Hopefully this study will contribute with a grain of sand to the understanding to how the phenomenology of power impacts on women's meaning making, experience and oppression in different cultures.

Research has found a significant relationship between the experience of child abuse, trauma and mental illness (Bremner *et al.*, 2000; Meekums, 2000; Everet and Gallop, 2001; Hanson, *et al.*, 2006.; Whitaker, *et al.*, 2006.; Zielinski, and Bradshaw, 2006; Katerndahl, and Kellogg, 2005; Garno, *et al.*, 2005; Coid, *et al.*, 2003.; Lipman, *et al.*, 2001; Price, *et al.*, 2001). Mental health professionals may be in a good position to provide information about whether (and how) psychotherapy can help develop resilience to emotional trauma. For this reason, it remains for this study to ascertain whether psychotherapists who report being abused in childhood retain symptoms of this trauma in adulthood, and/ or how they have managed to surmount childhood abuse trauma. Therefore, more studies of the prevalence of child abuse suffered by health professionals -particularly psychotherapists and counsellors - would be a useful contribution to the understanding of child abuse and its relation to these professions.

2.2. Child Abuse

In the last four decades, a growing awareness of childhood abuse has been reported in the professional literature. Child abuse has been studied in different ways since its conceptualisation as abuse in the field of mental health. One of the most important studies was Kempe et al.'s (1962) seminal description of the battered child. Consequently, society has become increasingly aware of the different types of abuse-related problems. In the late 1970s and 1980s child sexual abuse became the focus of extensive research, and by the 1990s there were many studies of the psychological maltreatment of children. Recently, issues such as child neglect, witnessing domestic violence and other specific forms of child abuse have been studied.

Since its recognition, child abuse has become extensively researched. Different forms of child abuse, their incidence and long-term impacts on individuals have been identified. Consequently, health professionals are now becoming increasingly

aware of the social and psychological consequences and dimensions of child abuse at present.

Studies have been conducted on different types of samples, e.g. university students, psychiatric samples, and adult and/or adolescent child abuse survivors. However, some research has been conducted on the numbers of psychological health professionals who have suffered child abuse, and the prevalence of such abuse (Pope and Feldman, 1992; Nuttall and Jackson, 1994; Ferguson and Dacey, 1997; Little. and Hamby, 1999; Elliot and Guy, 1993; Little. and Hamby, 1996)

In a survey a random sample of 1,635 clinicians in United States, Nuttall and Jackson (1994) report that 656 (42% response rate), they found that 17% had experienced sexual abuse and 7.1% reported physical abuse. 13% of men and 20% of women reported sexual abuse whereas 7.3% of men and 20% of women experienced physical abuse. Participants were sexually abused at 8 years (mode) and 10 years for physical abuse. More of the half of respondents reported being physically abused for more of 3 years whereas 50% of both genders of those who reported sexual abuse was a year of duration. Ferguson and Dacey (1997) studied 55 women health care professionals that reported childhood psychological abuse. This group was compared with a non abuse control group (same size). They used the Childhood Experiences Questionnaire and measured three dimensions: anxiety, depression and dissociation. Participants that experienced psychological maltreatment have higher levels of depression, anxiety and dissociative experiences.

Pope and Feldman (1992) conducted a survey of 250 males and 250 female clinical and counselling psychologists; the return rate was 58% (290 completed questionnaires). One hundred and fifty-three women participated. Results showed that 27% of the sample suffered of childhood sexual abuse. 69.9% of female psychologists and 32.8% of male psychologists experienced some form of physical or sexual abuse.

Elliot and Guy (1993) compared 340 women professionals working in mental health with 2,623 women working in other professions. Psychotherapists reported higher rates of physical (13.8%) and sexual abuse (43.3%), as well as parental alcoholism (21.9%), death of a parent or sibling (11.4%) and hospitalization of a parent for a mental illness (8.1%). Nevertheless, reported less anxiety, depression, dissociation, and sleep problems that the comparative group. The TSC-40 was utilised to assess the trauma related symptomatology (psychological distress). The age average was 41 years and the majority of them were white (92%). The results support research that suggests that psychotherapists are often traumatized and grown up in dysfunctional families as children, and also suggest that clinicians might consider directly deal with abuse-specific concerns

Little and Hamby (1996) survey 501 clinicians, 32% reported a history of child sexual abuse. In a further report, Little and Hamby (1999) explored gender differences in abuse characteristics, effects and the recovery of 131 therapists that reported child sexual abuse history. Female clinicians reported: relinquishing guilt, talking about the abuse, renegotiating family-origin relationships, personal therapy, reading or writing about their CSA, hospitalization and CSA workshops, as the most recovery experiences

Pope and Tabachnick (1994) conducted a survey of 800 psychologists with a response rate of 59% (476). The majority in their 40s Most of the respondents agree have been in therapy themselves (400), with a median time therapy of four years. Women were more likely (89.6%) than men to have received therapy.

Elliot and Briere (1992) studied a sample of 2963 professional women (55% of the potential 6,000), their results shown that 26.9% reported an experience of CSA. Female professionals reported more anxiety, depression, dissociation, sexual problems, sleep disturbance and post-traumatic symptoms than the group that no reported abuse.

Feldman-Summers and Pope (1994), conducted a survey in the United States with 145 women and 185 men participants (66% return rate). This sample was selected

from 250 men and 250 women members of some of the divisions of the American Psychological Association (APA). The respondents reported child abuse before they were 18. Of 79 participants who experienced a type of abuse, 45% informed, *"there was a period of time when they could not remember some or all of the abuse".* (Feldman-Summers and Pope, 1994),

2.2.1. Definitions of child abuse

Child abuse is a socially defined construct. In other words, it is not an absolute unchanging phenomenon as it is located in a particular culture and historical context. Historically, differences have evolved in social attitudes towards children. For instance, Victorian and contemporary notions and perceptions differ considerably. As children were not considered to be different from adults in terms of expectations, behaviour and feelings, they were consequently subjected to experiences which we would now consider to be abusive. For example, in Victorian times it was not considered abusive to physically punish a child, and practices such as isolating infants and small children in rooms or beds at night was and still is common practice although not typically considered to be abusive behaviour.

Other examples of cultural differences in constructs of abuse are illustrated in the following quote: *"These include extremely hot baths, designed to inculcate culturally valued traits; punishments, such as severe beatings, to impress the child with the necessity of adherence to cultural rules; and harsh initiation rites that include genital operations, deprivation of food and sleep, and induced bleeding and vomiting."* (Korbin 1981:4)

There is no single definition of child abuse; definitions are constructed according to the notions held by a researcher, or the field of study (psychological, medical, legal). It is important to know who defines the concept, as well as their aims, goals and interests, as this dictates what sorts of behaviours are classified as abusive. The definition of child abuse that was originally developed from the 'battered child' in 1962 is now applied to a vast range of practices and behaviour.

It is problematic to define what child abuse is. It has a long history, that was not recognized as a "social ill" (Kempe and Kempe, 1978). It is a cultural, historical and political issue and does not easily lend itself to logical solutions. These are some of the reasons why the topic of child abuse is very complex. Another is that most maltreated children experience more than one type of abuse. This makes it even more complicated to include the whole issue in just one concept.

According to a study by McGee et al. (1995), different approaches have influenced the concept of child maltreatment: (a) the medical approach, (b) the legal approach, (c) the sociological approach and (d) the subjective approach. The medical approach is more concerned with the physical injury to the child. The legal approach results in measurable serious harm to the child - not necessarily physical harm. The sociological approach is defined by society or the state, while the subjective approach is the most recent; it arises through respondents' self-reports of occurrence and severity, and the maltreatment is defined by the victim.

Considering this classification, in this thesis, child abuse will be considered to have occurred only if individual participants define oneself as being abused.

A feminist approach to child abuse has been developed since the 1970s: At that time, studies about rape and incest were a cornerstone to knowing more about child abuse. In the 1980s it was recognised that post-traumatic disorders are not only suffered by men in war, but also by civilian women. This approach has brought the hidden life of women, once considered private, to the public sphere. In the 1990s domestic violence studies revealed the invisible reality for many women in the world.

In Britain, the term 'child abuse' was first officially used in a 1980 government circular. Definitions of child abuse, which derive from Department of Health (DoH) guidelines, have undergone considerable changes over time to include and reflect new types of abuse and concerns that emerge and need to be considered. These changes have resulted in the present classification into four discrete categories:

physical abuse; physical neglect; failure to thrive and emotional abuse (combined category) and being at risk - *i.e. "children living in a household with, or which is regularly visited by, a parent or another person who has abused a child and are considered at risk"* (Department of Health, 2000a).

2.2.2. Classification

According to research findings in the field, several classifications of child abuse have been made to include more types of behaviour in their scope (Bernstein et al. 1997). At the present time, classifications include: physical abuse, sexual abuse, emotional abuse, and child neglect (physical neglect, emotional neglect).

Table 2.1 Different types of abuse

Types of abuse						
Physical	**Psychological**	**Sexual**	**Neglect**	**Outside factors**	**Witnessing family violence**	**Other forms of abuse**
Introduced for first time in 1962 Culturally accepted. Bad behaviour is the "reason for the physical punishment	Most common forms of child maltreatment	More studied than other forms of abuse.	Difficult to determine not only by parameters	Such as parental substance abuse and psychiatric disturbance	Witnessing family violence especially "one's mother being battered by one's father"	Social discrimination. Racism sexism war extreme poverty, homelessness.
Serious child injury- substantial numbers of children are more severely maltreated	Difficult to define	Likely to be specially associated with long-term psychological impacts.	Broad overlap between emotional neglect and psychological maltreatment		Witnessing domestic abuse	Munchausen syndrome by Proxy. Introduced for first time in 1977 Child with an illness fictiously produced by a parent, typically the mother
Significant overlap amongst physically and psychological abusive parental behaviour. When the combination is present at high levels is especially harmful.	Recently received significant public or professional attention	Likely to be combined with physical or psychological maltreatment.	Almost no studies of children about the impact of child emotional neglect.			
	Figures that underestimated real prevalence.					
	Probable inherent or core part of all forms of child maltreatment Has broad impacts on later psychological functioning					

Corby (2000) includes foetal abuse and institutional, ritual and organized abuse in his classification of child abuse. Further, bullying is seen as a possible symptom of intrafamilial abuse, as well as being an abuse or crime in its own right. Racist bullying, similar to child prostitution (which was officially seen as being an offence up to the mid-1990s); is now considered as a possible symptom of child abuse rather than the child being considered a child offender. Finally, Corby includes domestic violence and the mental health of the parents as a concern in a review of issues relating to definitions. Other studies have considered witnessing domestic violence as a cause of childhood trauma (Fink, Bernstein, Handelsman, Foote, and Lovejoy, 1995). External factors such as parental substance abuse and psychiatric disturbance are frequently involved in an environment characterised by chronic unpredictability and unreliability. Other forms of abuse are: social discrimination, racism, sexism, war, extreme poverty and homelessness (Briere, 1992).

Abuse is not only a single way, it takes different forms, and this research will consider physical, sexual, emotional, neglect and witnessing domestic abuse. It will review the key definitions next.

2.2.2.1. Physical abuse

This type of abuse was the first to be defined by Kempe *et al.* in 1962, and was the first concern of child protection services.

Helfer and Kempe (1974) defined Physical abuse as *"being inflicted non accidentally...which causes or creates a substantial risk of causing disfigurement, impairment of bodily functioning, or other serious physical injury"* .

In Britain, physical abuse is defined by the Department of Health as involving *"hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill-health to*

a child. This situation is commonly described using terms such as fictitious illness by proxy or Munchausen syndrome by Proxy" (Department of Health (2000:5).

However this definition is more specific, and is not very useful as an operational definition because of the lack of guidance on behaviour to warrant protective intervention. In practice, there are many factors to take into account in deciding whether officially to define a situation as abusive. Guides to some of the factors that need to be taken into account are considered by Corby (2000) as being: the seriousness of the injury, the intention, the age of the child, the context and risk. Corby, (2000) points out that the seriousness of the injury is a measure of the abuse; also, intention is a key variable in deciding whether an action is abusive or not. The age of the child is a factor to be considered; usually, the younger the child suspected of being physically abused, the greater the likelihood of official registration. Further, physical punishment is less acceptable in the case of very young children. Context and risk are also important factors to be considered when deciding whether or not to define actions as abusive, as are family strengths and weaknesses, the child's general health and development, the child's reaction to the incident and the adequacy of parental care.

Physical abuse includes poisoning, suffocation and Munchausen's syndrome by proxy which are relatively uncommon forms of abuse, but the fact that they are highlighted by the DoH probably reflects the fact that they often result in fatalities or other serious outcomes. Munchausen's syndrome was first diagnosed in 1977 and is usually detected when a child is reported to have an illness that has been fictitiously produced by a parent, typically the mother. The child is subjected to further abuse by exposure to the medical treatment prescribed; thus, Munchausen's incorporates a range of abuses, which have a common causal base, which is parental psychological or emotional disturbance.

2.2.2.2. Sexual abuse

Childhood sexual abuse has been defined as *"the involvement of dependent, developmentally immature children and adolescents (less than 18 years old) in sex acts that they do not fully comprehend and to which they are unable to give informed consent or that violate the social taboos of family roles".* (Kempe, 1978) usually but not always *"perpetrated by a member living in the same family space"* (González-Serratos, 1978).

It is defined by the Department of Health in Britain as *"...forcing or enticing a child or young person to take a part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) and non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities or encouraging children to behave in sexually inappropriate ways." (DoH 2000:6).*

Molestation frequently begins when the child is less than 8-9 years old. The perpetrator usually is someone in his mid-20s or older and is generally male (Briere 1992, Finkelhor, 1979). As in other types of child abuse, different factors such as medical, social and behavioural factors may define sexual abuse. It is difficult to prove child abuse in court; medical evidence is better accepted with some form of corroboration from a social and behavioural assessment. A child's testimony may not be accepted unless other evidence corroborates that. Videos can be used as evidence if cross-examination with the child is possible (Cobley, 1995).

2.2.2.3. Psychological abuse

Childhood trauma as a result of child abuse is increasingly recognised as an important public health problem. The Department of Heath guidelines defined emotional abuse as *"the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development.*

It may involve conveying to the children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being placed on children. It may involve causing children frequently to feel frightened, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill-treatment of a child, though it may occur alone" (Department of Health, 2000:5-6).

It is very difficult to define emotional abuse, because it involves areas of major uncertainty and sensitivity that are difficult to prove. For example, there is a question whether abusive parenting is being authoritarian or extremely permissive. Does constant criticism affect children, if so, how much?

Garbarino and Gilliam (1980:7) define psychological maltreatment as *"Acts of omission or commission by a parent or guardian that are judged by a mixture of community values and professional expertise to be inappropriate and damaging"*.

It is difficult to prove the causes and effects in this area. Burnett (1993) studied both the public and professionals to find what people understand as psychological abuse, and found the following forms: (1) confining a child in a small place, (2) severe public humiliation, (3) the 'Cinderella' syndrome[1], (4) severe verbal abuse, (5) encouraging or coercing a child into delinquency, (6) threatening a child, (7) refusal of psychiatric treatment, (8) not allowing social and emotional growth, and (9) not providing a loving, nurturing atmosphere (Burnett 1993: 446).

Ferguson and Dacey (1997) studied the relationship between psychological maltreatment in childhood and adult symptoms of depression, anxiety, and

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[1] *Peter Lewin (1976) is a psychiatrist often linked with this syndrome. He first described this condition with reference to a female patient aged 12. The symptoms she exhibited were "inattention, temper tantrums, failing grades and wanting to leave home" (1976:109). Her mother died when she was five. In the presence of her stepmother, the girl exhibited very good manners. She mentioned being criticized for many of her household duties, which included taking care of her stepsiblings. Her stepmother complained to the doctor about her errors and the bad luck of the family. This patient when at home frequently felt ill. She was looking forward to her 'prince' to enable her to leave home soon. Her father did not intercede to help his daughter. He was aware that his daughter was not the problem, but he did not want to irritate his wife.*

dissociation. They compared a sample of women health care professionals that reported experience of childhood psychological abuse to a control group of non-abused women. Participants were heath care professionals, with ages from 20 to 61 years; mostly white middle-class college-educated women. The authors did assess abuse history with the Childhood Experiences Questionnaire (CEQ) constructed for that particular research. Eleven of the 30 items assessed psychological maltreatment. Their findings showed that there was a higher anxiety, depression and dissociative experiences score by abused women than that of non-abused women.

Hart and Brassard (1991) identify five subtypes of psychological abuse as follows: spurning, terrorising, isolating, exploiting/corrupting and denying emotional responsiveness. The authors describe these subtypes as follows:

(a) Spurning: *verbal battering, hostile degradation, rejection*

(b) Terrorising: *threatening to hurt or kill a child, child witnesses family violence*

(c) Isolating: *preventing child from interacting with peers or adults outside the family, confining child in a closet or closed room for an extended period of time.*

(d) Exploiting/corrupting: *modelling or encouraging child to engage in antisocial or criminal behaviour, encouraging child to use drugs or alcohol, keeping child in role of surrogate parent to other children or as surrogate spouse.*

(e) Denying emotional responsiveness: *emotionally neglecting the child, being psychologically unavailable to child, ignoring child's attempts to interact with parents.*

It is generally acknowledged that psychological abuse is possibly an intrinsic element in all kinds of maltreatment.

2.2.2.4. Neglect

Child neglect comprises a broad range of child protection issues, which had not been classified as neglect until recent times. The Department of Health (2000)

defined neglect as: *"The persistent failure to meet a child's physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment, It may also include neglect of, or unresponsiveness to a child's basic emotional needs. (DoH 2000:6).*

In the United States, neglect occurs if the child is (1) malnourished, ill-clad, dirty, without proper shelter or sleeping arrangements; (2) without supervision, unattended; (3) ill and lacking essential medical care; (4) denied normal experiences that produce feelings of being loved, wanted, secure and worthy (emotional neglect); (5) failing to attend school regularly; (6) exploited, overworked; (7) emotionally disturbed due to constant friction within the home, marital discord, mentally ill parents; (8) exposed to unwholesome and demoralising circumstances (Polansky *et al.* 1972).

Neglect takes place as 'act of omission', and is often the result of parental –or caretaker- ignorance or indifference (Briere, 1992). Little research has conducted regarding the impact of neglect-related symptomatology. However, it has been shown that disturbed attachments in the relationships to others have been found in the short and intermediate terms. Further research suggests that the severe negative effects need to be investigated in greater depth (Briere, 1992; Egeland and Farber, 1984).

2.2.2.5. Witnessing domestic abuse

Witnessing domestic violence is defined for this research as: the fact of being present (by hearing or observing) the emotional, physical, psychological, sexual or economical abuse of a woman by a man in a present or previous close relationship with the woman.

In England and Wales, domestic violence is the highest offence committed between 1995 and 2004/2005 (59%) followed by domestic burglary and vehicle thefts. Repeated victimization by domestic violence also has the highest rate; 46% of the victims are victimised twice or more (Nicholas et al, 2005). In Britain, domestic violence has been one of the three most reported violent crimes to the police, in 1980 it comprised around the 25% of all reported crime (Dobash and Dobash, 1980). Some conclusions on domestic violence report that one in nine women and over 5000 children suffer domestic violence each year (Stanko *et al.* 1998). Witnessing the mother being battered by her partner has been associated with consequent psychological disturbance (Jaffe, Wolfe and Wilson,1990; Briere, 1992).

Women may be violent to their partners, but it is often in self-defence (Hague *et al.*, 1996). There are different ways that children may experience the abuse of their mother and the witnessing of this violence is enough to cause trauma to children; sometimes those children may also be the targets of such aggression.

A study of 48 families in England and Wales reported the types of violence experienced by children who witness domestic abuse, as follows: physical abuse (25%), sexual abuse (6%), emotional abuse (29%), controlling behaviour (15%), overheard violence (28%) and actually witnessing violence (41%). The effects on children in this study included: *"fear, powerlessness, depression or sadness, impaired social relations, impacts on child's identity, impacts on extended family relationships and their relationship with their mother, effects on educational achievement and anger, very often displayed as aggressive behaviour. The child's relationship with the father or father figure is also clearly affected by the violence to the mother"* (McGee, 2000:69). The psychological effects are likely to arise independently from the type of abuse (Table 2.2 below)

Table 2.2 Child abuse impacts regardless the type of maltreatment

Initial reactions to victimization	1) Post-traumatic stress 2) Alterations in normal childhood development 3) Painful affect 4) Cognitive distortions
Accommodation to ongoing abuse	1) Coping behaviours to increase safety or 2) decrease pain during victimization
Long-term elaboration and secondary accommodation	1) Impacts of initial reactions and abuse related accommodations on the individual's later psychological development 2) Survivors' ongoing coping responses to abuse-related dysphoria

Extracted from Briere 1992:17-18

2.2.2.6. Other forms of child abuse

Briere (1992) includes less studied types of abuse such as witnessing family violence, the association between alcohol or drug intoxication with maltreatment of any type, cruelty and deprivation related to extreme poverty (both in urban and rural areas), and other situations as social discrimination, racism, sexism, cultural child maltreatment and war.

Alcohol and drugs

Parental alcoholism has been frequently associated to child maltreatment and domestic abuse. However, substance-addicted parents are not the only factor that detonates or increases abuse; coexisting abuse –physical, psychological or sexual abuse- may overlap the negative impact on child's psychological functioning. (Briere, 1992; Elliot and Edwards, 1991).

Extreme poverty and homelessness

Children living in cars, cardboard boxes or in the streets produce negative impacts from living in such conditions. Cruelty and deprivation are associated to these conditions and have negative effects in the physical and mental health such as abuse-related disorders and dysfunctional behaviours (Rescorla, Parker and Stolley, 1991, Briere, 1992).

Social discrimination and war

Considerations of social discrimination, sexism, racism and war have been documented as source of child abuse (Ayalon and Van Tassel, 1987; Briere, 1992). Physical and sexual abuse are some of more common forms of abuse used as a way for domination in war specially against women and young girls such as torture, rape and physical assault (Briere, 1992).

2.3. Trauma

Trauma comprises a number of different aspects that have been analysed by health scientists, including those resulting from physical or psychological injury. The root of the word trauma is Greek. It means 'to pierce'. In the context of physical injury it denotes that the 'skin is broken'. Regarding the psychological aspect, trauma is *"an event that in a similar intense or violent way ruptures the protective layer surrounding the mind with equally long-lasting consequences for psychic well-being"* (Bentovim, 1992:24).

Traumatic events provoke intense fear, helplessness, or horror (American Psychiatric Association, 1994). Symptoms of trauma include: re-experiencing the traumatic incident, nightmares, and flashbacks; avoidance, psychic numbing; symptoms of heightened physiological arousal; hypervigilance, disturbed sleep, a distracted mind; as the symptoms of post-traumatic stress disorder (Brown, 1995; Walker, 1992).

Psychological distress and dysfunction are the effects of trauma for childhood abuse. Psychological effects impact not only in the period of life as children but also in adulthood (see table 2.3 below). Post-traumatic reactions influence dhildren's psychological and social maturation and interfere with their normal development (Briere, 1992).

Table .2.3. Major types of psychological disturbance from child abuse

Long-term psychological impacts
Posttraumatic stress
Cognitive distortions
Altered emotionality
Dissociation
Impaired self-reference
Disturbed relatedness
Avoidance

Extracted from Briere 1992:18

Childhood abuse trauma has been identified in association with a range of adverse psychiatric outcomes, including depression, anxiety, dissociation, post-traumatic stress disorder, borderline personality disorder, alcohol and substance abuse and other psychiatric disorders. Also, other traumatic childhood experiences, such as adaptation to parental separation or childhood family violence have also been associated with psychopathology (Bremner *et al.*, 2000).

Sexual child abuse, if untreated, increases the risk of later mental health problems it has long-term psychological impacts (Berliner 1991).

The term mental illness frequently involves severe disturbance such as hallucinations and delusions. People use to perceive such behaviour as threatening, disturbing, dangerous and difficult to understand (Busfield, 1996).

Lasting psychological symptoms can frame post-traumatic stress. Post-traumatic stress disorder (PTSD) has been identified in victims of natural catastrophes, disasters, war or accidents, but also in victims of torture, child abuse and rape. Specific PSTD related symptoms to child abuse are shown in table 2.4 below.

Poor self-image is correlated to physical, sexual and psychological abuse (Briere and Runtz, 1990; Briere, 1992).

Table 2.4. PTSD related to abuse

Symptoms	Such as
PTSD related to sexual abuse survivors	
Flashbacks (usually triggered when in contact with abuse-related stimuli.	Intrusive sensory memories Choking sensations Feeling hands
Intrusive thoughts Nightmares	
PTSD related to physical abuse survivors	
Autonomic arousal	Tension, 'jumpiness' flinching
Avoidance of abuse-related stimuli	
Violent nightmares	
Intrusive thoughts of being violent or of suddenly being injured	
When flashbacks	Triggered by survivor's own anger or being in presence of someone who is physically frightening
PTSD related to psychological abuse survivors	
Terrorizing or witnessing violent assaults upon others	

Extracted from Briere 1992:21-22

Abuse-related negative cognitions can arise: they are listed as abuse-specific responses such as: hyper-vigilance to danger (*e.g.* betrayal, abandonment, or injustice); abuse related powerlessness such as passivity in the face of danger, self-perceptions of inadequacy and inability to cope with aversive circumstances, procrastination or underachievement in school or work; learned helplessness and impaired self-efficacy (Seligman, 1975; Peterson and Seligman, 1983; Briere 1992a); abuse-related poor self-esteem or stigmatisation, that is, internalisation of negative judgments can later produce in survivors guilt, shame and self-blame (Finkelhor and Browne, 1985). Negative self-evaluation may lead to the conclusions that '*one deserved the abuse and that one is inherently bad*' (Briere, 1992).

Altered emotionality includes depression (such as apathy, withdrawal, lack of interpersonal responsiveness and visible sadness); absence of maternal nurturance may produce severe dysphoria (Spitz, 1946); anxiety (insecure or anxious attachment) and as a result, fearfulness and frustration (Briere, 1992).

Judith Herman is a professor of psychiatry at Harvard medical school. She has researched different types of violence ranging from child abuse and domestic violence to political terror. Her seminal piece is her book on 'Trauma and Recovery' (1992) that reflects her feminist political perspective. She explains that the different forms of trauma have common effects on survivors such as disempowerment, disconnection from others, or denial. She covers different trauma effects of violence including: PTSD, chronic stress, anxiety disorders and major depression. Herman proposes a three stage model of recovery that includes: establishing safety, remembrance and mourning, and reconnection. Her model of recovery is based in the importance of empowering survivors.

The neuropsychoanalist Allan Schore developed the 'Affect Regulation Theory' that is the result of his synthesis of neuroscience with developmental studies. In his Affect Regulation Theory he states that "the early social environment mediated by primary caregivers, influences the evolution of structures in the infants brain" (Schore, 1997).

His work has mainly focussed on the functions of the right brain and its relationships with other parts of the brain. The concept of regulation and self-regulation is the principle, on which "the social experience of attachment is impacting the development of the regulatory systems in the brain that regulates all forms of cognition, affect and behaviour". Schore indicates that this loss of the ability to regulate feelings has an effect of trauma in adults.

Attachment theories analyses the career-child relationships and the ability of the child to form connections to caregivers, this situation determines the type of attachment, identification/no identification with the perpetrator of the trauma, and further behavioural consequences in adult life (Fonagy *et al.*, 1994).

Research on childhood abuse trauma has examined different consequences of abuse in this particular stage of life; as well as the long-term effects on adult life. In the next section it will be reviewed the importance and concept of life events.

2.4. Life events

The Holmes and Rahe scale was a pioneering system (Holmes and Rahe, 1967). However, it had some disadvantages, such as conflation of positive and negative life changes. Strong associations between life event scores (*i.e.* child maltreatment, economic deprivation or circumstances such as natural disasters and war) and risk of maladjustment have been reported in the literature (Fonagy, *et al*, 1994).

Life events can have an effect on an individual's physical, social or emotional functioning (Billings and Moss, 1981). Life events ethologically might be short-term threats and log-term threats; contextual threat and unpleasantness often exist in the context of life events. Short-term threat implies a threat on the day of the event or soon after, and a long-term threat is about one week after the event (Brown, 1989). Some events have no disturbing long-term effects and some others have been classified according to stressful aspects of life change such as "*degree of adjustment, desirability, predictability, controllability and entrances vs. exists from the social field*" (Billings and Moss, 1981:139). Events such as a death of a family member or job loss are more likely to be associated with impaired functioning than other events such as job promotion or marriage. Moderators such as personal and social resources help to manage the stress reactions produced by life events, as well as the actions taken to modify the problems. Coping responses and social resources can help to mediate the effects of life events on emotional and physical functioning but variant individually according to the appreciation of each individual. (Billings and Moss, 1981; Dohrenwend and Dohrenwend, 1974, 1978; Lazarus, 1966, 1980).

Major events such as childbirth, death of spouse, being fired from a job or being made redundant have been found to cause major effects on emotional functioning (Brugha and Cragg, 1990). Life events may vary from doctoral examinations, natural disasters, imprisonment, injuries and serious injuries, physical illness,

death, childbirth or even work related situations. In their study, Monroe and Peterman (1988) reviewed the cause and effects in life events. They found that there was wide social and temporal context regarding understanding the implications of life events in relation to psychological dysfunction.

Active attempts to provide solutions to the impact of the stressful events can involve cognitive and behavioural strategies whereas independently grouping reactions that tend to want to avoid the problem (Billings and Moss, 1981; Lazarus 1966). There is generally a relationship between life events and psychological functioning, but third variables need be considered because it can guide to erroneous conclusions (Cohen, 1988). Negative life events are strongly related to impaired functioning than other life events in general (Mueller *et al.*, 1977; Sarason *et al.*, 1978; Vinokur and Selzer, 1975; Billings and Moss, 1981).

2.5. Resilience and coping

Child abuse conducts to developmental damage that has implications on mental health and its effects are reflected in adulthood (Walker, 1992). Recently scientists have asked why some people with a background of childhood trauma do not become ill. What helps the emotional health of people to resist the impact of trauma?

There is no consensus among researchers about a single definition of resilience. On the other hand, there is sufficient agreement about the factors that contribute to resilience, even if it is agreed that genetic makeup and temperament are continuing forces that contribute to the process of becoming resilient (Grotberg, 1995b).

According to Folkman (1984) coping is the "*cognitive and behavioural efforts to master, reduce, or tolerate the internal and/or external demands that are created by the stressful transaction"* (1984:843). According to Lazarus and Folkman (1984)

there are two processes to deal with stress: coping appraisal and coping, these two mediate the stress and the stress-related adaptation outcomes. The role of coping is to regulate the emotions or distress and to deal with the problem that is producing the stress. Having control is stress reducing and not having control is stress inducing, however the nature of the events might produce the opposite, because the potential for control can produce stress because of its costs.

Scott *et al.* (1999:326) summarise studies on resilience to child maltreatment, which have examined protective factors. They report that protective variables are *'1) dispositional/temperamental attributes of the child (e.g., responsiveness, independence, intellectual ability); (2) a warm and secure family relationship; and (3) the availability of extrafamilial support (e.g. peers, teachers).'* They include as other protective factors: global behavioural ratings, locus of control; external attribution of blame, ego-control and ego-resilience.

Valentine and Feinauer (1993) explored the resilience factors associated with female survivors of childhood sexual abuse. They interviewed 22 women from the state of Utah, and in their findings they reported the following themes: ability to think well of oneself, religion or spirituality, external attributions for blame and cognitive style, and inner direct locus of control. Regarding this inner direct locus of control, they define resiliency as *'the power or ability to return to original form or position after being bent, compressed, or stretched'* (Valentine and Feinauer, 1993).

The universal capacity for resilience is developed and nurtured from: (1) factors of external supports and resources; (labelled I HAVE) (2) inner, personal strengths; (labelled I AM) and (3) social, interpersonal skills (Grotberg, 1995a).

The International Resilience Research Project suggests that there are two major conceptual frameworks for studying resilience: (a) the pathological framework and (b) developmental/life-span framework (Grotberg, 1995b). This proposal suggests that a feminist framework be used, so that power in its different forms can be explored.

Investigation of resilience to maltreatment in childhood and adolescence, and investigation of factors that contribute to that resilience can offer a contribution to experts working in the field of recovery process from child abuse trauma. This is especially true amongst psychotherapists because *"evidence shows that psychotherapists are particularly likely to have been abused as children, either physically or sexually, and it is probable that many enter this profession as one means of surmounting this experience"* (Tantam, Van Deurzen *et al*, 2000).

This thesis will take the definition of resilience by Masten, *et al.*, (1990:426) as *"the process of capacity for, or outcome of successful adaptation despite challenging or threatening circumstances"*. According to Bernard (1995:1) resilience is a characteristic that "*can enable people to develop social competency, skills in problem-solving, a critical consciousness in relation to oppression, autonomy, and a sense of purpose*".

2.6. Power

This study proposes to inquire about how different constructions of power (*i.e.* power over others and power over self) assist interviewees to overcome childhood abuse. The researcher will analyse the resilience process from a feminist standpoint, based upon feminist post-modern understandings of different types of power active in the development of resilience, using Interpretative Phenomenological Analysis (IPA).

In regard to the concept of power; it has been difficult to find a definition of power related to the psychological aspects of this research. The concept of power is very complex. Power can be approached on several levels of investigation: personal, interpersonal and organisational levels. Even though the term 'power' is itself ill-defined, there are several approaches in psychology that look at the capacity that people have to overcome obstacles or resistance to change. As Bandura points

out: *'If people believe they have no power to produce results, they will not attempt to make things happen'* (Bandura, 1997:3).

According to Elworthy (1996) power is linked more to force, domination, manipulation, rule and control than with physical force. Galliher *et al.* (1999) argue that gender and power are central constructs in feminist discourse. In male-dominant societies, more men than women hold power in the form of social status, resources, security, respect, authority, and positive self-regard. They analyse power related to gender differences in romantic/marital relationships. These authors state that the gender gap in power filters down throughout the marital/ romantic partnerships, and other relationships between men and women. This analysis is based upon the definition by Pratto (1996) where power is defined as the means by which a person (or group) gets what is desired, despite opposition (Pratto, 1996).

Feminist theories have analysed power in different ways. The aim of the feminist post-modern posture involves a search for the truth by deconstructing the category of woman and its 'variations in age, class, country, colour, sexuality and positions in power relations have served to undermine any homogeneity in the term feminism' (Webb, 2000:45).

Feminist studies were firstly concerned with violence against women and focused on the sexual trauma of rape. Studies, reports and speaking out to raise public awareness led quickly to an increase in awareness of domestic violence. Different support groups were established, a diverse series of books and articles identifying and studying incest, rape and feminist analyses of childhood sexual abuse were provided.

Issues of power and inequality and their impact on interpersonal relationships were investigated in the first feminist analyses of incest dynamics. In the last decade, a rapid growth in therapy and advances in research on child sexual abuse survivors have increased knowledge in the field. However, there are many issues to cover in

child abuse, and the gender research perspective has important contributions to make in this field.

The English philosopher Thomas Hobbes states that power 'is a person's means to obtain some apparent good' (1651:78). He distinguishes natural powers from instrumental powers. He states that natural powers are strength, prudence, eloquence and intelligence and that instrumental powers are wealth, reputation and friends. The instrumental powers can be acquired by natural powers, and then invested to acquire more power. Elworthy (1996) claims that there is another type of power that resides within the person and she refers to this power as: "inner power".

Oksenberg (1983) examines the Hobbes' view to see if 'power consists in the various capacities that are exercised by the imagination' (1983:801). Oksenberg (1983:801) proposes that 'if this is true, then to control someone, is to control his(/her) imagination'. In her analysis it is argued that if a person is dissatisfied, it does not show a limitation of his/her power, but of his knowledge, and that knowledge is a form of power.

In her Hobbesian scrutiny of power she analyses power in relation to individuals and to the Sovereign. The power that she exemplifies as the "Boss" could be an individual, an economic or social class, an institution, an employer, part of the complex, or a nation. She revises the exercise of power referring to the dependent relation to the subject, how the Boss can effect compliance by limiting the subject's viable options. The 'coercion' works through the subject's fear where the *'threat of danger is more powerful than the exercise of that threat, (...) if the subject resists or opposes the Boss, the Boss's resources have to be reallocated to force or coerce their efforts'* (Oksenberg, 1983:803). In other words, the power of the insane can exist outside the structure of the power relations: anybody has this sort of power.

In feminist theory there are several terms related with power: powerlessness, empowerment and dominance power. This study will consider both the definition of

"Power is the ability to get what we want" (Boulding, 1999), as well as the Hobbes definition that says *'power consists in the various capacities that are exercised by the imagination'*.

Feminist theory analyses power in terms of the way control is used to oppress others. The concept of power in feminist theories regarding child abuse has been investigated with a particular focus on understanding different forms of power such as dominance power: when someone has power over another; and empowerment, the process aimed at changing the nature and distribution of power in a particular context, or the process of transferring power (Rodwell, 1996).

2.6.1. Empowerment

In this study empowerment describes the process that the individual performed to engage with, acquire power and stop the abuse. Empowerment has been studied in different contexts particularly in the field of economic development, and in many fields of study, including education, sociology, psychology, anthropology, women's studies, theology, public health and nursing (Vander, 1997).

The concept of empowerment is defined as a process of transferring power. It is mainly used by feminists focused on women's' ability to influence their own lives. 'It can be defined as *'a process of helping people to assert control over the factors which affect their health'* (Gibson, 1991:359). Empowerment promotes personal autonomy and facilitates self-management (Schunk, 2001).

Rodwell (1996) argues that empowerment includes the development of a positive self-esteem and recognition of the worth of self and others. Studies regarding child abuse conclude that interventions to improve achievement and increase feelings of self-efficacy can help to empower women abused and/or neglected as children (Schuck, and Windom, 2003).

In terms of health issues, empowerment has been covered in prevention programs (Worell, 2001; Vander, 1997) in the treatment of domestic violence and child abuse survivors (Garza, 2000; Daniels, 2001). Some of these studies have found, for example, that activities such as literacy, sport participation and physical skills are related to the development of empowering qualities women traditionally lack: (1) bodily competence, (2) perceptions of a competent self, and (3) a proactive approach to life. Such programs promote physical and psychological health, confronting interpersonal abuse and violence, balancing career and family, integrating multicultural and diversity issues, and negotiating relationships (Cressy, 2002, Ghose, 2001, Johnson, 2002, Worell, 2001).

In the field of psychology, empowerment has been studied as authority delegation, motivation enrichment, employee ownership, autonomy, self-determination, self-management, self-control, self-influence, self-leadership, high-involvement and participative management. Mushin and Joon (2001) argue that empowerment can be built or trained in women to bring them self-management skills. Bandura (1997) classifies the structure of self-efficacy as a generative capability and personal causation. Self-efficacy allows people to select challenging settings, explore their environments, or create new ones (Bandura, 1997).

Empowerment has been researched as an independent variable or as a dependent variable related to self-efficacy. Self-efficacy is *"the belief in one's capabilities to organize and execute the sources of action required to manage prospective situations"* (Bandura, 1986). According to Bandura (1997), self-efficacy is multidimensional and states *"the power to make things happen should be distinguished from the mechanics of how things are made to happen"*. He also adds, *"the power to originate actions for given purposes is the key feature for personal agency. (...) Beliefs of personal efficacy constitute the factor of personal agency"* (Bandura, 1997:3).

According to Oksenberg (1983:807) *'Malign power relations can be quite stable as long as no outside forces change the distribution of options available to the subject'*. Oksenberg (1983) examines why malign power relations remain stable for

so long. In her answer she refers to the concept of experiencing a sense of being in darkness. As we learn from our experience, and are essentially conservative in our psychological structures. Human capacities for imagining alternatives are strongly limited by early experiences. Structures of power have an astonishing stability and this is also because we learn from our experience and *'our most formative experiences of power, and power relations are those we have during our prolonged and wholly dependent infancy'* (Ibid :815). She states that we associate well-being and security with dependence on power figures but a malign relationship with these figures leads to more incapacitated response.

Empowerment in this study will be considered as the process of focus on women's' ability to influence their own lives in order to stop and overcome child abuse. This study will focus on the role of that empowerment in overcoming child abuse.

Constructs revolving around the concept of "inner power" have been paired with empowerment. However, dictionary definitions indicate that 'inner' is an adjective and it has two usual meanings. The first meaning is given as 'inside; towards or close to the centre of a place'. The second meaning is given as '(of feelings, etc.) private and secret, not expressed or shown to other people'. "Power" in the same dictionary has several meanings: (a) control, (b) ability (c) authority (c) influence (d) energy (e) good/evil spirit (Oxford Dictionary 2000:669). Empowerment is a process rather than identity.

2.6.2. Inner power

On the other hand, according to Elworthy, (1996), inner power is '*power over*', *inner* power is receptive. It resides within. *'It lies in the interior, the spirit, the psyche, the body'* (1996:80), the author mention that 'the healthier these are, the stronger the power'. In this thesis the operational definition of inner power is '*power over'* the self.

Some researchers have termed this the capacity for 'inner strength', and linked it to temperament. However powerful these terms are in commonsense psychology, there are few satisfactory definitions in scientific studies. Bandura's concept of self-efficacy is also closely related to inner strength or power and has been the subject of many studies (Bandura, 1997; Tangenberg, 2001).

Valentine and Feinauer (1993) consider inner power as an inner direct locus of control. They reported that some of the participants describe that they recognized their personal power early in life. Inner locus of control was also reported in the same study as a sense of self inside and that *'this sense of control and power seemed to enable these participants to do well in school, to overcome fears, and to have small successes along the way'*. They found in their participants '*the ability to reframe situations'*. The women in this study did not consider the experience of sexual abuse as an insuperable situation: they were able to see it as a challenge and developed skills that assisted them to survive. They were also able to see beyond their circumstances and believed there was something better in store for them. In addition they did not perceive themselves as powerless victims as they progressed through life' (:223)

Oksenberg, (1983:813) for example, points out that: *'The move from identifying power as the means to obtaining what a person desires directly leads to seeing that the imagination is among the greatest of these powers, and the control of the imagination gives the greatest control over power'*

Imagination, on the other hand, is *'the faculty which envisages possibilities, which works them out in detail, which formulates them in such ways as to make them viable and available options'* (Oksenberg, 1983: 811).

Taking into account the Oxford definitions of the words inner and power, this study will take the definition of imagination as the faculty of inner power, where imagination *'is not one single faculty; its exercise involves many different sorts of skill, many of them acquired through practice and imitation. It involves separating variables, and recombining them by defining and re-describing situations, tracing*

possible consequences, drawing inferences from hypothetical considerations, constructing ramified counterfactual alternatives' (Oksenberg, 1983:811).

In her study Tangenberg, (2001) examined narratives of mothers living with HIV/AIDS. The author explored the role of recovery in helping women to survive those diseases. Tangenberg looked at the narratives obtained in focus group transcripts about life experience and support services. Results showed the importance of recovery, spirituality, positive thinking, inner strength, and social support in helping women cope with the complexity of living with highly stigmatised conditions. The relevance of recovery principles to end addiction underpinned women's feelings of self-efficacy and support.

2.6.3. Dominance power

The concept of dominance power is related to manipulation and control as with physical force. This kind of power comes from outside. Tedeschi and O'Donovan (1971) argue that power is an important factor in human interactions, and psychologists cannot avoid or deny the existence of their own power. Sewards and Sewards (2002) propose that both the fear and power-dominance drives are represented in four distinct locations of the brain: the medial hypothalamus, lateral/dorsolateral periaqueductal gray, midline thalamic nuclei, and medial prefrontal cortex. They identify *'sensory/mnemonic inputs to these representations, and outputs to premotor structures in the medulla, caudate-putamen, and cortex, and their differential contributions to involuntary, learned sequential, and voluntary motor acts'* (Sewards and Sewards, 2002:553). They also examine the potential contributions of neuronal activities in these representations to the subjective consciousness of fear and anger.

Oksenberg's theory (1983) based on Hegel, defines power relations as malign (a) if it is asymmetrical, so that the abuser (which she names 'Boss') gains more than [he] loses by the relation, and the victim (which [she] refers to as Subject) loses more than she gains within the relation, and/or (b) if the goods are subject to a

zero-sum economy in such a way that abuser gains are made at the cost of the abused and vice versa, and/or (c) if the abuser has closed the victim's options in such a way that the victim believes that despite his/her losing, he/she would lose even more by leaving the relation than by staying in it.

2.7. Exploring feminist theory in psychology

From the early nineteen fifties and, during and after the Second World War, women in Western Europe were incorporated in the work force during a period of rapid industrial growth. In the late 1950s and early 1960s, poorer women continued to work for wages whereas affluent, middle class white women were more likely to return to work in the home. This situation undermined both women's conditions limiting women's access to higher education and equality within the family and in society (Bartky, 1990). Feminist methodologies developed, based upon different sociological, economic, political and psychological theories to analyse such phenomena, such as Marxist political economy, neo-Marxism, phenomenology, or existentialism (Burman *et al.*, 1996; Bartky, 1990).

French philosopher Simone De Beauvoir (1908-1986) is often heralded as an important precursor to the second wave of modern feminism. Her writings emphasise social justice and highlight various inequalities of access to social and political institutions dominated by men. Her philosophy inspired many women to strive for liberation and equal rights. Her book 'The Second Sex' analyses the exploitation of women and inspired women not to give up or accept such mistreatment.

Simone de Beauvoir inspired the theories of the French psychoanalyst and feminist Luce Irigaray. Irigaray was much influenced by the ideas of de Beauvoir, but they differ in the sense that Irigaray was a psychoanalyst and Simone de Beauvoir was not sympathetic to psychoanalysis. Irigaray's work was founded upon her interest in women and madness, the unsuccessful 'sexual revolution', the mother-daughter

relationship and, very importantly, the criticism of psychoanalysis that standardizes patriarchy. She analyses hysteria as the way that women express themselves through somatic symptoms (Whitford, 1993). Irigaray's view is that a desire for women to be 'equal' to men infers a denial of their identity as women, and that women need their own autonomously sexed identity. Irigaray argues that the difference between men and women is significant. She argues (Irigaray, 1993) that it is important to find intrinsic values in being women – not only as mothers - and to rethink and transform socio-cultural values (Irigaray, 1993).

Twentieth century feminists' critiques of patriarchy investigate power relations in a variety of institutions including: the social, scientific, disciplinary, educational and political (Burman *et* al., 1996; Whitford, 1993; Wilkinson, 1986). For example, Irigaray defines patriarchy as "an exclusive respect for the genealogy of sons and fathers, and the competition between brothers" (Irigaray, 1987:202).

Carolyn Wood Sherif is a Psychologist interested in the sociological and historical reasons and its relationship with research methods. Sherif shows that dominant beliefs direct the ideology of psychology's elite, affecting psychological research and making psychology "*prone to bias in its conception, execution, and interpretation*" (Sherif, 1987:42). Sherif criticises traditional research methods, methodologies and epistemologies in the history of psychology as science (e.g. Francis Galton's study where he evaluated 9,337 persons and he reported that women tend to have psychological capacities inferior to men's.). She identifies how the research methods preferred by psychology had racist and detrimental consequences producing ethnocentric, androcentric and sexist bias in psychology (both in theory and in practice).

The underlying assumptions in psychology have been challenged by feminists who have contributed to shaping the discipline by highlighting *'gaps, silences and ambiguities'* (Hekman, 1990:189) as well as conceptualisations in psychology regarding women. The collective voice of women is challenging psychology by examining and exploring the exclusions in research, and its effects in practical and political inequalities. Feminist discussions have included themes such as

inequalities and power relations, but also race, class, cultural and heterosexual presuppositions are now being included in feminist analyses (Burman *et al.*, 1996).

2.7.1. Feminism differs from gender

Feminism is different from gender. Feminism was born at the end of the 19th century from the movement for women's rights. By the beginning of the 1900s, women's were campaigning for equal access to education, political representation and legal rights. Towards the end of the 20th century, feminists were more focused on theories of male dominance and power relations as a determining factor. Feminism was campaigning for social transformation of unjust gendered power relations and women's liberation from oppression (Ramazanoglu and Holland, 2002; Sanday 1981). Male-female differences were conceptualized by sociologists in relation to the division of the reproductive work, this conceptualization initiated the term gender (Connell, 1987; Stoller, 1968). Gender is an analytical category that endeavours to understand the social and cultural origins and differences of male-female individual characteristics. It differentiates the biological from the sociological characteristics of male and female behaviour. It excludes the assumption of natural differences between men and women and it sustains that gender differences are socially constructed (Busfield, 1996). Oakley mantains that 'sex is a biological term' and gender 'is a psychological and cultural one' (1972:158). In psychology gender issues have an inclination to be interpreted as women's problems, for the reason that notions of normalised masculinity are often applied to the disciplinary models consequently, certain methods have given a male bias to many results in psychological theory (Burman *et al.*,1996).

Feminism is a perspective which assumes that "*women's experiences, ideas and needs... are valid in their own right*" (Klein, 1983:89). It seeks to acquire awareness of action to change women's position in society. This can be achieved through research, politics or theoretical or practical approaches (Wilkinson, 1986). Gender, on the other hand, *is "an analytical theory designed to refer to and aid the*

understanding of the social and cultural origins of male-female differences in personal characteristics and behaviour" (Busfield, 1996:32).

The term gender comprises how particular people experience: (a) sexuality and reproduction, (b) masculinity and femininity, (c) the boundaries and interstices between them, and (d) cultural categories (Ramazanoglu and Holland, 2002).

Feminists criticise scientific research, particularly when in the empirical research positivist research assumed that men and women have the same perspectives. Critics of androcentric theories that generalised or directed the content and results to the extent that women's experiences are ignored or go unseen. They thus reflect a sexist society (Wilkinson, 1986). It is important to remove sexist bias from science because it reflects values and power divisions (Stanley and Wise, 1983). This is different from approaches to theorising about gender, which have been identified by Busfield as (1) sex and gender roles, (2) patriarchy, (3) capitalism and dual systems theory (4) texts, language and deconstruction.

Busfield (1996) lists some points in order to clarify the concept of gender: (a) Gender differences are a social product that varied across time and place. Therefore which is masculine and feminine is constructed, and class, age and ethnicity also influence differences between women and men. (b) Gender suggests a binary categorization of male and female, masculinity and femininity. The conceptualisation of a person as a male or female it comes to gender identity, but the initial categorization is more possible to be binary. (c) Gender is a concept of social difference whose meaning cannot be recognized without the reference of the other. (d) Asymmetry in structural relations is found between men and women, such as inequality and power. (e) The gender relations permeate social life and cannot be studied independently.

There is a long-standing ambiguity between sex and sexuality, and sex and masculinity and femininity. Sex is a term with a biological connotation, and gender is a psychological and cultural term (Stoller, 1968; Oakley, 1972). Male power and domination are issues that concern both gender and feminist studies. Feminists

reject a focus on biology. Instead, feminist theory takes women's lives as a serious starting point of concern and for feminists the invisibility of women is an issue. They argue this is an important reason for concentrate on studying women. Feminist research recognises women's oppression, involves critiques of positivist social science, and analyses and deconstructs relations of power, in its aim to enhance equal opportunities in women's lives.

2.7.2. Why adopt a feminist perspective?

Conducting research focused on women, involves taking into account women's needs, interests and experience in order to improve women's lives (Klein, 1983).

Methodological critiques often involve aspects of objectivity, where there is an assumption that the researcher can stand back from her/his research subjects. Feminists have argued that positivist researchers can fail to recognize the fact that they are also human and that they also affect the research in different ways (Stanley and Wise, 1983). Reflexivity may bring some clarification of the nature of the research and the influence of conscious subjectivity of the researcher.

Feminist theory and methodology emphasize the inseparability of theory and experience. The emphasis is on the social construction of meaning and the situation of women in society, which is related to the analysis of subordination of all women and the variety of experiences between women.

A wide range of methods can be used in feminist research. The emphasis is on methodological guidelines that are political/ ideological, and offers alternative models and methods for research in the intellectual journey that might be methodological innovation. Its purpose is political change involving the revaluation of subjective experience, redefining knowledge, making knowledge from human experience and from the specific perspective of women (Wilkinson, 1986; Spender, 1978; Klein, 1983). Qualitative methods have been rescued and innovated in

different ways in this endeavour. Feminist theory has attempted to redefine the power differences in the relationship between the researcher and researched. In other words, the concern involves, 'rethinking the status of the participants in the research' (Wilkinson, 1986:20).

Sherif (1987) points out that natural scientists and philosophers from the positivist paradigm influenced research in psychology are at the top of a hierarchy of research methods. Accordingly, "experimentalists, 'mental testers', and statisticians ranked the highest while developmental, clinical and social psychologists ranked the lowest" (p. 37). Over time, specialities sought to improve status by adopting the highest hierarchic methods. These practices however, produced bias in psychology, resulting in a science that imitated the format of natural sciences. It therefore leads to the collection of false evidence, which was unable to clarify issues relating to women and gender.

Male-centeredness of psychology is criticised by Weisstein (1971) she analyses how psychology attributed the lowest position in society and individual struggles of women to psychological characteristics that caused both and seem unavoidable. This situation impacted on social circumstances on personal experiences and actions (Weisstein, 1971). Feminist and critical intervention in psychology provides evidence of the lack of both awareness and appreciation of women's psychological experiences. Research and the production of models and theories that focus on women address the invisibility of women's experiences in the existing theories (Burman et al., 1996). It develops understanding of women's experiences such as motherhood, postpartum, menstruation and menopause, and also introduces new theoretical resources to do research.

Feminist research is research that may *'contribute to ending the oppression of women'* (Klein, 1986). The concept of power and the exercise of power, sexual inequality and difference, cultural oppression are some of the issues fundamental to feminist research. Understanding that there exists an alternative for the liberation of women is a way to develop 'feminist consciousness'. A major issue is that there are often intolerable situations in social reality for women and they need

to be addressed and transformed. As Bartky (1990:15) argues: "Feminist consciousness is consciousness of victimization". This victimization is a result of a hostile power in society as manifest in men's treatment of women.

Some feminists argue that the term 'gender' depoliticises the feminist project (Stoller, 1968; Jackson, 1992 and Scott, 1986) Therefore the need for studies of women and mental disorder that attend to class, age and ethnic differences are also important. Feminists have attempted to make all women more visible and valued.

The research and writings of feminists aim to challenge psychology especially in its theories, methods and practices (Burman *et al.*, 1996). Such research can accurately reflect women's experiences and make a contribution to improving not only women's lives but also the therapeutic value of psychology.

Since the beginnings of feminism, many different currents of feminist thought have developed, resulting in the post-structuralist and social constructionists discussed at the present. The theory, research and practice of such feminists have explored the structure of power relations between men and women and between women. Recent black, non-white, Latin-American and lesbian critiques are questioning the consensus of women's positions and show how women are divided by issues of class, race or sexuality. Most feminist theoretical models reflect the white middle-class heterosexual position of the researcher (Burman *et al.*, 1996).

Some men have contributed to the feminist thought by producing analyses and knowledge of women and gender, such as Thomas Kuhn, John Stuart Mill, Karl Marx, Friedrich Engels, or Michel Foucault. Feminists have joined the ranks of male revolutionary thinkers by arguing against positivism and its imitation of the methods of natural sciences, to conceive knowledge about human beings. Feminist research thus aims to rectify the tendencies of androcentrism in science.

The feminist perspective is important not only for feminist psychology but also for psychology in general and science (Wilkinson, 1986). Feminist contributions to

psychology and research practice have developed a critique of positivism, and an alternative understanding of research, theory and research methods. For most feminists, a focus on women's experiences is utilized to contribute to a deeper understanding of female and male psychology across the whole of human experience.

2.7.3. Feminist theories and psychology

Placing women's issues at the core of concern of research psychologies can lead to a revaluation of women's experiences. It is important contribution to knowledge in psychology (Burman *et al.*,1996). According to Busfield (1996), feminist psychologies use psychodynamic foundations but also sociology and anthropology.

Feminist methodology aims to concentrate on the importance of research for women, it is important the "*approach of the researcher to the conceptualisation of the problem, relationship with the respondents, and the collection, analysis and dissemination of the data*" (Nicolson,1986:147). It is appropriate to develop learning on the part of the researcher to rupture the constraints of positivism.

Feminist theory has demonstrated the ideological and androcentric biases that psychology and positivism have assumed for social and psychological phenomena. Feminists refuse biological explanations to understand women's mental disturbance, and mental disturbance in general. Instead, feminists have analysed how women are structured as subjects in relation to ascribed characteristics of their gender –particularly in childhood- and formulate comparisons with men's emotional development. Feminist psychology has drawn on some ideas from sociology and anthropology (Busfield, 1996).

Chesler is a feminist who gave her attention to women madness in the late 60's and earlier 70's her analysis of the positions of women within psychiatric institutions and her focus on patriarchal mental health system and its effects to

oppress women. Chesler was the first to concentrate her central focus to examine women's madness; her book "Women and Madness" was first published in 1972. In her book, Chesler examine madness from a perspective of the devalued female role, which produces dissatisfaction and unhappiness. Chesler analyses madness as women's and men's alienation (or rejection) of their roles. She explains that when a woman is unhappy with her role her unhappiness most often becomes diagnosed as depression, resulting in suicide attempts or frigidity. But when men reject their roles, they are more likely to be labelled as 'criminals'. Chesler's radical research made visible the enormous abuse that the mental health system perpetrated on women, by labelling women with misdiagnoses, over-prescribing medication, and giving shock treatments and lobotomies when origins of distress could be traced to social problems rooted in gender inequality.

Different theoretical positions are associated to feminist thought including liberal, radical and socialist perspectives. Chesler's radical perspective based its reasoning upon an ideological commitment to the idea that patriarchal power prevails in the whole of our social organization. Other more contemporary positions within feminism including postmodernists and poststructuralists still query relationships of power but following the movement towards equality between genders enshrined in western legislation investigate the more subtle operations of power.

Postmodernism and post-structuralism turns its critical attention to the analysis of inequalities in power in terms of language, meaning, culture and discourse based on either economical, political, social, ethnic differences between men and women- and between women, that shape both our subjectivity and our consciousness (Busfield, 1996; Burman et al., 1996; Stainton et al, 1989). A post-structural phenomenological feminist position combines this analysis of power and gender with the methodological discipline of phenomenological research, which aims to honour research participants meaning making structures and expression of those structures through language in their own terms.

2.7.4. Phenomenology

For Spielberg (1975) phenomenology is an analytical philosophy that can be explained more in action than in theory. It implies movement toward knowledge, a movement to travel towards knowledge that perhaps is not going to be short or smooth. Spielberg proposes an alternative to 'Husserl's phenomenological idealism' and proposes a 'phenomenology of our consciousness reality' without going back to a 'naïve realism'.

The 'Critical dictionary of psychoanalysis' defines phenomenology as "the study of experience". It describes phenomenological studies as a means to (a) *confine themselves to conscious experiences without postulating that they are the effect of underlying processes, without explaining them as the effect of underlying processes, without explaining them as the manifestations of phenomena, essences, principles, etc. of which the senses have no knowledge; (b) formulate their data from the subjects point of view'* (Rycroft, 1995:130).

According to the 'Dictionary of psychology, phenomenology is "*a philosophical doctrine that advocates that the scientific study of immediate experience be the basis of psychology"* (Reber, 1995:564). The word 'phenomenon' has its roots from Greek, it means 'an appearance, that which appears', the term implicates both 'physical occurrence' and 'internal experience' (op. cit.)

Spiegelberg (1975) sustains his position that neither Hegel nor Husserl created the term 'phenomenology'. He argues that Husserl in his subjectivism violated the ideal of freedom from unexamined presuppositions' (Spiegelberg (1975:xxiii). Phenomenology was developed by Edmund Husserl, with a main focus on events, occurrences, happenings, (Reber, 1995).

According to Spiegelberg, phenomenology for Husserl was a universal foundation of philosophy'. He argues that present phenomenology is a philosophical movement whose primary objective is the direct imagination and description of phenomena as consciously experienced. However, this interpretation does not

have theories regarding their causal explanation. It is thus considered as free as possible from unexamined preconceptions and presuppositions (Spiegelberg, 1975).

The term of phenomenology, as Spielberg describes, is not recent as it dates from at least to the 18th century with Johann Heinrich Lambert (1728-1777) in his 'Neues Organon' (1764). Phenomenology, Spiegelberg writes, "was not founded: it grew" (:3). He maintains that it was 'fountainhead' by Edmund Husserl (1859-1938). Husserl was trained as mathematician and was attracted to philosophy by Franz Brentano (1838-1917). Husserl's first work resulted in a general repudiation of "psychologism". However, it seems that his main intentions were to differentiate psychology from philosophy (Spiegelberg, 1975).

Brentano initiated the concept of 'intentionality'; that he explained as the relationship between mental acts and the external world. He introduced the concept of 'intentional relation' that it is related to our way of perceiving. Husserl distinguished 'empty' intentional references from those completed with intuitive content. The intentional act he called 'noesis' and its objective referent he named 'noema', both are the elements which could purify the phenomena and help to construct interpretations (Spiegelberg, 1975). However, Sokolowski considers that phenomenological terms such as "noesis, noema, reduction, life world and transcendental ego", at the present are becoming fossilized and cause problems. The principal concepts of phenomenology are intentionality, temporality, evidence, intuition, and life world and phenomenologists have used these terms. Hermeneutics and deconstruction are metamorphic forms that are in some way on the edges of phenomenology (Sokolowski, 2000).

According to Husserl, phenomenology is *"the general doctrine of essences, within which the science of the essence of cognition finds its place"* (Husserl, 1990:1). Husserl considers that the phenomenological method is the method *"of the critique of cognition"* (op.cit.) He sustains that *"phenomenology proceeds by 'seeing', clarifying and determining the meaning, and by distinguishing meanings"* (Husserl, 1990:46) where not only meaning but also the confusion of thinking can be

appraised. Mental process and mental life are related to the 'seeing' that is gathered individually. In the words of Husserl, "Phenomenology is directed to the 'sources of cognition,' to general origins which can be 'seen'" (Husserl, 1990:44).

Sokolowski describes phenomenology as "*the study of human experience and of ways things present(s) themselves to us in and through such experience*" (Sokolowski, 2000:2). For Sokolowski, it is a philosophical movement that attempts to re-introduce the philosophical life in our current situation, "*it considers human reason as ordered toward evidence and truth*" (op. cit, 2000:7). Phenomenology deals with the issue of appearances. Sokolowski explains that the problem of appearances has been considered since Plato; appearances are generated by words, not only spoken or written but actually have been changed enormously with the use of technology, from letters to microphones to the internet and electronic mail. Sokolowski explicates that phenomenology formulate the analysis in three major themes (1) parts and wholes, (2) identity in manifolds and (3) presence and absence. He defines phenomenology as a "*sort of understanding: phenomenology is a reason's self-discovery in the presence of intelligible objects*" (Sokolowski, 2000:4)

Different currents within phenomenology have been born. For example, Martin Heidegger (1889-1976) developed the hermeneutic phenomenology, this philosophy "*interpret(s) the ontological meanings of human conditions as being-in-the-world, anxiety and care*" (Sokolowski, 2000:7). Phenomenological existentialism was adopted by French philosophy such as by Gabriel Marcel (1889-1973) who spoke of metaphysical meditations on human existence and explored hope. Such an approach can be seen in Jean-Paul Sartre's (1905-1980) exploration of imagination and the emotions. Or as Maurice Merleau-Ponty (1907-1960) study of the phenomenology of perception. He based his philosophy of the "lived" body, a phenomenology of human "presence" (Sokolowski, 2000; Spiegelberg, 1975).

Phenomenology has been disseminated to countries as Netherlands, Switzerland, Italy, Spain and Latin-America. Phenomenology has influenced not only

philosophy, it has also influenced psychology (Brentano and Carl Stumpf); but also has influenced different particular currents in psychology, such as gestalt psychology (Karl Bühler). Psychopathology (Karl Jaspers), and indirectly influenced Carl Rogers. It has influenced sociology (Alfred Schultz), and also other areas of knowledge such as mathematics and physics.

Phenomenological inquiry is an investigation where phenomenology is applied to research. Its focus is to elucidate the essential nature of the meanings of human experience. It endeavours to describe the structures that lie beneath consciousness (Rudestam and Newton, 2001).

Phenomenology "*is a fresh approach to the concretely experienced phenomena, as free as possible from conceptual presuppositions, and an attempt to describe them as faithfully possible*" (Spiegelberg, 1975:10). Phenomenology is in contrast to positivism and traditional empiricism, it is in contrast to rationalism, it is different to analytic philosophy, different from pure linguistic analysis and also different to existential philosophy. In other words, phenomenology does not confine its data to the sense-experience; instead it sees it as relations, studying them carefully through the use of experience and imagination (see table 2.5 below).

Table 2.5 Differences and similarities between other philosophical movements and phenomenology

Philosophy	***Differences/Similarities***
Positivism and traditional empiricism	*"Unconditional respect for the positive data of experience"*
Rationalism	*"It stresses conceptual reasoning at the expense of experience"*
Analytic philosophy	"(It) substitutes simplified constructions for the immediately given in its complexity"
Linguistic analysis	Believes that "*the study of ordinary language is a sufficient basis for studying the phenomena in all their complexity, which ordinary language cannot and need not try to exhaust.*" However phenomenology "*shares its respect for the distinctions of phenomena reflected in the shades of ordinary language*"
Existential philosophy	"Believes that existence is unfit for phenomenological analysis and description since it tries to objectify the unobjectifiable". Phenomenology *"holds that it can and must dealt with the phenomena"*

Extracted from (Spiegelberg, 1975:11-12).

In psychology, the descriptive psychology of Brentano focused on 'intentionality' and considered the 'inner experience'. Carl Rogers – founder of client-centred therapy - referred to phenomenology as the most important ingredient of his analysis. This exemplifies the relevance of phenomenological philosophy to psychology (Spiegelberg, 1975).

2.7.5.Thomas Hobbes: an overview

For the purpose of this thesis, some of the concepts of Hobbes will be reviewed, such as: imagination, memory, dreams, understanding, mental discourse, prudence, good, evil, cruelty, love, neglect and power. Hobbes analysed circumstantial evidence to contribute to his philosophical understanding of power directly relevant to this study.

Thomas Hobbes (1588-1679) analysed the operations of bourgeois power in relation to peace. He was an English philosopher, contemporary of Francis Bacon (1561-1626) and Galileo Galilei (1564-1642), both of whom he met at different times of his life, and sustained a philosophical and friendly relationship with them. He became part of the circle of philosophers in Paris. He was the second son of a vicar of Westport. When young Hobbes was educated in Malmesbury, he was a brilliant scholar. Later, he studied in Oxford. He sustained different jobs in his life; he was tutor to the son of William Cavendish (first Earl of Devonshire) and lived many years either at London or Chatsworth. He lived also in France where he was tutor of Charles, Prince of Wales and tutor of the son of Sir Gervase Clinton. His major work is the *Leviathan*, in which he states his doctrine. His philosophy displeased many rich people, politicians and churchmen, although his work was well accepted by the 'reading classes'. Hobbes was a political philosopher, with an 'impressionable political consciousness' (Oakeshott, 1946). The *Leviathan* presents his analysis of the lineaments of power in a systematic way; likewise his main concern was peace. He wrote about equity and justice. His philosophical reflection about politics was expressed in terms of good and evil, right and wrong,

justice and injustice. Hobbes analyses circumstantial evidence to contribute to his philosophical understanding of power.

The *Leviathan* is a book of Hobbes's doctrine in nature, man and society. It is divided in four parts: 'of man', 'of commonwealth', 'of a Christian commonwealth', and 'of the kingdom of darkness'. Leviathan is described by Hobbes as an artificial man, this man is the commonwealth, or the state. The sovereignty is an artificial soul, *'is himself a good or evil man'* (Hobbes, 1651:6). Hobbes initiates his analysis of power with the *'thoughts of man'*, first by its own, and then in chain or in relationship, one to other. These thoughts, explains Hobbes, are a *'representation or appearance'* of an object. This object is worked on the eyes, ears and other parts of the body. For Hobbes, the external body is the source of sense.

Human beings are creatures of *sense*; sensations are always in motion that consequently established in the brain and produce ideas. Being the body the source of sense in relationship to an object, humans retain an *image*, an *appearance*; we imagine what we saw, smell, felt, heard or any other sensation. *Imagination* is the consciousness of those images (Oakeshott, 1946). It is the impression that remains in us from the image made in seeing or any other of our senses. For Hobbes, imagination was not only in men but also in other living creatures. *Memory* is the recall of images, and many memories are called experience. Imagination for Hobbes might be presented in different ways. *'Simple imagination'* that *"is the imagining the whole object as it was presented to the sense"* (Hobbes, 1651:10) and *'compounded imagination'* that is an imagination conceived from an image, such as a centaur –composed from the sight of a horse- or an image of ourselves with the actions of other person. It is a *"fiction of the mind"* (Hobbes, 1651:10).

The series of imaginations when we are asleep are called dreams. And a train of imaginations or succession of thoughts is a mental discourse. Hobbes states that there are *good thoughts* and *evil thoughts*, good thoughts are inspired by God and bad thoughts are inspired by the devil. The mental discourse could be unguided – without design, inconstant- and regulated -with a design, regulated by a desire-.

Understanding by Hobbes could pertain to a man or a beast; "*The imagination that is raised in man, or any other creature endued with the faculty of imagining, by words, or other voluntary signs, is that we generally call understanding*" (Hobbes, 1651:13).

According to Hobbes, the mental discourse of regulated thoughts could be of two kinds: (a) '*when of an effect imagined we seek the causes*' and (b) '*when imagining anything whatsoever, we seek all the possible effects, that can by it be produced*' (Hobbes, 1651:15). Mental discourse develops into *prudence* by combining images from the past with a present situation that we want to anticipate the response of others; it is wisdom, it is '*a presumption of the future*' (Hobbes, 1651:16). Hobbes' philosophy is based on reasoning; his philosophy is both contemplative and didactic. I will integrate these conceptual foundations into my analyses of the operations of power later in this study.

2.7.6. Feminist phenomenological theoretical position

Feminist research may use many methods of inquiry to investigate women's oppression. The philosophy of science has influenced many alternative methods to the construction of feminist knowledge. The different trends of phenomenological research include empirical, heuristic, hermeneutic, and recently interpretative phenomenological analysis. In empirical phenomenological research, naïve descriptions of a phenomenon are collected and the researcher uses reflective examination and interpretation to describe the configuration of the experience. In the heuristic phenomenological research, the purpose is to discover or to find the meaning of an experience. The hermeneutics phenomenological research derives understanding of the context of the experience; the researcher is very involved to explain the process, which includes the data. The interpretative phenomenological analysis, explores in depth how individuals perceive their personal and social experience; the researcher try to make sense of the individual's personal perception of their experience. (Rudestam and Newton, 2001; Moustakas, 1994; Polkinghorne, 1989; Smith and Osborn, 2004).

Interpretative phenomenological analysis (IPA) is related to both: phenomenology and hermeneutics. It is an exercise of double hermeneutics, where both participant and researcher are trying to make sense of the phenomena in question. To make sense for IPA is to understand. An IPA research focus is on understanding how participants think about what is happening, or has happened, to them.

According to Harding, feminist methodologies use phenomenological approaches 'to understand women's world' (Harding, 1987:3), to understand different phenomena from the perspective of women's experiences. Phenomenological approaches are different from the traditional approach to knowledge. The traditional approach has based its analysis on men's experiences and the conclusions have been answered as Western, white and bourgeois men view the 'discovery', which leads to a partial bias or absolutely wrong understanding of human life. Men and women are culturally different. Women are from different races, social classes and cultures; therefore women's experiences are different respect to other women according with these parameters. But there are also within each individual experiences derived from the different contexts of life. As an oppressed group, women have to struggle: e.g. socially, economically, politically, educationally or psychologically. Such experiences make 'women's experiences' different in the social world, and it is important to understand them in order to change women's conditions of life. Feminist epistemologies can thus help to conceptualise feminist understandings (Harding, 1987)[2] of how this might be achieved.

Feminist methodology has made three main sets of challenges to the trajectories of research agendas in which women questioned the male domination of science and particularly social science research. The first wave of feminist challenges analysed science, reason, progress and truth, and criticised it for producing biased knowledge. The second wave criticised social sciences for contributing to the

[2] *Harding differentiates method, methodology and epistemology. According to her, research method 'is a technique for (or way of procceding in) gathering evidence'. Methodology 'is a theory and analysis of how research does of should proceed' and epistemology 'is a theory of knlowledge'. (1987:2-3)*

invisibility of patriarchal power, sexuality and reproduction as mechanisms for women's oppression; including womens' oppression within other groups of women such as racism, heterosexism and class. The third wave of feminist encounters with aspects of postmodernism and poststructuralism expressed doubts that any methodology would be capable of generating knowledge that portrays actual reality (Ramazanoglu and Holland, 2002) as it is.

Even though there is no a unified definition of postmodernism, in general, postmodernism is a movement (either artistic, philosophic and economic) that has challenged first and second wave feminist understandings of knowledge and power. It has produced radical criticism of feminism that abandons the unified conception of women and challenges the conception of authority of feminist knowledge of or for women. Poststructuralism emerges from postmodernism and is, in feminist methodology, based in the work of philosophers such as Foucault, Deleuze, Derrida and Guattari (Ramazanoglu and Holland, 2002). Jane Ussher's study of madness is a good example of a postmodernist analysis of women and mental disorder. Her work has theoretical roots in deconstruction –Jacques Derrida- and the concept of discourse –Michael Foucault- (Busfield, 1996), which situates her work in the framework of poststructuralism.

Ussher builds upon Chesler's work "women and madness" (1972) mentioned above, which in many ways deconstructs the concept of madness, and the mental health system, asylums, psychiatrists, sexual relationship between patients and therapists, including the perspectives of lesbians, women of other socio-economic cultures and feminist psychology. This deconstructionist analysis was not named as such by Chesler but can be understood as a form of proto-deconstructionist feminism. Chesler analyses the bureaucratisation of mental asylums leading to the maltreatment of mental patients as less than human, suggesting it is worse to be in psychiatric hospitalisation than in jail. She criticises the further abuse that the bureaucratic system does to women as patients "Such supervision, however, doesn't protect the female as patient-child from rape, prostitution, pregnancy and the blame for all three- any more than similar 'motherly' supervision protects the female as female child in the 'real' world, either within or outside the family'"

(Chesler, 1972:36). She proposes that understanding women in a way that honours the experiences of women themselves is a way to challenge women's oppression. In a similar way, Ussher proposes that researchers 'listen to women' as a way to understand women and help to change the oppression of women. (1991).

Feminist psychologies give meticulous attention to the intricate dynamics of human mental life. This area is the province of psychodynamic psychology of which much criticism has been made. Critics of Freud's theories argue that he concludes that women are biologically and psychologically inferior to men based on his own prejudice against women and the female anatomy. In Freudian theories, men are described as the norm, women as lacking a penis, as 'castrated' men, therefore women are inferior to men. There are feminists who are for and against Freud. Kate Millett with her book 'Sexual Politics' (1972), claimed that Freud and his followers popularised 'the invidious relationship between the sexes, to ratify traditional roles and to validate temperamental differences (Millet, 1972:178). On the other hand Juliet Mitchell attempted to rescue Freud from this attack arguing that Freud offered a description of gender differences under patriarchy that has mistakenly been popularised as an excuse for adopting a bourgeois and patriarchal socio-cultural position (Busfield, 1996).

Nancy Chodorow and her work on "The reproduction of mothering" (1978), and other feminists such as Adrienne Rich (1976) and Dorothy Dinnerstein (1976) react against feminist criticism of women's commitments to domestic roles as wives and mothers. Chodorow disagrees with this marginalisation of mothering and domesticity, and she tried to reclaim the inherent power in motherhood and understand it's role in women's psychology (Busfield, 1996).

Psychodynamic therapists Luise Eichenbaum and Susie Orbach developed a feminist analysis of women's psychology, object relations and mental health. Their objective is to construct an explanation of women's emotional development that honours the specificities of women's experience by combining sociological and psychodynamic theories to explain women's psychology. They use the conception

of social role to explain women's circumstances in the social world and discuss psychological problems as one of the effects of inequality. They also analyse the mother-daughter relationship in its familial and social context (Busfield, 1996; Eichenbaum and Orbach, 1983).

Denise Russell (1995) analyses women, madness and medicine. She examines different biological and medical arguments of modern psychiatry. Her radical theoretical approach challenges the understanding of schizophrenia, depression, premenstrual syndrome, anorexia, bulimia and criminality; she proposes to dissolve the difference between sanity and madness in the context of oppression and repression by focussing on social relations rather than individuality.

The sociologist Joan Busfield explores gender and mental disorder in her text "Men, women and madness" (1996). Busfield shows evidence of different constructions of mental disorder and gender to contribute to an understanding the different mental functioning of women and men, and the prevalence of different mental disorders across the gender divide. She uses historical, social and cultural theories that help explain how many diverse factors are involved in the construction of masculinity and femininity.

Sandra Bartky's phenomenological analysis of oppression examines the victimization of women by the system of social power through psychological oppression, domestic racism, cultural depreciation and sexual objectification. She also analyses narcissism, femininity, alienation, masochism, shame and patriarchal power in terms of its impact on women's experience (Bartky, 1990).

2.7.7. Feminism, Psychology and abuse

There are considerable variations between general psychological theories and feminist theories concerning child abuse. Psychological theories have a different focus of attention and the majority of psychological models consider sex and

satisfaction as an axiomatic situation for abuse, 'power' is considered secondary. Feminist models consider that an examination of asymmetrical power relations can provide valid explanations of abuse (Warner, 1996).

Several fields seek to explain child abuse, including biological, psychological, political and social theories. In psychology, different theories -or a combination of them- include frameworks and paradigms related to the ethological, the sociobiological, the cognitive-behavioural, psychoanalytical and psychodynamic, the systemic-family dysfunction theory, as well as the social structural and feminist approaches. However, there is much disagreement between feminist theory and more generic approaches, as previously mentioned.

Ethological and sociobiological perspectives to understanding abuse are generally derived from the theories of Charles Darwin (1809-1882); especially his theory of evolution that proposes that living creatures survive due to their ability to adapt to their changing environments. Ethologists such as Konrad Lorenz (1903-1989) used Darwin's theory to explain the behaviours he observed. This gave rise to Lorenz' theory of 'imprinting'[3], from his observations on geese and ducks, and explained that imprinting was also evident in human behaviour. It was claimed that this had implications for human behaviour later on in life such as the choice of sex partner. The notion for 'imprinting' from Lorenz provides a conceptual basis to the ideas of Bowlby (1907-1990) who developed the theory of attachment. It is argued that poor attachment experiences, such as maternal deprivation can develop severe personality dysfunction in children or when adults (Lorenz, 1970; Bowlby, 1998; Corby, 1989). Feminists, however, disagree with these theories particularly regarding maternal/caring functions that are considered *'natural'*. Criticisms of Bowlby's attachment theory concern the notion of 'natural motherhood' and its claim that even short intervals of separation may provoke long-lasting harmful effects (Corby, 2000).

[3] *Imprinting* is the *"inborn tendency when very young to follow moving objects close to them that usually are their mothers"* (Corby, 1989:31).

Kempe (1922-1984) applied Bowlby's reasoning to explain child abuse (Kempe, 1968) and argued that mothers who abuse their children suffered from poor attachment experiences and that the focus of the treatment should be on the parents (Corby, 2000).

Sociobiology emerged in the middle 70's based on Darwin ideas that instincts preserve life and ensure that the genetic characteristics of the healthiest of the species are passed on through the generations. Child abuse was difficult to explain in terms of ensuring own gene's survival theory: i.e., how could parents maltreat their children if they need them to survive and re-generate? It was explained that in difficult survival conditions, parent animals often neglect the weakest off-spring in order to let the strongest survive. However, it is doubtful the value of applying these theories to human behaviors.

The psychodynamic perspective on abuse comprises theories developed from the ideas of Sigmund Freud and others that followed a psychoanalytic training, developing his original ideas. Freud developed his theories –including his ideas on hysteria[4] - from his work with mainly white middle-class women and was also influenced by Darwin. His early professional experience led him to believe that many psychopathological conditions resulted as a consequence of the sexual abuse of his clients as children. Freud's views were unconventional; and were generally rejected in Freud's culture at that time. The reason was that sex was considered a taboo topic, as well as the inference that sexual abuse was relatively common in society (Corby, 2000). Later Freud claimed that psychopathology was instead based upon the incestuous fantasies of children towards their parents, rooted in what he called the 'Oedipus complex' (Freud, 1932).

Contemporary psychoanalysts are divided on this issue. Alice Miller (1986), for instance criticizes classical Freudian psychoanalytic practice; her main argument is

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[4] *Hysteria Condition where people experience symptoms like paralysis that have not observable organic cause* (Corby, 1989:28)

that assuming that patient disclosures are desire fantasies in fact harms their psychological health.

The more sociological family dysfunction theory derived mainly from the work of Minuchin (1974) is based on systems theory. The work of Arnon Bentovim has proven to be the most influential and therapeutic intervention is to "try to unravel poor communication and entangled relationships which seem as major causes of the abuse". Applied to physical, sexual and emotional abuse this theory uses the notion of 'scapegoating' This concept relates to situations when every one of family troubles become established in one family member and leads to the physical or emotional abuse of that one person. Treatment is claimed to work with the whole family (Corby, 1989).

Some feminists criticize the approach of systemic-family dysfunction especially regarding incest as a form of family dysfunction, because (1) it removes the point of abuse from the power of the perpetrator (who usually is a male) who has committed abuse of a child and because (2) the therapist is prepared to reunite the family following the occurrence (Corby, 1989).

2.8. Summary of the literature review

In this chapter the concept of child abuse was reviewed. Also included in this chapter is an examination of other key concepts such as: trauma; life events; resilience; aspects of power; the philosophical bases of power, using the philosophy of Hobbes and the feminist approach; an exploration of feminist phenomenological theoretical position; and the relation between feminism, psychology and abuse.

The definitions of 'child abuse' are numerous. The evolution of the term began with the description of the battered child by Kempe *et al.* (1962). The term evolved according to the extended studies from understanding and social attitudes not only towards abuse but also towards children. Research of child abuse has increased

knowledge to help us to differentiate between different types of child abuse, that according to the Department of Health in Britain, these could be classified as: physical, sexual, emotional, neglect, and witnessing domestic abuse –included as other concerns.

The recognition of the short and long-term consequences of childhood abuse was briefly reviewed as well as the traumatic effects of child abuse ranging from cognitive distortions, altered emotionality, dissociation, depression, anxiety and posttraumatic stress to acute mental illnesses such as schizophrenia.

Life events might have ethological effects that affect individual functioning at different levels such as physical, social or emotional functioning. Negative life events could cause an impact on psychological functioning and are related to impaired functioning.

Coping strategies are the way in which individuals handle stressful situations (Folkman and Lazarus, 1988b). These strategies might be positive or negative and will affect resilience. Resilience is the successful adaptation to threatening circumstances (Masten *et al.*, 1990).

Power is a concept socially constructed. Thomas Hobbes developed an extensive philosophical study of power in the 17th century. In feminist discourse power has become analysed from a different perspective (Bartky, 1990). Patriarchy is an explanation of constraints on women and oppression within domestic settings and society.

Inner power based on the concept of Elworthy (1996) is defined with an operational definition as 'power over' the self. Imagination as "the faculty that envisages possibilities" (Oksenberg (1983:811) is explored and its relevance to recovery and healing of trauma. Also, the importance of inner locus of control as a sense of self provides a solid base to explore internal power.

A brief history of feminism was reviewed, its definition and difference from the concept of gender. Gender is an analytical category that looks to understand the social and cultural origins and differences of male-female characteristics, whereas feminism recognises women's oppression. Involves critiques of positivist social science and analyses and deconstructs relations of power.

It can be seen that different theoretical explanations of child abuse do not consider power as a main area of concern. Feminists consider that constructions of power, patriarchal power and a binary system (abuser-victim) that immobilise, exclude, render invisible, interpolate and silence women play an important role in the perpetration of abuse (Warner, 1996).

Feminist theories and feminist psychology use sociology and anthropology. Feminist psychology refuses biological explanations to understand women's mental disturbance. Post-structuralism and postmodernism analyses the inequalities in power. A feminist phenomenological theoretical position combines, power, gender and phenomenology. It honours participants' meanings; it look at the presences and absences and in this study it focus the attention to the mental life. This research looks at phenomenology as Sokolowski formulae: (1) parts and wholes, (2) identity in manifolds, and (3) presence and absence. Feminism, psychology and abuse are the axes of this research; phenomenology provides the pathway for analysing inner power, imagination and resilience to childhood abuse trauma.

The next chapter will describe the different steps used to explore all these issues in this three-part research study. In other words, the method's chapter will explain the methodology, aims, procedures and instruments used in each of the three studies in this thesis.

CHAPTER 3

Research Design and Methods

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3. RESEARCH DESIGN AND METHODS

This chapter explains the way in which the research was planned and conducted. Mixed methods with a variety of resources including both quantitative and qualitative approaches to the collection of data were used. As such, it combined the rigour and the precision of a quasi-experimental design with quantitative data, and a non-experimental design with depth analysis of data from the qualitative method. Samples of the questionnaire, interview and follow up interview are included as appendices at the end of this thesis.

3.1. Introduction

The selection of the methods applied was in order to assess a large number of participants using standardised measures and then to conduct an open-ended interview to explore more specific phenomena to expand and illuminate the questionnaire findings. According to the classification of Creswell (1998), this is a sequential study using a mixed-method research design, in which initial quantitative data is produced first and gathering of qualitative data is conducted after.

The complete research is organised in three phases:

1. Screening the questionnaire
2. The survey
3. Interview study

Table 3.1 shows how the research progressed. It started with screening questionnaires for their suitability. The development of the questionnaire then took place over several stages including a review of the content and results from a limited number of surveys, which had previously been carried out in this field. A draft of the questionnaire was then developed. A key point of this process was to

maximize the response rate by ensuring clarity and brevity. A pilot study was conducted to re-assure clarity and to estimate a probable response rate.

Table 3.1 Research design

Phase	Method	Step	Data source
1	**Design of the questionnaire**	a. Selection of the questionnaire for Childhood abuse trauma symptoms	Psyclit and Medline databases
		b. Selection of the questionnaire for Coping	Psyclit and Medline databases
		c. Selection of the questionnaire for life events	Psyclit and Medline databases
		d. Selection of the questionnaire for power	Psyclit and Medline databases
		e. General health questionnaire	Psyclit and Medline databases
		f. Prepilot –judges-	Five independent psychotherapists and counsellors
		g. Ethical approval	ScHARR Ethics Committee
		h. Pilot	10 first members of the list of the UPCA
2	**Survey**	a. Invitation to participate in the study	UPCA sent the invitation
		b. Receiving the letters	Members of the UPCA
		c. Preparing the materials	Main researcher
		d. Survey	Main researcher
		e. Sending questionnaires to people who agreed to participate in the research	Main researcher
		f. Receiving questionnaires	Participants
		g. Sending reminders	Researcher
		h. Capturing the data	Research and a research assistant
		i. Cleaning the data	Researcher
		j. Statistical analysis	Questionnaire data
3	**Interview study**	a. Preparation of the protocol	Main researcher
		b. Preparation of the schedule	Main researcher
		c. Sample selection	Main researcher
		d. Ethics application	Main researcher
		e. Sampling modification	Main researcher
		f. Interviews	Participant
		g. Check transcription	Participant
		h. Follow up	Participant
		i. Interviews transcript check	Participant

The quantitative study uses a questionnaire; this core research tool is designed to determine differences between participants who reported experiences of childhood abuse and those participants who reported no such evidence.

A core questionnaire was made from a selection of questionnaires made through searching in databases –PSYCINFO and MEDLINE- using a systematic review method. The questionnaires that compose the core questionnaire were regarded as being the most suitable due their qualities of reliability and validity (please see sample in appendix 1). It comprised a total of 180 questions, which took an average of 30 minutes to complete. In order to fit the questionnaire on to eight A4 sheets to form a 'booklet', it was structured so that the first section included four questions that comprised demographic information. On the first page were logos, the title of the research, the main aim of the study; information about confidentiality and a sentence of thanks was included. The ordering of the questionnaires was chosen to be the least threatening to participants at the beginning and the most sensitive towards the end of the core questionnaire. A tick box was located on the right-hand side of each item for every question. At the end of the core questionnaire was Section eight, a thanks for answering; a paragraph asking if they were willing to participate in further research; a form and the way to contact them. There was also a statement of consent to use the information in future publications with assurance that non-identifying information would be used. The final back page was blank. The questionnaires included the following:

(a) "The General Health Questionnaire – 12" (Goldberg, 1978a).
(b) "The List of Threatening Experiences" (Brugha and Cragg, 1990).
(c) "The Ways of Coping Questionnaire – R" (Folkman and Lazarus 1988)
(d) "The Empowerment Scale" (Rogers, Chamberlin, Langer and Crean, 1997).
(e) "The Childhood Trauma Questionnaire – 40" (Briere and Runtz,1988).

The seventh section of the questionnaire related to the impact of child abuse in the psychotherapy practice and the eighth section focused on power over others at work with questions designed by the researchers[1].

[1] Prof Digby Tantam, Mrs.Carol Saul and Silvia Pimentel-Aguilar

Phase Two was the survey of the questionnaire. This evaluative survey of psychotherapists and counsellors was designed as a cross-sectional study to explore the prevalence and incidence of child abuse as the keystone of the study. It was complemented by interview research into professional women's experiences of overcoming childhood abuse trauma. A postal, self-administered questionnaire was conducted. The homes or work places of the interviewees were the chosen environment for this survey. Responses to survey items about child abuse provided information on the factors that intervene to build resilience. The sampling bias is explained below.

The sampling method was different for each study: self-selected sample for the survey and stratified purposive sample for the interview study (see Table 3.2)

Table 3.2 Sampling method

	Sample	**Method of analysis**
Survey	Self-selected sample	Statistical analysis Descriptive and inferential statistics
Interview study	Stratified purposive sample	Interpretative Phenomenological Analysis

Variables for the survey and qualitative study were very different. For the survey, it was important to understand the relationships between child abuse, symptoms of trauma associated with child abuse, emotional morbidity, coping skills, and empowerment (Table 3.3).

Table 3.3 Variables of the survey

Variables	
Independent variable	Child abuse (presence or absence)
Confounding variable	Recent life events
Dependant variables	Symptoms of child abuse (TSC-40) Emotional morbidity (GHQ-12) Coping skills (WAYS-R) Empowerment (The power scale)

For the interview study, the interest was more involved with the specific process of overcoming childhood abuse, from children to adults (see Table 3.4).

Table 3.4 Qualitative study

Focus for inquiry	What helped to overcome the abuse?
Fit of paradigm to focus	No previous research that identifies inner power No previous research that relates power and overcoming No previous research that relates power and resilience to childhood abuse
Fit of inquiry paradigm	Is it imagination involved in the exercise of inner power?
Where the data was obtained	In the United Kingdom
From whom?	From psychotherapists and counsellors
About whom?	About themselves and their own childhood
Phases of the inquiry	a. Interview b. Follow up

3.2. Phase 1: Design of the questionnaire

3.2.1. Introduction

This section reviews how the core questionnaire was designed. It explains the selection process of the different questionnaires that form the core research tool. This selection resulted in a research tool composed of 5 questionnaires with established validity and reliability. Furthermore, two sections were constructed to investigate dominance-power and the impact of childhood abuse in psychotherapy and counselling practice.

The selection of the instruments of measurement not only examines the characteristics of the study, but also the language and the up-dating of each questionnaire. A systematic literature search was the methodology used for this purpose. Validity and reliability were considered important factors in the selection of the research tools.

3.2.2. Aims and objectives of the systematic review[2]

The objective of the systematic review was to conduct a literature search to select a precise questionnaire for each topic involved in the process of overcoming childhood abuse trauma. Systematic review is different from a literature review. A systematic review (or systematic overview) is "*A review of a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise relevant research, and collect and analyse data from the studies that are included in the review. Statistical methods (meta-analysis) may or may not be used to analyse and summarise the results of the included studies*" (Cochrane, 2007). The focus was also upon the empowerment that the subjects of this study could have achieved up to the date of the application of the core research tool. Further, it was designed to eliminate a possible relationship between the presence of negative recent life events and poor general health.

3.2.3. Questions addressed by the systematic review

The purpose of this study selection is to identify those articles that help to answer the following questions:

Which are the most relevant, reliable, and valid questionnaires suitable for adult professionals in mental health who have possibly experienced abuse; and which design can give the highest reliability and validity?

The different topics related to child abuse considered in this research were as a follows: general health, life events, coping/resilience, power and trauma.

[2] Systematic review: "reviews of the empirical literature concerning the efficacy or effectiveness of an intervention –in this case a questionnaire- that considers all of the relevant studies taking account of quality criteria" (Marks et al. 2002)

3.2.4. Methods

Comprehensive literature searches were undertaken to identify key questionnaires relating to childhood trauma, life events, general health, coping/resilience and power. The findings were reviewed systematically by drawing on systematic review methodology, following the CRD[3] Report No. 4 (Khan et al. 2000). Firstly, a systematic literature search was achieved through databases such as PsycINFO and Medline for each issue. The survey was made from various databases between 1977-2001. Secondly, a careful selection of the potential questionnaires to be analysed was made considering characteristics such as the instruments suitable a) for adults not for children, b) for individuals not for parents or families. Thirdly, reliability and validity were important factors in selecting the instruments, considering all of the four types of reliability (internal reliability, test/re-test reliability, inter-observer reliability and intra-observer reliability). Instrument validity was particularly important in selecting the questionnaires. Finally, the availability of a Spanish version of the research tools was explored, since the original aim was to apply the same research tools to a Mexican sample.

3.2.5. Search Strategy

The search focussed on childhood trauma, coping, life events, general health and power. The next section will explain the specific aspects that were investigated for each topic of each instrument.

3.2.5.1. Childhood Abuse Trauma

Inclusion/exclusion criteria

A comprehensive literature search on research tools was undertaken in the Medline and PsycINFO databases. The search years were 1977 to 2001 in both databases. Synonyms for instruments (i.e. questionnaire, instrument, measure,

[3] CRD is the Centre for Reviews and Dissemination

inventory, scale, test) were searched in conjunction with search items for child abuse (including trauma, maltreatment, neglect, etc.). There were, however, no restrictions by date or language, but the most actualised versions of the questionnaire could still be selected. (Table 3.5)

Table 3.5 Search History No. 1

Search History in PsycINFO – Silverplatter Webspirs
* #9 #4 and #8
#8 #5 or #6 or #7
#7 instrument*
#6 explode 'Questionnaires-' in DE
#5 'Psychometrics-' in DE
#4 #1 or #2 or #3
#3 child* near5 (abus* or trauma or maltreatment or neglect)
#2 'Child-Neglect' in DE
#1 explode 'Child-Abuse' in DE

Date of the search: 29 of March 2001

This search yielded 502 references. A supplementary search was conducted on specific named childhood trauma measures (search History No 2). The results were broad; 502 records needed to be considered. A selection was made from this search and then cross-referenced with the authors considered relevant to the childhood trauma measurements (Table 3.6).

Table 3.6 Search History No. 2

Search History in PsycINFO – Silverplatter Webspirs
#14 #11 and #9
#13 #11 and #6
#12 #11 and #4
#11 #1 or #7 or #10
* #10 child* maltreatment measur*
#9 #3 and #8
#8 (Riddle) in AU,CA
#7 childhood maltreatment inventory
#6 #3 and #5
#5 (Runtz) in AU,CA
#4 #2 and #3
#3 child* abuse
#2 (Briere) in AU,CA
#1 crisis symptom checklist

Date of the search: 29 of March 2001

Data Extraction

A detailed examination of the results from these two searches identified 64 potentially relevant references. All the abstracts were read, and after analysis seven articles were selected. The full text of the questionnaires that reflect the reliability and/or validity were obtained. These were the following: "Trauma Symptom check list", "Davison trauma scale", "Childhood trauma questionnaire", "The childhood trauma interview", "Childhood abuse trauma scale (CATS)", "The early trauma inventory" and potential research tools were subsequently identified. Key characteristics of these questionnaires, including the subscales, reliability etc. are provided in Table 3.7.

Table 3.7 Description of the key features of 7 major childhood trauma abuse measures

Instrument	Characteristics	Subscales	Reliability/Validity	Ease of use	Applicability to Mexico
Trauma Symptom Checklist-40 Authors: Briere J. and Elliot, D.M.[4]	-It is a questionnaire improved from the TSC-33 questionnaire (Briere and Runtz). -It was applied to 2,963 professional women across the United States. - It was applied to a sample of 31 males and 39 females. In this study, the Symptom Checklist was applied (SCL-90-R). -"Specific Abuse characteristics investigated included: age at first abuse incident, duration and frequency of abuse, whether at least one incident involved sexual contact with a biological parent; whether any incident involved physical force or threat of harm: and subjects rating of how traumatic she/he perceived the abuse to have been" (Briere and Elliot, 1992:392). -"All the subscales measure symptoms that are common among survivors of CSA."[2] Whiffen, Benazon, and Bradshaw, 1997:110).	*6 subscales*: 1. Anxiety 2. Depression 3. Dissociation 4. Sexual Abuse Trauma index 5. Sexual Problems 6. Sleep Disturbance Three of the subscales measure symptoms that are common among survivors of Child Sexual Abuse (CSA): a. Dissociation subscale. b. The post-sexual abuse trauma. c. Sexual problems subscale.	- Discriminant validity evaluation. - a. the Sexual Problems subscale displays reasonable reliability (alpha=.73). - The additional two items appear to have increased the internal consistency of the sleep disturbance subscale (alpha=.77) - Discriminant analysis indicated that TSC-40 subscale scores were highly significant discriminators of sexually abused versus nonabused subjects [F(6,2831) = 18.45, p <.0001]. -" Discriminant structure coefficients and post hoc univariate t-tests both revealed that anxiety, Depression, Dissociation, Sexual Abuse Trauma Index, Sexual Problems, and Sleep Disturbance subscale scores were each significantly higher for sexually abused women than for those with no sexual abuse history."[5](Elliott, D.M., Briere, J.1992:393).	*- 40 items.* *- 4 point frequency rating scale:* *1.Never* *2.Occasionally* *2. Fairly Often* *3. Very Often*	- Needs translation. - Needs to know the questions
Davidson Trauma Scale. Authors: : Zlotnick, C., Davidson, J., Shea, T., and Pearlstein, T.6	-Self report measure. - Total sample: 62 women survivors of sexual abuse. Instrument reported on 8 papers in PsycINFO databases.	- Provides a measure of the 17 symptoms of Posttraumatic Stress Disorder (PTSD) listed in the DSM-IV.	"Good internal consistency, test-retest reliability and validity in a variety of other trauma populations as well as in survivors of childhood sexual abuse" (Zlotnick, Davidson, Shea, and Pearlstein, 1996:255)	5 point measure of the frequency: "not at all" to "every day" and the severity "not at all" to "extremely distressing".	*- Needs translation.* *- Needs to know the questions*

[4] *Elliott, D.M. and Briere, J. (1992). Sexual abuse trauma among professional women: validating the trauma symptom checklist-40 (TSC-40).* Child Abuse & Neglect, *vol. 16, pp391-398.*
[2] *Whiffen, V. E., Benazon, N. R., Bradshaw, C. (1997). Discriminant validity of the TSC-40 in an outpatient setting.* Child Abuse & Neglect, *Vol. 21 (1) pp. 10-115.*

[6] *Zlotnick, C., Davidson, J., Shea, T., and Pearlstein, T. (1996). Validation of the Davidson trauma Scale in a Sample of Survivors of Childhood Sexual Abuse.* Journal of Nervous and Mental Disease. *Vol. 184(4) pp. 255-257.*

Childhood Trauma Questionnaire (CTQ) Authors: Bernstein, D., Ahluvalia, T., Pogge, D, and Handelsman, L.	-"Self-report inventory that provides brief and relatively non-invasive screening of maltreatment experiences before the age of 18 years." (Bernstein, D., Ahluvalia, T., Pogge, D, and Handelsman, L.1997:340). - It was administered on a sample of 398 adolescents admitted to the inpatient service of a private psychiatric hospital. -"Patients were allowed to refuse to complete the instrument for any reason" however, none of the patient refused to complete it (Bernstein, D., Ahluvalia, T., Pogge, D, and Handelsman, L.1997:342). -It was also applied to a sample of substance-abusing adults. As well in university students. - Reported in 35 articles of psycINFO databases.	Five rotated factors: 1.Emotional abuse 2. Emotional neglect 3. Sexual Abuse 4. Physical Abuse 5. Physical Neglect.	The internal consistency of the CTQ factors was extremely high both the entire sample and in every subgroup examined - Internal consistency was determined by Cronbach's a. -Test-retest reliability over 2-to-6 months interval, as well as convergence with a structured trauma interview. - Validity scale, constructed to detect maltreatment under reporting. - They were more concerned with minimising false-negative errors (i.e. the non detection of true cases) (:343).	-Self-report inventory -70 items. Emotional abuse-12 items Physical abuse - 7 items Sexual abuse - 7 items Emotional neglect -16 items Physical neglect - 8 items - Instructions were read silently by the subject. - 5 point Likert-type scale, with response options ranging from "never true" to "very often true". - Requires about 10 to 15 minutes to complete.	- Needs translation. - Needs to know the questions
The Childhood Trauma Interview Authors:Fink, Bernstein, handelsman, Foote, Lovejoy.	- Brief semistructured interview - All perpetrators are named. - Semistructured interviews and self-report instruments do allow for standard assessment processes across all subjects, this includes reliability and validity - The CTI allows for systematic investigation of extrafamilial as well as intrafamilial traumatic	-Six areas of childhood interpersonal trauma: 1.Separations and losses 2. Physical neglect 3. Emotional abuse or assault 4. Physical abuse or assault 5. Witnessing violence and 6. Sexual abuse or assault.	interrater reliability scores ranged from 0.73 to 1.00, which indicated very good reliability. Seventy-nine percent of this instrument variables had reliability coefficients at or above 0.80, and 63 had coefficients at or above 0.90 Correlations between scales were all significantly higher than non analogous correlations, which supports the convergent and discriminant validity of CTI	-It was designed to be brief: 20-30 minutes for administration. And comprehensively assess six categories of intrafamilial and extrafamilial interpersonal trauma from childhood. -Written in a conversational style. - Severity and frequency of the traumatic experiences are scored from 0 to 6. - It includes a manual with	- Needs translation. - Needs to know the questions

	events. -The CTI involves systematic inquiry into traumatic experiences by using a conversational style with multiple initial questions and uniform follow-up questions focused mainly on the behavioural aspects of traumatic experiences.			instructions, detailed criteria was used to facilitate systematic administration and scoring.	
Childhood Abuse and Trauma Scale (CATS) **Authors: Sanders, B. and Becker-Lausen, E.**[7]	- Yields a quantitative index of frequency and extends various types of negative experiences in childhood and adolescence.	Three intercorrelated factors: 1.Neglect/Negative Home Atmosphere. 2. Sexual Abuse. 3. Punishment.	"Strong internal consistency and test-retest reliability of the scale" .89 (p<.001). (:315, 319) - CAT scores correlated significantly (r=.4; p<.001) with scores on Bernstein and Putnam's Dissociative experiences Scale. The Gutman split-half reliability of the CAT was.86. These results reflect that this scale might provide a useful measure of the degree of subjectively assessed stress or trauma produced by various types of negative experiences in childhood	- A paper-and-pencil measure. - Ease of administration to large groups of subjects. - Could be administered anonymously to increase truthful reporting. -38 items. -Home environment questionnaire. -0 to 4 responses alternatives. -Contains questions related to the individual's childhood or adolescent experiences of sexual mistreatment, physical mistreatment and punishment, psychological mistreatment, physical or emotional neglect and negative home enviroment.	- Needs translation. - Needs to know the questions
Name: The early trauma inventory (ETI). **Authors:** Bremner, J.D., Vermetten, E., Mazure C.M.	- It was developed based on a perceived need for a comprehensive and reliable assessment of childhood trauma for research and clinical purposes.	Four domains of childhood traumatic events: a. General trauma b. Physical trauma c. Emotional trauma d. Sexual abuse General trauma component assesses occurrence of events ranging from parental loss to natural disaster, to criminal	Inter-rater reliability, test-retest reliability and internal consistency	-Semi-structured interview. -56-item interview that assesses traumatic experiences before the age of 18. - Open ended format - 45 min to administrate	-Needs translation. - Needs to know the questions

[7] *Sanders, B. and Becker-Lausen, E. (1995). The measurement of psychological maltreatment: early data on the child abuse and trauma scale. Vol.19(3), pp.315-323.*

	victimisation. Also assesses: the age of the individual when the abuse began and when it stopped; the perpetrator(s) of the abuse; and the impact of the event on the individual at the time (rated on a 7 point Likert-type scale ranging from -3 "extremely negative" to +3 "extremely positive". Current impact of the trauma is also assessed by domain using a 7 point scale. A Childhood Trauma Exposure Index was developed to have a continuous variable measure of abuse that could be easily assessed in research or clinical applications.		-a. General trauma 24 items b. Physical abuse 9 items c. Emotional abuse 8 items d.Sexual abuse 15 items.

3.2.5.2. Life Events

Inclusion/Exclusion Criteria

A thorough literature search was carried out to identify whether life events questionnaires follow a similar pattern to childhood abuse trauma measure. It was carried out by investigating PsycINFO and Medline databases. The first search concentrated specifically on life events measurements written in Spanish.

Table 3.8 Search History No. 3

Search History in PsycINFO – Silver platter webspirs
#11 life events and (Spanish in la)
#10 #2 and #9
#9 (Holmes) in AU,CA
#8 (Holmes Rahe) in AU,CA
#7 life events test
#6 life events measure
#5 life events checklist
#4 life events questionnaire
#3 life events scales
#2 life events
#1 (explode 'Life-Experiences' in DE) or (explode 'Quality-of-Life' in DE)

Date of search: 26 April 2001

To ensure clarity and to replicate the search history, a new search was carried out with the terms more clearly defined (Table 3.9).

Table 3.9 Search History No. 4

Search History in PsycINFO – Silver platter webspirs
#17 #15 and (Spanish in la)
#16 #14 and (Spanish in la)
#15 #10 and #13
#14 #3 and #13
#13 #11 or #12
#12 validity or reliability
#11 ('test-construction' in DE) or ('test-reliability' in DE) or ('test-validity' in DE) or (rating-scales in DE)
#10 #7 or #9
#9 #3 and #8
#8 questionnaire* or scale* or tool* or checklist* or inventor* or measure*
#7 #4 or #5 or #6
#6 social readjustment rating scale
#5 stressful life events questionnaire
#4 undesirable life events questionnaire
#3 #1 or #2
#2 explode 'life-experiences' in DE
#1 life event*

Date of search: 26 April 2001

Analysis of the records showed that some life events measures in Spanish are a translation of the Social Readjustment Rating Scale (SRRS) of Holmes and Rahe. This has been used frequently in studies with Spanish native speakers in countries such as Chile, Spain, and Mexico. (Bruner, Acuña, and Gallardo 1994; Rivera, Vollmer, Aravena, Carmona, 1985; Gonzalez de Rivera, J.L. 1989). This scale is very useful in measuring life events, but it was developed in 1967.Hence, it is appropriate to search for more recent scales. For this reason, a new search of life events measures was conducted, but this time the search focused on measures in English.

Table 3.10 Search History No. 5

Search in PsycINFO – Silver platter webspirs
#11 #9 and #10
#10 (validity or reliability) near5 life events
#9 #5 and #8
#8 #6 or #7
#7 validity or reliability
#6 ('test-construction' in DE) or ('test-reliability' in DE) or ('test-validity' in DE) or ('rating-scales ' in DE)
#5 #3 and #4
#4 questionnaire* or scale* or tool* or checklist* or inventor* or measure*
#3 #1 or #2
#2 'Experiences-Events' in DE
#1 life event*

Date of the search: 3 May 2001

Data Extraction

The results identified 365 references. All the abstracts of these references were read and analysed. From this analysis, four potential articles were selected. The results of the analysis of the instruments selected are shown in Table 3.11.

Table 3.11 Life Events scales

Instrument/Author/ Date	Characteristics	Validity/Reliability	Applicability to Mexico	Comments
The list of threatening experiences/ Brugha, T.S. and Cragg, D. (1990).	-Brief life events questionnaire. -12 items -12 major categories of life events. - study made on 50 subjects.	- High test-retest reliability. - Except in the category "something you valued was lost or stolen", this category was found to be unreliable. - Test-retest reliability was estimated by the coefficient of Cohen's Kappa. - The agreement coefficients were highly statistically significant. - Concurrent validity making use of the Life events and Difficulties Scales (LEDS) - developed by brown and Harris	-Needs translation.	-Six months period of life events measure. -The author cites some of his own investigations several times. -Authors recommend that users of this instrument (LTE) would consider modifying the wording of the category "dealing with material loss or theft" by specifying the degree of material loss considered to be a major threat to a typical subject in the study population.
The interview for recent life events (IRLE)/ Paykel, E.S. (Paper:1997; first version 1967; last version 1980)	-Semi structured interview. -Comprise 64 events. - Events are grouped into ten categories: work, education, finance, health, bereavement, migration, courtship and cohabitation, legal, family and social relationships, marital. - Administration takes from half an hour to one and quarter hours.	- Two studies have reported reliability and validity if the /English language version is used - Inter-rater reliability study shows a high agreement for specific events, occurrence, month of occurrence, independence, and no so high for objective negative impact (0.76) - For the Italian version, the authors reported high inter-rater reliability. - Validation has not been tested for the Interview for Recent Life events. Informants lack of detailed access to, and recall of events occurring to subjects.	- Even though there are translations to other languages, there is no translation to Spanish.	- Defines the concept of events as "dateable occurrences involving changes in the external social enviroment". - Internal occurrences (e.g. changes in perceptions or satisfactions) are not included, just physical illness. - Translations have been prepared in Italian, French, Dutch, Bengali, Kannada, and Arabic. From 1976 until 1993).

Negative life events Questionnaire (NLEQ)/ Pitzner, J. K. and Drummond, P. D.	- Three new abuse scales: Psychological/verbal Control Physical/Sexual A negative life event scale to measure the cumulative effects of events over the lifespan. - Items were grouped into sets under five headings and answered on a scale of severity from never (1) to very often (5). -First part contained 54 items that measured respondents' self-reports of psychological, physical and sexual abuse. - Second part contains 34 items, which asked respondents about the occurrence of traumatic events in their lives. -Items about robbery, assault, natural disasters, financial hardship, serious illness and loss of a close one. - In this second part, items responses were: the event has not occurred (0); the event has occurred once only (1); and, the number of times the event has occurred if its more than once. (2,3...).	-Test-retest reliability of the measures. - concurrent validity - Correlations indicated a strong association between the prior occurrence of negative life events and a current pattern of psychosomatic complaints, clinical depression, and general anxiety, fear, and panic.	- Needs translation.	
Life Events Scale (ALE)/ Ferguson, E., Matthews, G., and Cox, T. (1999).	-Three stable factors: threat, challenge and loss. -No confounding with social desirability. -Theoretically appropriate associations with various stressors, coping behaviours, personality and health measures. - 16 adjectives for three life events factors: threat, challenge and loss.	-Excellent internal test-retest reliability. -Good construct validity.	It needs translation.	The translation of the adjectives will need be evaluated again, because they can have other meanings.

3.2.5.3. General Health Questionnaire

A detailed literature search was carried out to identify the version of the GHQ that could provide validity, reliability and practicality. The search was conducted by investigating PsycINFO and Medline databases.

Inclusion/Exclusion Criteria

Firstly, a literature search was conducted for the General Health Questionnaire (GHQ) searching for the different versions. Then, to find the Spanish version, the search focused on the validity or reliability of the GHQ limited by language; in this case, Spanish.

In this search, from 225 results very specific results were found in Spanish, i.e.15 records. The analysis of the abstracts found three articles related to the validity of the GHQ in Mexico (Romero-Mendoza, Medina-Mora, 1987; Padilla-Pau et al., 1984; Ezban, et al., 1984), one of which compared the 60-item and 28-item versions. Other articles discussed the Argentinean GHQ studies. Another the Spanish studies; and one the Chilean study (search history No. 6). Only one from Spain reported the validation of the GHQ of 12 items (Tomas, et al., 1995).

Table 3.12 Search History No. 6

Search in PsycINFO – Silver platter webspirs
#6 #5 and (Spanish in la)
* #5 #1 and #4
#4 #2 or #3
#3 validity or reliability
#2 ('test-construction' in DE) or ('test-reliability' in DE) or (test-validity in DE) or (rating-scales in DE)
#1 General Health Questionnaire

Date of the search: 26 April 2001

Data extraction.

Different versions of the GHQ were found. The different versions mainly differ on the amount of items, e.g. 60 items, 30 items, 28 items, 12 items. The results of the general health questionnaire are shown below in Table 3.13.

Table 3.13 General Health Questionnaire

Country/ Author/Year	Characteristics	Reliability/Validity	Ease of use	Applicability to Mexico	Comments
Mexico/ Romero-Mendoza, Medina-Mora, 1987.	Comparison of 60-item with 28-item version of D. P. Goldberg (1972). -296 male and female Mexican adolescents and adults were studied.	Abstract does not report this aspect	The responses in 28-item version are shorter and quicker than the 60-item version.	It is already applied.	It is not the shorter version of 12-items.
Padilla-Pau et al., 1984;	Number of items not reported - Random sample of 501 adult patients from the general medical practice of a health centre near Mexico City.	Abstract does not report this aspect		It is already applied.	Abstract does not report which version it is.
Ezban, Medina-Mora, Palaez and Padilla, 1984	Number of items not reported	Abstract does not report this aspect		It is already applied.	It is already applied.
Tomas, J.M., Oliver A., Sancerni M. D. and Espejo, B. 1995.	12 item version - Study with 381 normal male and female Spanish adolescents and adults (13-29 years)	Abstract does not report this aspect		It has been applied in Spain	It will be important to read the complete article
Vieweg, B.W., Hedlund J.L. (1983).	Comparison of 12 item version , 60 item version and 30 item version	- Reliability, internal consistency of 0.95 for GHQ-60, 0.92 for the GHQ-30 and 0.83 for the GHQ-12. - Alpha coefficients for GHQ-12 ranged from 0.82 to 0.90 in four studies. - Validity. This is probably the most tested of the questionnaires, validation studies in many different countries.	The responses in 12-item version are the shortest of all the versions		

3.2.5.4. Coping strategies and Resilience

A detailed literature search was carried out to identify questionnaires that could provide a reliable measure for coping strategies and/or resilience. The search was conducted by investigating PsycINFO and Medline databases.

Inclusion/Exclusion Criteria

Inclusive boolean key words were included as questionnaire* or scale* or tool* or checklist* or inventor* or measure* and details of reliability and/or validity were important to know.

Table 3.14 Search History No 7

Search in PsycINFO – Silver platter webspirs
(validity or reliability) near5 resilience
(validity or reliability) near5 coping
(Test-construction' in DE) or ('test-reliability' in DE) or ('test-validity' in DE) or (rating-scales in DE)
Questionnaire* or scale* or tool* or checklist* or inventor* or measure*
Resilience
Coping

Date of the search: 8 June 2001

Data Extraction

The results identified 59 potential pertinent references. After the abstracts were carefully read, six instruments were selected to be examined in detail. "The resilience scale", "The personal resilience questionnaire", another version of "The personal resilience questionnaire", "Ways of coping questionnaire-revised", "The cope scale" and "The coping responses inventory". The results of the analysis of the instruments selected are shown in Table 3.15

Table 3.15 Resilience and Coping Scales

Instrument	Characteristics	Subscales	Reliability/Validity	Ease of use	Aplicability to Mexico
Resilience Scale Authors: Jew, C., Green K. E., and Kroger, J.	- 4 different studies were made by the authors to have completed and proved the questionnaire. An initial pool of a total of 109 items were written based on the coping skills and abilities previously identified by other authors (Mrazek and Mrazek) as used by resilient people Five experts judge each item. The items addressing each factor were reduced to the 5 best, for a total of 60 items. Four factor subscales were initially formed A second study was made it readministered the 60-itms survey. As in the 1st study, the independence scale failed to correlate significantly with any measure. In the third study no significant differences were found for any resiliency subscale between students rated adequate versus poor in social, academic, or psychological functioning Finally, in the 4th study; the structure, internal consistency and stability reliability of the revised measure were assessed. The revised scale contained now 49 items, this scale was examined using principal components analysis with varimax rotation and Rash anlayses. Of the original 49 items, 35 were retained. 3 subscales as a result of those previous studies re-labeling: Other person Orientation, Active Skill Acquisition, Independence/Risk Taking.	In the final instrument three subscales were labelled: 1. Future Orientation. 2.Active Skill Acquisition 3. Independence/risk-taking	These subscales were modestly related to achievement measures, however "findings consistent with Werner and Smith's (1982) predictions. The internal consistency reliability for each subscale was .90 for Future Orientation, .57 for Active Skill acquisition and .79 for independence/Risk-taking. The stability reliability was .57 for Future Orientation, .48 for active skill acquisition and .68 for Independence/Risk Taking. The subscale Independence/Risk-taking subscale did not correlate with any validation measure consequently this subscale remains problematic.	- 35 items - Likert scale for response. - 30 minutes in average to answer.	- It needs translation.

Resilience Scale Authors: Wagnild, G. and Young, H. M. (1993)	It was developed to measure a personality characteristic or coping resource that facilitates adaption	Morale Life Satisfaction Depression Physical Health	Results support the internal consistency reliability and concurrent validity as an instrument to measure resilience.	- 25 items	-Has been translated to Russian. It needs translation to Spanish.
The personal resilience questionnaire Author: Colgate, M. A.		- Seven subscales: 1. Identity 2. Cognitive flexibility 3. Self-efficacy 4. Social support 5. Organisation 6. Optimism 7. Social Comfort			It needs translation
Ways of coping Questionnaire-revised. Authors: Folkman and Lazarus (1988)	Three factors: problem, emotion and search for social support.	Subscales: 1. Practical coping 2. Wishful thinking 3. Stoicism. 4. Seeking emotional social support. 5. Accepting responsibility. 6. Positive reappraisal 7. Avoidance 8. Confronting coping.	The instrument shows adequate internal reliability, acceptability and validity.	- 66 items	It has been translate into Chinese, Dutch and Spanish.
Cope Scale Authors. Carver et al.			Adequate convergent and discriminant validity	- 60 items	It needs translation
The Coping Responses inventory Author: Moos, R. H.		8 types of approach and avoidance coping responses to stressful life circumstances of adults and youth (12 – 18 yrs old).			

3.2.5.5. Power

A detailed literature search was carried out to identify questionnaires that could provide a reliable measure for power, especially if the instrument could identify empowerment. The search was carried out by investigating PsycINFO and Medline databases.

Inclusion/exclusion criteria

The search also looked for measurements written in Spanish –if possible- about power and inclusive boolean key words were included as empower* questionnaire* or scale* or tool* or checklist* or inventor* or measure* and details of reliability and/or validity were also examined.

Table 3.16 Search History for power

Search in PsycINFO – Silver Platter Webspirs
#8 #6 and #7
#7 #4 or #5
#6 #2 or #3
#5 (Validity or reliability) near5 power
#4 (Validity or reliability) near5 empower*
#3 (Test-construction' in DE) or ('test-reliability' in DE) or ('test-validity' in DE) or (rating-scales in DE)
#2Questionnaire* or scale* or tool* or checklist* or inventor* or measure*
#1 Power

Date of the search: 12 July 2001

Data extraction

An examination of the results identified 66 possible relevant references. The abstracts of these references were analysed. Five potential research instruments were subsequently identified, namely: "The principal's power tactics survey", "Dominance scale", "personal construct of empowerment", "Power apprehension scale (PAS)" and "Empowerment scale". Key characteristics of these questionnaires, including the subscales, reliability etc. are provided in Table 3.17

Table 3.17 Analysis of Empowerment Scales

Instrument	*Characteristics*	Subscales	Reliability/Validity	Ease of use	Applicability to Mexico
The Principal's Power tactics Survey. Landry, Porter, and Lemon. 1989.	To measure power including Personal Power and Position power. And subsidiary strategies (Assertiveness, Sanctions, Upward Appeal, Ingratiation, Rationality, Exchange and Coalition.	Personal Power and Position power.	Reliable and valid enough		*It needs translation*
Dominance Scale. Steers and Braunstein's. 1977	Measure of the need for dominance	Subscales not reported	Demonstrated reliability and validity.		*It needs translation*
Personal construct of empowerment Rogers, Chamberlin, Ellison, Langer , Crean. 1977.	It was tested on 271 members of 6 self-help programs.	Factor analyses were used to identity 5 underlying dimensions of empowerment. 1. Self-efficacy-self esteem. 2. Power-powerlessness 3. Community activism 4. Righteous anger 5. Optimism-control over the future.	Tested validity and reliability.	28 item scale	*It needs translation*
Power Apprehension scale (PAS). Offerman. 1986.	It was applied in 310 undergraduates.	Two PAS subscales: 1. Dealing with concerns about having power oneself 2. Dealing with concern about the power of others	The primary Self subscale: high test-retest reliability and high internal consistency. The others subscale: moderately high test-retest reliability, but modest internal consistency. Good construct and discriminant validity.		It needs translation
Empowerment scale. Wowra, Scott and McCarter. 1999.	Applicable to adults. "Respondents with full time jobs scored significantly higher on overall empowerment and on the esteem, anger, and power subscales" (from the abstract).	5 subscales of empowerment: -Esteem -Power -Activism -Anger -Control	Reliability and factor analyses Adequate validity of the scale		It needs translation

From this systematic review, five questionnaires were selected:

1. "The General Health Questionnaire – 12" (Goldberg, 1978a).
2. "The List of Threatening Experiences" (Brugha and Cragg, 1990).
3. "The Ways of Coping Questionnaire – R" (Folkman and Lazarus, 1988).
4. "The Empowerment Scale" (Rogers, Chamberlin, Langer and Crean, 1997).
5. "The Childhood Trauma Questionnaire – 40" (Briere and Runtz, 1988).

Details of these results and other characteristics of the questionnaire are reported in the chapter of the results of the systematic literature search.

3.2.6. Systematic review for the questionnaires Update (December 2007)

A new Systematic Review for the questionnaire was performed. The aim was to conduct an updated search in order to see if any newer versions of the questionnaires already used or if newer questionnaires might be suitable for a better enquiry. The search strategy previously carried out was followed but this time was limited to the years of 2001-2007. The five factors already proposed (general emotional health, recent life events, coping, trauma symptoms and power) were analysed.

3.2.6.1 General Health Questionnaire Update

A new search for the General Health Questionnaire (GHQ-12) was performed. The aim was to conduct an updated search in order to see if any newer versions were more suitable. The search strategy previously carried out was followed but this time was limited to the years of 2001-2007. A total of 109 results were examined.

The analysis of the results showed that the GHQ questionnaire continues to be extensively used worldwide. New translations of the different versions (60, 30, 28, and 12 items) have appeared, including the test of the GHQ (28 items version,

Spanish) via the internet (Vallejo *et al.*, 2007). Specifically for the GHQ-12, new translations for various languages have been reported and these include: Hungarian (Ilona, *et al.*, 2007), Chinese (Ip, and Martin, 2006; Yongxin, and Yimin, 2006; Lee, *et al.*,2006; Ip, and Martin, 2006), Slovakian (Sarkova, 2006), Portuguese (Gouveia, *et al.*, 2003), Cantonese (Siu *et al.*, 2005), Finish (Lipsanen, *et al.*, 2003), Spanish (Lopez-Castedo, and Fernández, 2005), Japanese (Niiro, *et al.*, 2001), Bengali (Fuggle, *et al.* 2002) and Arabic (Daradkeh, *et al.*, 2001).

Studies on factorial invariance in different language versions have been done (Claes, and Fraccaroli, 2002; Makikangas, 2006) for assessing the independence of positive and negative items (Hu, *et al.*, 2007). Such studies found consistency and replicability factor structure in both data bases. Further analyses on sensitivity, specificity and discriminative validity (Preti, *et al.*, 2007) have been constantly performed. Also confirmatory analysis in other English speaking sample have been carried out, in Australia (Campbell and Knowles, 2007) and New Zealand (Kalliath, *et al.*, 2004).

The GHQ-12 has been used many interesting studies; for example the detection of postnatal depression (Navarro, *et al.*, 2007). Also, in different population samples such as hearing impaired (Fellinger, *et al.*, 2005a; Fellinger, *et al.*, 2005b) or facial disfigured (Martin and Newell, 2005) individuals. The GHQ-12 has been used in combination with other instruments to investigate mental health (Groom, *et al.*, 2003), including in Australia (Furukawa *et al.*, 2003). Further research has assessed the instrument's practical characteristics such as applicability (Aydin and Ulasahin, 2001) and cutting point (Joiner, *et al.*, 2002; Preti, *et al.*, 2007). All of the aforementioned studies confirmed that the GHQ-12 is a highly reliable instrument, thus supporting why it is widely used in different populations and for mental health screening.

3.2.6.2. Life Events Update

The result of 10783 articles about life events that were narrowed down to 628 articles related to questionnaires or any other word synonym of measurement may provide a fair idea of how extensive the study of life events is.

However, after narrowing down to 50 studies, a wide range of life events measures are reported in the literature. Negative life events and especially recent life events are reported as traumatic (Sherman and Sanders, 1998) or some of them are considered stressful (Green, *et al.*, 2006). Some of the questionnaires are in development (Chi, and Lin, 2005), or have been designed for children or adolescents (Costello, *let al.*, 1998; Liu, *et al.*, 1997) or have special life events (Lopes and Faerstein, 2001). When limited to 2001-2007 nine studies were brought, the search was limited by reliability and validity within five words near to life events. This strategy was adopted in order to make sure relevant new reliable and valid questionnaires were brought by the search.

There is a vast range of different life events (Turner and Wheaton, 1995; Sandin and Chorot 1993) and some of them have been translated into French (Baron, et al., 1991), into Spanish (Traver and Villar, 1996), into Chinese (Peng et al., 1992). The search of life events questionnaires focus on LTE-Q (Brugha et al., 1985) limited to years 2001-2007 produced the following three studies: Research in Canada with patients with SAD (Michalak, *et al.*, 2004), research with African-American mothers (Rankins, 2005), and research with homeless adults in central Florida (Zugazaga, 2004). The LTE-Q questionnaire is being used in a few studies, which may give the idea of that, is still an excellent option and a useful to show the presence in a short list of recent negative life events.

3.2.6.3. Empowerment questionnaire Update

The analysis of an up-dated search for power or empowerment questionnaires confirmed that the "Empowerment Scale" (Rogers *et al.*, 1997) is the appropriate

measurement of empowerment for this research. Translations into other languages such as Japanese (Hata *et al.*, 2003) or into Italian (Stratic *et al.*, 2007) have been done, both studies have analysed its psychometric proprieties.

After using filters 324 studies were considered relevant. On further examination 67 results were analysed. The search was done with the same strategy but limited to the years 2001-2007. Other questionnaires have appeared such as: The Psychological Empowerment Scale PES- (Chaoping *et al.*, 2006), Personal Progress Scale-Revised PPS-R (Johnson, D. *et al.*, 2005), Participatory Action Research Measure PAR (Axman, 2003) or the Powerless-Empowerment Scale (Shearer and King, 2001).

The PES (Chaoping *et al.*, 2006) has four subscales and excellent reliability coefficients reported (ranging from .90 to .97). The four subscales are: meaning, self-efficacy, self-determination, and impact. However its subscales do not comply to the full extent of the topics of empowerment that this study is interested in, particularly in the locus of control.

The report of the study of Hata and collaborators (2003), who applied the same questionnaire conducted in this thesis, indicates that low reliability of the retest mode was detected in the empowerment subscale and that the powerlessness-empowerment subscale has been assessed and reported only in one study.

Further analyses of the results of this search show that The Empowerment Scale (Rogers *et al.*, 1997; Wowra and McCarter, 1999; Corrigan, *et. al.*, 1999; Perkins, 2001; Hardiman, 2002; Hutchinson *et al.*, 2006) is the most frequently used of all questionnaires reported up to the present in the topic of empowerment and power. It is confirmed that the subscales 'Self-Esteem-Self-Efficacy', 'Power-Powerlessness', 'Community Activism and Autonomy', 'Righteous Anger' and 'Control Over the Future' offer good reliability and factor analysis. All the questionnaire subscales proved to be ideal for this research because they have

been constructed based in the concept of focus of control (created by Rutter, 1966), which supports the concept of inner power studied in this research.

3.2.6.4. Coping questionnaire up to 2007

From an updated search of coping and resilience measures 74 studies were analysed, the search was focused on questionnaires that reported its reliability and validity limited by the years 2001-2007. A wide range of coping measures have appeared in this years, instruments from adaptiveness of coping (Kohn, *et al.*, 2003), coping response (Aguilar-Vafaie, M. E; Abiari, M. 2007), coping self-efficacy (Chesney, *et al.*, 2006), multimodal coping inventory (Craig, 2006), the ARBQ (Ginzburg, *et al.*, 2006) for survivors of child sexual abuse but needs further validity. The resiliency scale for adults (RSA) has not been tested sufficiently (Friborg, et al., 2006) it measures coping for specific situations such as religious matters or illnesses.

The "Locus of Control Scale" (Cousson-Gelie, et al., 2005) was used in combination with the Ways of Coping Questionnaire to find psychological predictors of adjustment in survivors of breast cancer.

Other questionnaires have been tested in languages different to English, such as the COPE inventory, that has been translated into Turkish language but it has been particularly developed to detect the negative consequences of stressful life events (Agargun, et al., 2005).

Guppy and collaborators studied a Cybernetic Coping Scale in its short version of 20 items from which 15 items revealed to be a better source for this scale (Guppy, *et al.*, 2004). Willner and collaborators evaluated anger coping management for people with intellectual disabilites with the Profile of Anger Coping Skills (PACS) (Willner *et al.*, 2005).

Aguilar and Abiari (2007) found a relationship between coping to physical and mental health outcomes. However, another study in Mexico about religious coping in older Mexican adults was conducted using the IMSOL Religious Coping subscale (Rivera-Ledesma and Montero-Lopez, 2007). The Billings and Moos Coping Checklist was conducted to investigate its psychometric properties in a sample of 514 undergraduate students compared to 119 patients awaiting elective coronary artery bypass graft surgery. Four factors were detected: (1) Positive reappraisal; (2) Seeking support; (3) Avoidance; and (4) Information seeking. However the Ways of Coping Questionnaire is more reliable and has a wider range of scales (Oxlad, *et al.*, 2004).

Specific studies on the Ways of Coping Questionnaire (WOCQ) have been conducted, such as: reliability generalisation to identify variables that contribute to score reliability for this specific questionnaire (Rexrode, 2005). Examination of its psychometric properties and validity of The Ways of Coping Questionnaire in a study conducted with Spinal Cord injured persons; the authors recommend condition-specific measures of coping strategies to increase the validity of the questionnaire (Elfstrom, *et al.*, 2005). The Ways of Coping Questionnaire has been compared with other measures such as: the SVF120 (a situational WOCQ-like version) reported by Weyers, *et al.* (2005).

The Ways of Coping Questionnaire has been used in further studies on coping strategies, for example Ginsburg studied a sample of Russian migrants and its coping skills in relation to marital satisfaction patterns, the results of this study revealed that the reliability of the Ways of Coping Questionnaire was very low (Ginsburg, 2002), perhaps because of the lack of standarisation for that specific type of sample.

It has been translated into Swedish (Ahlstrom, and Wenneberg, 2002) to research a sample of patients with muscular diseases. Several researchers continue to use the Ways of Coping Questionnaire and it has been proven to be valid measure (Rexrode, 2005, Elfstrom, *et al.*, 2005).

Analysis of the Systematic Review on The Ways of Coping Questionnaire shows that although this instrument has been criticized for not having sustained reliable scores; its frequent use by researchers shows that is one of the most valid and practical questionnaires in coping research.

3.2.6.5. Trauma questionnaire update to 2007

An updated search up to 2007 was conducted, with the aim of looking for reliable and valid questionnaires on symptoms of trauma. Different strategies were used. New instruments have been designed such as: the Childhood Maltreatment Questionnaire (Demare, 2001; Higgins, and McCabe, 2001). However, these instruments have not been adequately tested to prove their validity and reliability. For example, Higgins and McCabe (2001) consider all the different types of abuse that this research considers, however their tool does not evaluate the symptoms of trauma. In light of these limitations it is reasonable to use the TSC-40 for the purpose of this research.

A further systematic search was conducted to find out if there was any further development to the TSC-40 tool. Descriptors such as 'trauma symptoms' 'checklist,' 'limited to adulthood (18 years +)' were used. 101 results were limited to years 2001-2007. It gave a total of 36 studies. Further analysis of these studies was undertaken.

Results show that the TSC-40 has been used in many studies within an extensive range of psychological characteristics including: self harm (Polk, and Liss, 2007), risks and resistance factors (Gumundsdottir *et al.*, 2006), hopelessness and neuropsychology (Hill, Juan R. 2005), posttraumatic stress disorder PTSD (Elklit, *et al.*, 2005; Elklit and Brink, 2004), or trauma in survivors of natural disasters (Bodvarsdottir and Elklit, 2004).

3.3. Phase 2. Methods of the survey

The questionnaire[8] resulted of the previous study, was conducted as an important component of this project. It attempted to isolate both the prevalence of childhood abuse among psychotherapy practitioners, to investigate variables as power and coping strategies, to consider recent life events and emotional health, and also to explore if childhood trauma was overcome in later years. Therefore, in this section, we shall examine how the questionnaire was applied in the field, and examine the methods of this quantitative aspect of the project.

3.3.1. Introduction

Firstly, after restating the research question and the hypotheses, the methodology of the project will be described in detail. This will be followed by the results of the questionnaire, with socio-demographic characteristics being reported first; secondly, the incidence of child abuse will be reported. Following this, an explanation of the results will be offered with regard to various specific factors that are important to this project, namely: emotional health, child abuse, life events, coping skills and power. An explanation of the ethics process will be given at the end of this section.

3.3.2. Aims and Objectives

This study aims to uncover the prevalence of childhood abuse within a sample of psychotherapists and counsellors, as well as understanding how they have overcome such abuse. The objectives pursued are as follows:

(a) To isolate the effects of childhood abuse on professional practice.

(b) To understand the emotional state of the respondents.

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[8] The questionnaire is in Appendix 1

(c) To determine if there is a recent life experience that could alter the actual emotional state of the practitioners or if there are ongoing trauma symptoms as a result of child abuse.

(d) To detect if there is significant variation in symptoms of trauma between practitioners who experienced child abuse and practitioners who did not; and whether or not any such difference is related to an effect on the emotional state of the subjects.

(e) To examine the coping strategies employed by the abused respondents.

(f) To isolate ways of coping leading to resilience which are used by subjects who have suffered child abuse.

(g) To determine if there is a relationship between the ways of coping and the abuse suffered by respondents.

(h) To discover whether or not power is related to resilience, and if it is, what kind of power facilitates resilience in childhood abuse trauma.

(i) To determine if the effects of childhood abuse are related to the way power is experienced.

3.3.3. Research Questions

Studies examining professionals report the experience of childhood abuse within practitioners and professionals in mental health (Nuttall and Jackson 1994; Follette et al, 1994; Elliott and Guy, 1993; Elliott and Briere, 1992; Pope and Feldman-Summers, 1992; Howe, et al. 1988). There is little research that investigates the numbers of psychological health professionals who have suffered child abuse (Nuttall and Jackson, 1994, Follette et al, 1994; Pope and Feldman, 1992). However, findings tend to suggest that there is a relationship between child abuse and psychotherapy practice. It is in the interest of this research to uncover the prevalence of child abuse within the professional community of psychotherapy and counselling practitioners, and to know whether childhood abuse is a factor for some individuals to enter in the psychotherapy profession.

Psychotherapy aims to help patients overcome powerful personal problems. As part of the training that underpins this difficult work, psychotherapists themselves must undergo rigorous psychotherapy at regular intervals. As a group, psychotherapists may be in a good position to provide information about whether (and how) psychotherapy can help develop resilience to emotional trauma. In pursuit of this, the questionnaire explores the opinions of psychotherapists regarding their own health, coping strategies, sources of empowerment and experiences of childhood abuse trauma. As recent life events can also affect the present emotional health of practitioners, the questionnaire also explores recent life events.

It is important to determine if psychotherapists who report being abused in childhood retain symptoms of this trauma in adulthood, and how they have managed to overcome childhood abuse trauma. This is because these details can reveal whether or not psychotherapy helps to surmount trauma, and in what way healthy psychotherapists can provide adequate help to their clients. With regard to how practitioners overcome childhood abuse, this research question states that practitioners who report childhood abuse would probably have low scores of childhood abuse trauma in the TSC-40 compared with practitioners who do not report abuse. Regression analysis is also used to analyse the relationship between the results of the GHQ-12, life events, and the TSC-40. Moreover, the 'Ways of Coping' questionnaire expands this issue and deals with the various strategies which each survivor can apply to their post-trauma lives.

Following on from this examination of specific coping strategies and power, it will be considered how resilience can be developed. In regard to this issue, the 'Ways of Coping' questionnaire will be further examined with reference to the type of abuse suffered by respondents to determine if there are any observable patterns to the development of resilience in later life.

The next related research question examines whether or not power is related to resilience. This question will be explored by the correlation of the empowerment

questionnaire and the ways of coping questionnaire with the respondents who report child abuse.

Another research question is if power is related to resilience, then is there a specific type of power that facilitates resilience to recovery from childhood abuse trauma? This hypothesis states that there is a relationship between the effects of childhood abuse and the ways power is reflected. This is explored by the correlation of the empowerment scale and the (low or high) scores of the TSC-40 within the group of practitioners who reported abuse in childhood.

The final research question explores whether there is a relationship between the effects of childhood abuse and if 'dominance power' (Elworthy, 1996) is reflected in such experiences.

3.3.4. Methods

The survey was based on a quantitative approach. Its purpose was to reveal the prevalence of suffering childhood abuse amongst a sample of psychotherapists. As well as discovering whether, and how psychotherapists have overcome childhood abuse trauma, it will also discover if this resilience and power are related. The questionnaire described has eight sections and it is explained in this chapter.

3.3.5. Study Design

This survey uses a core questionnaire (Appendix 1) structured by five standardised scales with established reliability and validity. This is a non-experimental study. It has a correlational design utilizing cross-sectional survey methodology that uses a core questionnaire as a research tool.

The questionnaire survey was sent by post to the willing respondents of an invitation letter sent through the UPCA (Appendix 2 –Information Research). Their members were the participants of this study. The postal method was chosen for obtaining respondents' views because it was cost effective, it was less time consuming, and provided easy access to geographically dispersed subjects. Since personal contact was not made by this method it offered the potential of producing more honest answers. It also offered respondents the opportunity to consider their response at their own convenience.

In general terms, the items were fixed-choice questions that varied from two choices to four choices depending on the structure of each scale (for more details please refer to phase 1 of this Chapter). There were only three open-ended questions in Section 7 and in the whole questionnaire. Two questions (7.2 and 7.3) were designed in visual analogue form to allow finer comparisons between participants. Items for section 7 and 8 were phrased clearly and pre-piloted and piloted in order to avoid ambiguity in answering as well as to avoid any overlap. The instrument had 180 questions in total and took an average of 40 minutes to complete. The study design comprises a pre-pilot, a pilot and the actual survey.

3.3.6. Study Process

To facilitate feedback of the questionnaire, a pre-pilot study was conducted with five psychotherapists, whereby the intended instruments were administered. Based on their feedback, the instrument was refined (for details see Chapter 4).

A pilot study was applied by recruiting a sample (10 professionals) through the membership list of the members of Universities Psychotherapy and Counselling Association (UPCA). It must be noted that this is a voluntary organization: it is not connected with the NHS in any way. The NHS may employ some members. However, this employment status is not related to their membership of the UPCA

or to their recruitment for this study. This research was not conducted through the NHS.

The pilot study explored a number of issues: how well the questionnaire worked; which questions could be eliminated to make it shorter; whether questions in Section 7 needed to be re-worded or not working well, and what general improvements in administration could be made. An analysis was made of the responses to help with the estimation of the sample size for the main study. The survey population consisted of members of the UPCA. The results of the pilot study are reported below in this Chapter.

3.3.7. Operational Definitions of the Questionnaire

Below are the operational definitions used.

a) Resilience: 'Overcoming Trauma' scores showing no significant trauma symptoms in the group of participants who suffered child abuse, information collected through the TSC-40 questionnaire.

b) Recent life events: information collected by the 'List of Threatening Experiences' (LTE-Q, Brugha, et al, 1985; Brugha and Cragg, 1990).

c) Emotional general health: information collected in 'General Health Questionnaire-12' (GHQ-12 Goldberg and Williams, 1988).

d) Coping processes: information collected through the 'Ways of Coping Questionnaire' revised version WAYS-R (Lazarus and Folkman, 1988),

e) Symptoms of child abuse trauma: information collected in the 'Trauma Symptom Checklist-40' (TSC-40, Briere and Runtz, 1989)

f) Empowerment: information collected in the 'Empowerment Scale' (Rogers, et al. 1997).

f) Impact of childhood abuse on respondent's practice. Section 7 will show the concept of childhood abuse on respondents' practice.

g) Dominance Power: power over others demonstrated by the practitioner collected by the information in section eight of the research tool.

3.3.8. Instrument

The core instrument was designed by considering: (a) its validity and reliability, (b) its suitability for adults (c) and the possibility of has been tested before with a sample of survivors of childhood abuse. The instrument includes questions for the assessment of childhood trauma, ways of coping, general health, power and recent life.

The chosen questionnaires were selected to fully cover childhood traumatic events: physical abuse, emotional abuse, sexual abuse, neglect and witnessing domestic abuse. Only those questionnaires applicable to adults were considered. Variables were included on type of abuse, perpetrator of abuse and traumatic impact on the individual.

3.3.9. Applying The Questionnaire

The questionnaire survey was constructed in three different steps. Initially, 390 letters were sent out inviting psychotherapists to participate in the survey (Appendix 2). Fifty sets of letters were sent out each week taking approximately eight weeks. Each envelope included an information research letter; a consent form (Appendix 3) and a pre-paid envelope.

Table 3.18 Outcome questionnaire procedure

	N
Total in population –pilot not included-	390
Total invitations returned	137
Agreed to participate	124
Total of questionnaires sent out	124
Total returned	52
Total 1st reminded	72
Total 2nd reminder	20
Total re-sent for completion	8
Total questionnaires completed	103

Table 3.18 shows that in total, 137 individuals responded to the invitation. However, 16 respondents did not agree to participate, though on further appeal 3 of these eventually accepted (Appendix 4). Thus, a total of 124 questionnaires were finally

sent out. To encourage answering the questionnaire and facilitate relaxation at the time of answering the questionnaire, a small paper bag with tea, coffee and sugar sachets was also included. This procedure was applied following the requirements that the ScHARR Ethical Committee established for this survey. Two stages of reminder letters[9] (with another questionnaire copy) were sent out to those who did not return their questionnaire. In addition, 12 questionnaires were sent back asking respondents to complete some details or missing scales (See appendix 7). The set questionnaires included an information letter (Appendix 8), a questionnaire (Appendix 1), a bag with a tea-coffee-sugar sachet, and a free-post envelope in all the rounds. A total of 103 completed questionnaires were returned. The response rate was 103/390=26.4% of overall group and 103/124=83% of the final sample (see Table 3.19).

Table 3.19 Response rate outcome

	N	% Total sample	% Willing to participate	% Respondents total
Sample Size	390			
Actually responded	137	137/390=35.1%		
Willing to participate	124	124/390=31.7%	124/137=90.5%	
Actual Response	103	103/390=26.4%	103/137=75.1%	103/124=83.0%

3.3.10. Sampling

The sample group for this research were psychotherapists and counsellors who were recruited through the membership list of the members of the Universities Psychotherapy and Counselling Association (UPCA). The whole membership population was invited to participate in the study. The population of the UPCA is 65 percent female and 35 percent male. A self-selected sample resulted from this invitation with the members who volunteered to take part in the study. A cross-sectional design was decided for comparing the groups of professionals of the

[9] Please see Appendices 5 and 6

UPCA (a) who reported experienced of any type of child abuse and (b) those who did not experience child abuse.

3.3.11. Data Entry

The quantitative data collected was double entered onto a computer database and data entry errors identified by matching the two data entry files using a validation facility EPINFO version 6.01b. Data entry was carried out by two individuals (the researcher and a research assistant of ScHARR). All errors were corrected with reference to the original questionnaires, and a final validated data file produced. Data Analysis was undertaken using the statistical analysis software SPSS version 11.5 and 12.

3.3.12. Data Analysis Process

The researcher checked the data, examining it for invalid or missing values. It was decided that fewer than 5 percent missing data was acceptable. Where more than 5 percent was missing, information could be provided, but readers would be made aware of the shortcomings. The number of valid answers and percentage differences would also be provided. After the data was double entered, differences between files were directly checked with the questionnaires and identified. 572 errors were found. Next, a correction of the numbers wrongly entered was made on a SPSS file and saved in a new renamed file. Missing values in the questionnaires were labelled with the number 9.

A full description was produced of the survey responses. A combination of simple correlation analysis and more complex multivariate regression analysis was employed to investigate a variety of potential relationships between the different questionnaires of the whole instrument. Analyses were carried out across the

whole cohort and also by sub-groups (i.e. child abuse experience, type of abuse, sex) to identify any variation between cohorts of sub-groups.

3.3.13. Survey Process

After analysis of the pilot study, corrections and improvements were made to the questionnaire to apply in the survey proper, before a study with the UPCA was implemented. The UPCA sent the set containing an information research letter, a consent form and a pre-paid envelope. This survey provided information about (a) the prevalence of psychotherapists abused as children; (b) the effects of child abuse on health and the quality of life in survivors in this kind of professional group; (c) the resilience factors; (d) how power works in the resilience process of child abuse analysed from a feminist perspective; (e) how power functions in the resilience process of childhood abuse in the background of different kinds of professional psychotherapists.

3.3.14. Ethical Procedures

The following section focuses on the ethical principles of proceedings that underpin this study. A protocol of this research was submitted to obtain ethical approval. Corrections and suggestions were made and followed in this survey.

This study is concerned with following the principles (autonomy, non-maleficence, beneficence and justice) and rules (veracity, privacy, confidentiality and fidelity) of ethics, and the ethical principles of psychologists respecting... *"the dignity and worth of the individual and the preservation and protection of fundamental human rights"* (APA[10] cited in Anastasie, 1988:665).

[10] APA American Psychological Society

According to the principle of autonomy, informed consent was obtained (Appendix 3). There was an information sheet in a covering letter format (Appendices 2 and 8). The participants had the option of not filling in the questionnaires. The subjects also had the right to leave the research any time they wished.

Questionnaires were selected according to characteristics of validity and reliability, tested and probed by international studies. These were administered by mail; a number system was employed to protect the anonymity of the subject identified in each questionnaire.

With regard to the non-maleficence principle, it should be emphasised that this investigation was a non-invasive study. Thus personal data was kept in confidence. Likewise, the research participants were treated fairly.

The results of this research are reported truthfully and accurately. Subjects were asked to tick a box if they agreed to participate in the study, and in the questionnaire they were asked to do likewise if they agreed to take part in an interview (page 14 of Appendix 1). All these procedures were submitted to the ethics committee of ScHARR in 2001.

Firstly, the development of the instrument of investigation (questionnaire) was made. Secondly, the research project was submitted to the ScHARR Research Ethics Committee (SREC). Finally, at the beginning of 2002 the researcher contacted the UPCA to enquire if it would be possible to conduct research with their members. The corrections on the research project, suggested by the Ethics Committee at that time, were made. Acceptance for the research was obtained from the SREC on the condition that corrections on the questionnaire procedure were made. This included a correction of the questionnaire procedure where an invitation letter 'Information Research Letter' (Appendix 2) and a Consent Letter (Appendix 3) were sent through the Universities of Psychotherapy and Counselling Association (UPCA). Those needed to be mailed and consented to, by the participant without including the questionnaire. Then, after receiving back the

acceptance letter (Appendix 3) already signed, the questionnaire (Appendix 1) could be posted to the participant. A pilot study following these procedures was conducted with ten members of the UPCA. The survey procedure to contact participants was followed as advised by the SREC by (a) sending initial contact letters with the assistance of the UPCA (Appendices 2 and 3); (b) they contacted their members by a set of initial contact letters and a consent form (Appendices 2 and 3) that the professionals interested returned to the researcher in a prepaid envelope; (c) The informed consent was received (Appendix 3); and (d) a set the questionnaire materials was mailed to those willing to participate in the study (Appendices 1 and 8).

With the support of my supervisory panel at that time, I tried to persuade the Ethics Committee to shorten the steps of the research process (by including the questionnaire with the invitation letter) that they had established for the study, in order to improve the poor response rate (2 out of ten).

The results of the small pilot study were sent to the Ethics Committee proving how the response rate was affected. This request was not approved.

The sets of information research letters were sent out at the beginning of February to follow the procedures that the Ethical Committee had previously established. An attempt to avoid giving excessive work to the UPCA, the association helping the researcher to circulate the invitation letters among its members, I sent out weekly a package of 50 sets (each one included: an information research letter, a consent form and a pre-paid envelope), until all the 400 members were contacted (10 for the pilot, 390 for the survey).

3.4. Phase 3: Methods of the interview study

The quantitative study of the Research in Surmounting Child Abuse was conducted (questionnaire design[11], participation consent[12], pilot questionnaire, and survey). As stated in the general research protocol (already submitted to the ScHARR Ethical Committee), a qualitative study must be applied in order to gain more in depth knowledge about the factors that have been identified as important to the process of overcoming child abuse. Participants had been already asked (by the survey) to participate in the study[13]; therefore the researcher knew that there was a sample already willing to take part in the interview study.

One focus of the proposed qualitative study is to examine whether female psychotherapists use the language of power in its different options such as dominance power, inner power, and empowerment to explain resilience, and whether the reports of women about power differ as feminists suggest (*i.e.* dominance power).

This is a retrospective study. Its purpose is to explore in more detail the strategies that the interviewees when children used to gain inner strength and help them to overcome the trauma of childhood abuse. Another aim is to explore if there is any relationship between the imagination and creativity in empowering them towards resilience.

The method used to explore these issues was through two series of in-depth semi-structured interviews to six participants willing to take part in a follow-up interview to the survey previously described. This approach was chosen to collect more detailed information with the aim of understanding the relationships between power, imagination and resilience in the experience of childhood abuse. The main aim of the study was to understand how the participants developed the personal resources to make creative and conscious use of the experience of childhood

[11] Phase 1 of this Chapter
[12] Appendices 2 and 3
[13] Page 14 of Appendix 1

abuse, and to inform their practice as professional counsellors and psychotherapists. The design allowed the application of Interpretative phenomenological analysis under a feminist scheme to honour women's voices.

3.4.1. Justification

The use of qualitative methods in psychology has increased significantly in recent years (Giles, 2002). Qualitative methods can be more appropriate when investigators are "opening up" a new field of study or are primarily concerned with identifying and conceptualising salient issues (Fitzpatrick and Boulton, 1994). Interviews are an accessible method of qualitative inquiry. There is no previous research that (a) identifies inner power, (b) relates power and overcoming trauma, or (c) power and resilience on childhood abuse. Different types of power have been identified in Feminist research, i.e. dominant power, empowerment and disempowerment. However, there is no research reported in the literature that investigates the power over self or inner power. Moreover, there is no investigation of what may be the faculty[14] of this inner power. Further, there is no reported research that provides knowledge about whether or not power is related to overcoming trauma or how the different types of power could be related to childhood abuse.

3.4.2. Antecedents

The participants already stated their willingness to participate, in this interview research. They were all asked to complete a questionnaire[15] by a Consent Form[16] and Information Research Letter[17] sent through the Universities Psychotherapy

[14] Faculty: category to describe the place that originates/generates/feeds power.
[15] Appendix 1
[16] Appendix 3
[17] Appendix 2

and Counselling Association. Questionnaires were then despatched to members willing to receive such literature. The questionnaire included a section, asking participants to indicate whether or not they would be willing to be contacted for subsequent interview (see Page 14 of Appendix 1). From the 400 consent letters sent to the UPCA, 137 were received agreeing to take part in the interview study (34.5 percent of the population). Sixteen of them did not agree to participate in the survey. 124 questionnaires[18] were sent out and a total of 103 were completed and returned. The response rate to the agreed questionnaire[19] was 103/124. Of the respondents, 35 percent were men and nearly 65 percent were women. 43 percent of the participants had no experience of child abuse whereas 57 percent did. Of the whole cohort, 62 participants stated their willingness to be interviewed.

3.4.3. Aims of the Interview Data

This qualitative study is designed to interview participants who may illustrate the characteristics of the different types of child abuse considered in this study. This is based on the method of stratified purposive sampling, which *"illustrates the characteristics of particular groups of interest and facilitates comparisons"* (Wengraf, 2001). Studying the classification made in Great Britain, derived from the Department of Health 1988 guidelines (DoH, 2000), five categories of child abuse were considered: physical abuse, neglect, emotional abuse, sexual abuse and grave concerns (DHSS, 1988). Initially, the objective was to study ten cases (two cases of each type that this study is taking into account: physical, sexual, emotional, neglect, witnessing of domestic abuse) plus a case with combination of all components – as a pilot interview. However, reconsideration was made on the basis of time and money because travelling around the United Kingdom was involved, and it was decided to have six interviews based in the typology already explained. Variables as the frequency of abuse, onset and termination of abuse and severity of abuse were considered important to include.

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[18] Appendix 1
[19] Appendix 1

3.4.4. Area of Importance

Empowerment is a very important concept in Feminist theories: it focuses on how people gain control and power over themselves. For example, child abuse trauma is an issue where power and control exists in unequal state in child-adult relationships: the adult did not offer protection and love but instead inflicted abuse. Empowerment is a process that could be involved in the recovery from an abusive experience. This research aims to find what are the processes and factors involved in gaining the power to overcome child abuse. Research in this area has not been conducted before. There is thus very little literature (PsycINFO search considered) on the relation of empowerment to resilience in research on childhood abuse trauma.

The new data that this research will provide will ascertain if imagination and creativity in female psychotherapists/counsellors builds inner power, and helps to develop the personal capacities needed to overcome childhood abuse. Data will be analysed using the interpretative phenomenological analysis method.

3.4.5. Study Design

In-depth, semi-structured interviews were conducted to obtain more detailed information than is possible using a survey. The interviews allow the researcher to access how subjects create and construct meaning from their experience. Qualitative research "is designed to observe social interaction and understand the individual perspective, (and) provides insight into what people's experiences are, why they do what they do, and what they need in order to change" (Rowan, and Huston, 1997). Such interviews helped the researcher to understand further the relationship between power, empowerment, imagination and resilience to childhood abuse, and to clarify that an understanding of power helps individuals to overcome this trauma. The interview research consists of in the following sections:

a) The pilot (Appendix 9).
b) The main interview (Appendix 10).
c) The review of the transcript with interviewee (Appendix 11).
d) Data analysis using IPA method to codify and interpret data (Appendix 11).
e) Follow up (Appendix 12).

This qualitative research will explore how the interviewee has used creativity and imagination to develop the personal capabilities needed to achieve resilience. It will also investigate how interviewees make conscious use of the experience of childhood abuse in such a way that it informs their clinical practice. This proposal suggests that a feminist framework be used so that power in its different forms can be explored. The proposed analysis is through the Interpretative Phenomenological Analysis (IPA).

3.4.6. Method

This qualitative research is designed to understand how the individual interviewees developed the personal resources to make creative and conscious use of the experience of childhood abuse and to inform their practice as professional counsellors and psychotherapists.

Data was collected from women respondents in a Survey (for more details please refer to phase 2 of this chapter) who have suffered childhood abuse and already agreed to participate in the present proposed interview study[20]. It was planned that data collection should start as soon as the ScHARR Ethics Committee approved this part of the research. A pilot interview[21] was conducted in order to check research prompts and probes. A semi-structured interview[22] with open-ended questions was used as a research method. The participants were contacted again

[20] See page 14 of Appendix 1
[21] Appendices 9 and 15
[22] Appendix 10

by a standard letter (including the interviewer presentation, the information sheet,[23] a Flow Chart of the interview process [24], and the informed consent [25]). Subsequently, if necessary, telephone contact and/or email[26] were used. In order to have validity analysis, another researcher helped to analyse the interviews only to verify agreement or disagreement in the inclusion of the meaning units specifically for the inner power in general. This validity analysis was made to provide rigour[27] to the study of inner power. Classification of themes, analysis of the data, reconstruction of the elements of the category of inner power, all the analysis of the interview study and the rest of this thesis were made by the author of this thesis. Participant verification and opinion is considered as an important part of the process, empowerment of the participant in the research process and transparency of the interview study.

The method that was employed can be described under the following headings: (a) subjects (b) sampling (c) research questions (d) ethics (e) interview process.

3.4.7. Subjects

This stage of the research comprises six semi-structured in depth interviews. These will serve as case studies to explore how survivors of child abuse have overcome their experience, how different types of power were constructed and how it has informed their professional practice as psychotherapists

3.4.8. Sampling

The size of the study was not determined with a formal sample size calculation. As this is an interview stage study, a statistical formal sample size calculation is not

[23] Appendix 13
[24] Appendix 17
[25] Appendix 14
[26] Appendices 16 and 18
[27] According to Smith (2004) Rigour "refers to the thoroughness of the study".

considered appropriate. It is, however, based in Patton's typology of purposive sampling (Wengraf, 2001).

This study aims to use one case study for each category of child abuse contemplated in the survey and examines: sexual abuse, physical abuse, emotional abuse, neglect and witnessing domestic violence (as a main issue of grave concerns classification). Participants are all women and the study considers the following inclusion criteria:

(a) Willingness to be interviewed.
(b) High participant resilience.
(c) High empowerment (taking into account the results of the questionnaire) and,
(d) Female gender.

It was intended to ensure that all types of child abuse experience were represented in the selected sample, using the empowerment score to select individuals with the highest scores in each type.

A following letter sent by post directly to respondents recruited the participants (see Appendices 13, 14 and 17). However, a consent form was presented at the interview for signing by the interviewee (Appendix 14). This included details of the boundaries of confidentiality during the interview, the storage of recorded data, and the final transcript. The participants were contacted by post, telephone, and/or email to arrange the time, place and details of the interview (appendices 16 and 18).

Initially, it was planned to have 10 interviews based on two of each of the five different types of child abuse (physical, sexual, psychological, child neglect and witnessing of domestic violence) plus a type where a mixture of the different types of child abuse were reported by the questionnaire respondents. Later, it was decided instead to have six interviews based on one of the five different types of child abuse (physical, sexual, psychological, child neglect and witnessing of

domestic violence) plus a type where a mixture of the different types of child abuse was reported by the questionnaire respondents. This number was chosen as a representative sample of case history interviews that would enable comparisons to be made both across, and within, the categories of abuse experienced. However, in practice, this was not possible (see the Results Section for further details).

Potential participants were identified because they have already stated their willingness to participate or not in this interview research. Previous to the survey, all of them were asked to complete a questionnaire by a Consent Letter and Information Research Letter sent through the Universities of Psychotherapy and Counselling Association. Questionnaires were then sent out to members willing to receive them. The questionnaire included a section, which asked participants to indicate whether or not they would be willing to be contacted for subsequent interview. All participants were both U.K. citizens and English speakers.

3.4.9. Location

The research was conducted in different places. Locations for the meetings were at a place agreed with the participants. The location of the interviews in the practitioner's place of work was deemed most appropriate as the research is related to their professional life. Because the psychotherapists are in different parts of the country, it was considered better for the researcher to go to the participant's city and ideally, the place where the interviewee's profession is conducted. In the event that the psychotherapist or counsellor did not have a private workspace, a safe alternative location was agreed by phone with the partaker. The majority of the interviews took place at the interviewee's homes.

3.4.10. Objectives and research questions of the interview study

The interview study will follow the next objectives and research questions:

The objectives of the interview study are:

a) To find out how female psychotherapists may have used imagination to help overcome childhood abuse.

b) To map out the psychological factors and processes involved in the development of the personal skills to make creative and conscious use of the experience of childhood abuse in their professional practice.

c) To explore whether the use of different types of power such as dominance power, inner power, powerlessness, and empowerment can help survivors to explain their resilience.

The research questions of the interview study are the following:

1. Central research question:

What helped female psychotherapists to overcome the abuse?

2. Particular theory questions:

a) What are the psychological factors and processes involved in the development of the personal skills to make creative and conscious use of the experience of childhood abuse in their professional practice?

b) Are there different types of power that can help survivors to explain their resilience?

c) Is it imagination involved in the exercise of inner power?

3.4.11. Ethics

It is important to consider the possible ethical issues and problems that may arise in the proposed study.

The interviews included psychotherapists and counsellors, all of them members of the UPCA (Universities Psychotherapy and Counselling Association) who had been abused as children. The interview schedule enquired into the impact of this abuse and the processes used in overcoming it. Therefore some of the questions could be upsetting to some recipients. The information sheet[28] and informed possibility interview consent letter[29] warned of this and it has suggested that should contact their supervisors if they had any doubts on this matter. Participants had one week at least to confirm their participation to the study.

The permission of the UPCA was obtained in order to contact their members who were willing to be contacted for a following research.

Participants did not receive any payments or compensation for taking part in this specific study. A printed article or report of the research was promised to those who showed an interest in knowing the results of the research. Informed consent was obtained from interview participants[30]. The main researcher obtained it by post and/or in person. An information sheet and a Flow Chart about the research interview was previously posted to participants. (Please see Appendices 13 and 17)

The interviews were electronically recorded following the signed consent of the participant. After the transcription had been produced and corrected/accepted by the participant, the recordings were deleted from the computer using software called 'cyberscrub' that wipes and erases data with methods that far exceed US Department of Defence Standards for file deletion DOD 5220.22. Music or other data was recorded instead.

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[28] Appendix 13
[29] Appendix 14
[30] Appendix 14

The potential benefit for the research participants is that they can talk, share and correct their own interview comments within a certain time, and that this process can also be cathartic/therapeutic and empowering. Furthermore, knowledge of the factors that increase resilience can contribute to improving their work as a psychotherapist and may help to improve psychotherapeutic strategies. The application and widespread dissemination of such knowledge can help childhood abuse survivors to promote psychological health and improve their quality of life of survivors of child abuse. Knowing how an understanding of power informs resilience is valuable in helping survivors of child abuse overcome trauma, as well as adding to current psychological theory. The knowledge obtained by this research therefore has both theoretical and practical applications: it can be used in both academic research, and in childhood abuse treatment, education and therapy.

Due the sensitivity of the topic, potential discomfort or distress could be caused to research participants by some of the interview questions[31]. Awareness about this issue was made through the information sheet[32] of the research. It is stated in the informed consent[33] that no responsibility will be taken by the researchers or ScHARR if emotional stress is caused by the research.

The potential risk of discomfort and/or embarrassment for the researcher could possibly be (a) misunderstandings caused by cultural differences and Spanish accent of the researcher, and (b) delays incurred by traveling to interviewee's chosen location. The Interview Sheet[34] stated the boundaries of the researcher's confidentiality. The interviewee's disclosure of any risk of harm to vulnerable adults and/or children would necessitate the researcher reporting this to the police.

Measures to ensure confidentiality such as an anonymisation procedure by coded number was applied in the survey. In the interests of confidentiality, a number will change interviewees' personal data details and interviewees will have the chance

[31] Appendix 10 and 12
[32] Appendices 13 and 14
[33] Appendix 14
[34] Appendix 14

to have a copy of their interview transcript if they so require[35]. No personal identifying feature will be mentioned on the tape. Also they can 'vet' any information on the recording of the interview if they wish, within 2 days after receiving the transcript. The main researcher, the supervisor researcher and a transcriber of the interviews (while the interview is being transcribed) had access to the data generated by the study.

3.4.12. Sampling

A stratified purposeful sampling for collecting data was chosen to ensure the representation of all characteristics of the particular types/combinations of child abuse represented in this research as well as the selection of participants who obtained higher scores on empowerment. This choice was made to have a clear base to develop the emerging theory and facilitate comparisons. The researcher is aware that the findings cannot necessarily be generalised.

3.4.13. Inclusion/exclusion criteria

Different characteristics were selected for this study: (a) Due to the feminist nature of this study, there is a genuine interest to study women and consider how women have overcome the abuse. (b) Initially the inclusion criteria required was that a participant of each type of abuse was going to be studied and a participant with the most variety of types was going to be selected as an opposite case. However, due to the several problems encountered in practice there was a need to understand better the real nature of the sample. (c) Due to the interest in power and empowerment, the researcher decided to analyse participants with the highest mean scores on the empowerment questionnaire, and one case was selected as opposite case.

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[35] Appendix 17

Abuse does not follow neat and tidy patterns that could be chosen clearly by a researcher. Indeed in the original survey out of 32 possible patterns of abuse only 9 occurred in the sample. Early on it was obvious that single abuse was for some patterns very rare and that a second abuse nearly always happened. Several approaches were tried to draw a sample.

3.4.14. Initial sampling technique

Participants were first classified according to the type of abuse (sexual, physical, emotional, neglect, witnessing domestic abuse) and scored according to the severity of that abuse. The top ten were then to be drawn from the sexual group and the top five from each of the other groups. The following practical problems were faced.

3.4.14.1. Problem 1

There was nobody in the witnessing group who experienced a single type of abuse as such, thus the researcher could not draw five people from it.

Modification 1

As sampling technique 1, but five participants from the remaining abuse categories who had also witnessed domestic abuse.

3.4.14.2. Problem 2

There was considerable overlap between the groups (see Table 3.20). By default the fifth group included participants who would otherwise have been in the other groups. Also it had not been noticed that males had incorrectly been included in the sample. The researcher and the statistician also became increasingly aware

that rarely was one type of abuse reported without one or more of the others also being reported.

Thus the modified sample was discarded and a totally new approach was adopted.

Table 3.20 Main cluster patterns found in the study

Group	Description	Minors	N
1	Emotional, but not sexual abuse	Witnessing (neglect)	19
2	Sexual Abuse, but not physical, not witnessing no neglect	Emotional	10
3	Physical and emotional abuse but no neglect	No sexual, no witnessing	6
4	Neglect but no witnessing	No sexual, no physical, emotional	11
5	Sexual but no neglect, no witnessing	(No physical), no emotional	13
6	Neglect but no emotional abuse, no sexual	No physical, no witnessing	7

Type	Sexual	Physical	Emotional	Neglect	Witnessing Domestic Abuse
1	X		✓		✓
2	✓	X	✓	X	X
3	X	✓	✓	X	X
4	X	X	✓	✓	X
5	✓	X	X	X	X
6	X	X	X	✓	X

3.4.15. Sample technique 2

This time we did not specify in advance the required characteristics of the sample. Instead, we planned to base our sampling on the patterns that actually occurred within the participants presenting. To do this involved an inspection of the patterns so as to group together similar ones. This was done using cluster analysis and looking at the dendogram. There appeared to be nine specific patterns, but some were only represented by 2 or 3 cases, so there was a need to amalgamate the groups to provide a workable sampling method. The top 5/6 scores for each group were selected.

3.4.15.1. Problem 3

No one had experienced all five forms of abuse. However, three people had 4 out of five forms of abuse. It was believed that all of these should be included.

Modification 2

The one person who had four abuses out of five who was drawn was added to the sample.

3.4.15.2. Problem 4

In preparing to contact the participants for interview, it was discovered that some had either refused a further interview or had subsequently withdrawn their agreement.

Thus the subsequent participant in the same cluster was contacted (Table 3.21).

Table 3.21 Quantification of the main clusters' patterns.

Groups		Minors					
	N		N		N		N
Type 1	19 **	Witnessing	8 **	Neglect	9 **	----------	----
Type 2	10*	Emotional	12 **	----------		----------	----
Type 3	9 **	No sexual	10 **	No witnessing	6 **	----------	----
Type 4	11 **	No sexual	12 **	No physical	9*	Emotional	5*
Type 5	13*	No physical	10*	No emotional	5*	----------	----
Type 6	7*	No physical	5*	No witnessing	6*	----------	----

* Strictly as type indicated. ** Including other types of abuse

It was difficult to apply the theory in practice. The complexity of childhood abuse and of human beings (changing their minds, lack of time; changing of interests) forced us to compromise on our ideal in order to realise the achievable.

3.4.16. Interview process

In order to prevent the potential risk of discomfort and/or embarrassment for the researcher or misunderstandings caused by cultural differences and Spanish accent of the researcher, the researcher took a set of sessions with an English language tutor who worked three sessions in a one to one format to improve her pronunciation on the interview questions and prompts. Also, in order to prevent any delays incurred by travelling to interviewee's chosen location, the interviewer travelled to arrive two hours in advance of the estimated time of the appointment.

In order to satisfy several aspects of reliability, the interview was recorded. Also, participants were able to read their own transcript of the interview as well as free to made corrections on it, to censor information and/or add some more information. Moreover, this process was designed to empower the participants in the present research. Further, the interviewees were provided with an interview consent form that explained this and other specific points regarding the interview questions. In addition, they were also given a flow chart explaining the interview process in order to determine beforehand whether they wanted to carry on in the study. Altogether, this arrangement gave a complete picture of the research and allowed the participants their right to withdraw at any time. An agreement to use the information was signed after they checked and agreed the content of the transcription.

3.5. Contradictions of the methodology

This section is a discussion of the contradictions and balances that the researcher found in the practise of carrying out feminist research and the pragmatic realities of the research. There is a conflict between conducting the feminist approach and the heath science research. On one hand, validity and reliability are extremely important for the positivist methodology but on the other hand, the influence of the researcher's subjectivity is crucial to the feminist approach.

The role of validity and reliability, in relationship to objectivity, is to eliminate the human element. The intention of this is to remove the voice of the researcher and to report it as objectively as possible. However, from the feminist research viewpoint, subjectivity is recognised as having an important role that affects the research, and it is therefore necessary to write in the first person in the report.

It has been recognised that in Health Science Research, a conflict exists of whether the report should be written in the first or third person. For quantitative studies, projecting objectively is crucial, while for qualitative studies, subjectivity should be the central concern. However, as this thesis used a combination of quantitative and qualitative methodology, I opted to report the results mainly using a third person voice.

In feminism (Roberts, 1981; Oakley, A. 1981; Harding, 1987), the interviews are the product of a social meeting between two people. However, this is not entirely objective, and it is reflected in the meeting there and then by both individuals. In the case of this study, it reflects how child abuse is seen at that point and also when the participants reviewed the transcripts; if they disagree with the information contained in the transcript, it is because they are in a different social environment. The same process occurs when the interview data is analysed; there is more of the researcher in it. The analysis of the interview data is the scrutiny of the meeting between two people, the researcher and the participant.

Also, the research is conducted within the School of Health and Related Research (ScHARR). While the researchers at ScHARR conduct an array of research methods, the primary concentration is in the area of quantitative methodology, such as randomised control trials (RCTs) or in Health Services Research that apply qualitative research that mirrors to quantitative research. This research focus situates the student in a difficult position that might pull the researcher in two directions, as it is important that the results were recognised within ScHARR.

In this case, different routes have been used in the process of selecting the techniques of the research. Often I felt pulled between conducting feminist research and qualitative research, which in some ways mirrored positive research. Also, it is difficult to submit research that is expected to be written in the third person, where feminist research recognises what the researcher is bringing to the research. Furthermore, being thorough is important in reporting science, especially in order for other people to understand what was done in the research and how the research was conducted, but at the same time a mixed methods approach may be reported either in the first or third person.

The contradictions of conducting feminist research and submitting a protocol to a University Ethics Committee can be a pragmatic impediment. In my attempt to balance the relationship researcher-participant I proposed the inclusion of a paragraph that informed the participant about my personal details. These details included information about my cultural and professional background prior to the formal interview taking place. This way, participants could have a fair choice to decide whether they wanted to have an interview with me, especially because the interviews were likely to occur at their work place; however the Ethics Committee requested I delete that specific paragraph. It was requested to include a paragraph stating that neither I nor the University would take responsibility for the stress that may result from the interviews. The purpose of this amendment was to cover the point of "What arrangements have been made to provide indemnity and/or compensation in the event of a claim by, or on behalf of, participants for negligent or non-negligent harm?" since there was no way to provide any possible compensation in the event of a claim. Instead, I tried to empower the participants to minimise any possible potential stress that may arise.

I attempted to overcome some of those contradictions in the practice as a researcher. For example, as there was no way to compensate participants for taking the time and suffering to answer the questionnaires. I included coffee and tea sachets with the questionnaire. I felt that a cup of tea or coffee might provide a little bit of comfort and support while the participant answered the questionnaire.

Although the questionnaires are standardised tools to measure objectively, I felt that coffee stains personalised the participant-researcher relationship.

For all the interviews, I brought tissue paper and bottles of water for the participants or myself. By including the question 'what would you like to tell the world about your experience?' in the interview schedule was an attempt empower the participant. And in fact the participant was given the interview transcript to check or amend any information she wished.

In the next chapter, the results of the first phase of this thesis are presented, namely the results of the systematic review for the design of the questionnaire. The aim of the systematic review were to find suitable questionnaires that investigates each one of the factors that are proposed that intervene in the process of overcoming childhood abuse, namely: general emotional health, recent life events, coping strategies, trauma symptoms and empowerment. Also it explains the results in designing the questionnaire and the final questionnaire.

CHAPTER 4

Results of the Systematic Review for the Questionnaire and Questionnaire Design

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4. RESULTS OF THE SYSTEMATIC REVIEW FOR THE QUESTIONNAIRE AND QUESTIONNAIRE DESIGN.

In this chapter the results of the first part of the research are presented. The chapter firstly focuses on the results of the systematic review for the design of the questionnaire. Then, it explains how the final questionnaire was prepared for distributions and explains how the questionnaire was pre-piloted to ensure content validity. Finally, it presents the results of the pilot study.

4.1. Introduction

Five separate reviews and corresponding search strategies were conducted to select the most suitable questionnaires (For more details, please refer to Section 3.2.5). These underpin the selection of the instruments of the five different topics, which are of particular interest to this research. Namely: emotional morbidity, recent life events, coping strategies, power/empowerment and symptoms of trauma for childhood abuse.

The reviews covered reliability, validity, applicability to adults and practicality. The data sources were MEDLINE and PSYCINFO. The time period covered was searched to its inception in 1970. However, some cut-off dates varied according to the development of each scale (e.g. GHQ). Review of the relevant sources and articles from the literature was conducted.

4.2. Results and questionnaires selected

The five reviews had their own search strategy. However, the reviews covered aspects of reliability, validity, applicability to adults and facility to answer. The following five scales (questionnaires) were selected:

1. "*The General Health Questionnaire – 12*" (Goldberg, 1978a).
2. "*The List of Threatening Experiences*" (Brugha and Cragg, 1990).
3. "*The Ways of Coping Questionnaire – R*" (Folkman and Lazarus, 1988).
4. "*The Empowerment Scale*" (Rogers, Chamberlin, Langer and Crean, 1997).
5. "*The Childhood Trauma Questionnaire – 40*" (Briere and Runtz, 1988).

The characteristics of each scale are explained next:

4.2.1. "The General Health Questionnaire–12" (Goldberg, 1978a).

A systematic literature search of the data sources was described in the methods chapter using the search strategy shown in table 4.1.

Table 4.1 Search strategy for General Health Questionnaire

(Spanish in la)
validity or reliability
('test-construction' in DE) or ('test-reliability' in DE) or (test-validity in DE) or (rating-scales in DE)
General Health Questionnaire

Date of the search: 26 April 2001

After analysis of the 225 results collected by this strategy (for more details see table 3.13 in the methods chapter) the General Health Questionnaire –12 (GHQ-12) was selected. This questionnaire was introduced in the 1970s. It is better known as the GHQ-12 and is one of the most used versions of the GHQ because is short and the quickest to answer. It was designed to detect minor psychiatric illness in general population surveys, in primary care settings or among general medical outpatients. It is a self-administered screening questionnaire used to measure non-psychiatric mental illness. 60 items composed the first version and

subsequently other versions of the same questionnaire were developed. Thus at present, there is a version with 30 items, 28, 20 and 12 items. Each item has four response options with different methods of scoring. The standard method is a binary method characterised as (0-0-1-1, score ranging from 0 to 12 for the GHQ-12). The questionnaire could also be scored using a four point Likert scores of 0 to 3 (0-1-2-3, score ranging from 0-36 for the GHQ-12). For chronic disorders, the items are scored differently; the positive items are scored in the binary method, but the negatives are scored 0-1-1-1 (Donath, 2000). This research uses the standard method of scoring. The questionnaire identifies four identifiable elements of distress: depression, anxiety, social impairment and hypochondriasis.

4.2.2. "The List of Threatening Experiences" (Brugha and Cragg, 1990).

The systematic review of psychometric literature of the data sources for the topic of life events already described in the methods chapter was carried out using the search strategy shown in table 4.2.

Table 4.2 Search strategy for Recent Life events measurement.

[Spanish in la]
(validity or reliability) near5 life events
Validity or reliability
'Experiences-Events' in DE
(Test-construction' in DE) or ('test-reliability' in DE) or ('test-validity' in DE) or (rating-scales in DE)
Questionnaire* or scale* or tool* or checklist* or inventor* or measure*
Social readjustment rating scale
Stressful life events questionnaire
Undesirable life events questionnaire
Life events and (Spanish in la
(Holmes) in AU,CA
(Holmes Rahe) in AU,CA
Life events test
Life events measure
Life events checklist
Life events questionnaire
Life events scales
Life event*
Quality-of-Life [explode] in DE
Life-Experiences' [exploded] in DE

Date of search: 26 April 2001

The selection from the 365 results brought four questionnaires (for more details see table 3.11 in the methods chapter). The "The List of Threatening Experiences" was selected from the mentioned instruments. This questionnaire was introduced in the 1980s, and was created by Brugha et al (1985). It is also known as the LTE-Q that is the version for a questionnaire (as its counterpart as interview). It is a short questionnaire with 12 questions and is quick to answer because it is a tick questionnaire and it takes less than15 minutes to complete. The scale looks at recent life events, (in this thesis it refers to those occurring in the last three months) and also examines whether the respondent thinks they have a continuing influence. It is intended for adults, or family caregivers. The scoring is binary 1 for the life event that has happened and 0 if not. This questionnaire has not a cut off point. Brugha et al (1985) explain:

"It is scored on the basis that the more life events the adult has been through, the higher the score and therefore the greater the likelihood of some form of longer term impact on the adult, child or family".

This is particularly the case if the events still affect the respondent.

4.2.3. "The Ways of Coping Questionnaire – R" (Folkman and Lazarus, 1988).

A systematic literature search looking for coping and/or resilience instruments or questionnaires was performed. The method has been described in the methods chapter. The search strategy is shown in table 4.3.

Table 4.3 Search strategy for coping and resilience

(validity or reliability) near5 resilience
(validity or reliability) near5 coping
(Test-construction' in DE) or ('test-reliability' in DE) or ('test-validity' in DE) or (rating-scales in DE)
Questionnaire* or scale* or tool* or checklist* or inventor* or measure*
Resilience
Coping

Date of the search: 8 June 2001

From the 59 results, potential six scales were finally selected. (For more detail, see table 3.14 in the methods chapter). The "Ways of coping questionnaire" was

selected for its properties of internal reliability, validity, practicality (66 items, Likert type response) and also because it has a Spanish version. This measure explores the role of coping strategies, assesses thoughts and actions that individuals use to cope with stressful situations in the daily life. Folkman and Lazarus (1988) developed this instrument at the beginning of the 1980's. It is a four point scale. Several revisions were tested and a final revised scale was done in 1985. The scale may be self-administered. Respondents may indicate whether they used each of the given response choices in a given stressful situation (in this thesis 'abuse') by marking a thick in a special box for that. Different researchers adopted their own techniques to score the instrument. It has eight subscales: (1) confrontive coping, (2) distancing, (3) self-controlling, (4) seeking social support, (5) accepting responsibility, (6) escape avoidance, (7) planful problem solving, and (8) positive reappraisal

4.2.4. "The Empowerment Scale" (Rogers, Chamberlin, Langer and Crean, 1997).

Systematic review was conducted to find a questionnaire that may help to measure power. Procedures have been already described in the methods chapter. The search strategy undertaken is shown in table 4.4.

Table 4.4 Search strategy for power

#8 #6 and #7
#7 #4 or #5
#6 #2 or #3
#5 (Validity or reliability) near5 power
#4 (Validity or reliability) near5 empower*
#3 (Test-construction' in DE) or ('test-reliability' in DE) or ('test-validity' in DE) or (rating-scales in DE)
#2 Questionnaire* or scale* or tool* or checklist* or inventor* or measure*
#1 Power

Date of the search: 12 July 2001

Selection of the results brought by this strategy was 66. After analysis of the results obtained by the search, five instruments were selected (for more details see table 3.15 in the methods chapter). A final selection was conducted and the "The Empowerment Scale" (Rogers, Chamberlin, Langer and Crean, 1997) was

selected. This questionnaire was introduced at the end of the 1990s. It is a quick response questionnaire because it has 28 items and each item has four response options in Likert types which facilitate a quick answer. It was designed to measure the personal construct of empowerment by consumers of mental health services, in members of self-help programs in six states of the United States. It is a self-administered questionnaire and it has five factors (1) self-efficacy-self-esteem, (2) power-powerlessness, (3) community activism, (4) righteous anger and (5) optimism-control over the future.

4.2.5. "The Childhood Trauma Questionnaire – 40" (Briere and Runtz, 1988).

The systematic review for a questionnaire can be useful to evaluate symptomatology associated with traumatic experiences from childhood or childhood abuse. It was conducted using the search strategy shown in table 4.5. The process has been already described in the methods chapter.

Table 4.5. Search strategy for Childhood abuse trauma questionnaire

Instrument
Questionnaire* or *scale or tool* or checklist* or inventor* or measure*
Psychometrics
Child* near5 (abus* or trauma or maltreatment or neglect)
Child neglect
Child abuse

Date of the search: 29 March 2001

Briere and Runtz developed this questionnaire from the earlier TSC-33 in the late 1980s. Briere reported the last review of the TSC-40 in 1996. This checklist is intended for professional researchers only. It is a self-report instrument and it has 40 items with Likert type responses. It requires 10-15 minutes to complete. It is a relatively reliable measure (alpha for full scale between .89 and .91). The questionnaire can score from 0 to 3. It measures aspects of posttraumatic stress and other symptoms found in some traumatized persons. It consists of six scales: dissociation, anxiety, depression, sexual abuse trauma index (SATI), sleep disturbance and sexual problems.

4.3. Preparing the instrument

All the materials for the survey were designed to obtain the best response rate possible. It should be noted that there was not approval by the Ethics committee to initially send the questionnaire. Instead the initial contact to potential participants through the UPCA was indicated by the SREC.

The initial invitation letters were printed in different coloured paper, depending on the different week. This approach was adopted to differentiate the different week of work. However, all the invitation letters were sent in a white envelope, to increase the response rate (Edwards *et al.*, 2002). These invitation letters were sent from the researcher to the UPCA, and then from the UPCA to their members. This procedure was conducted for the invitation to the pilot questionnaire study and for the invitation to the main survey.

The instrument was made in a leaflet format in lilac colour. The informed consent letter was in a pink-lilac colour that matched with the colour of the questionnaires. As incentive, a little bag with sachets of sugar, tea and coffee were included in each questionnaire set to encourage participation and bring a bit of relief that a warm drink may give. A self-addressed envelope was also included; all was in a brown A4 envelope addressed directly to the participants willing to participate in the research.

The questionnaire consisted of a total of 180 questions that took an average of 40 minutes to complete. In order to fit the questionnaire on to eight A4 sheets to form a 'booklet', it was structured so that on the initial pages there were logos, the title of the research, and the main aim of the study, information about confidentiality, and a statement of thanks (See Appendix 1). The ordering of the questionnaires was

chosen to be the least threatening to participants at the beginning and the most sensitive towards the end of the questionnaire, see Table 4.6.

Table 4.6 Sections of the core questionnaire and what it measures

Section	Measurement	What it measures?
1	Introductory section	Questions about socio-demographic details such as: age, gender, marital status and childrearing
2	General Health Questionnaire - 12. (Goldberg, 1978a).	Questions to detect minor psychiatric illness
3	RLE-Q Recent Life Events Questionnaire (Brugha and Cragg, 1990).	Questionnaire to measure recent life events occurred in the last three months
4	Ways of Coping Questionnaire-Revised. (Folkman, S. and Lazarus, R., 1988).	Questions to identify coping strategies
5	The Empowerment Scale (Rogers, S. E, Chamberlin, J., Langer, E. M., Crean, T. 1997).	Different types of power and general empowerment
6	Childhood Trauma Questionnaire - 40. (Elliot, d. M. and Briere, J. 1991).	Symptoms of Childhood abuse trauma
7	Impact on psychotherapy practice [1]	The seventh section is about the impact of child abuse in psychotherapy practice
8	Dominance power	About power over others at work with questions designed by the researchers[2]

A tick box was located on the right-hand side of each item for every question. Two questions (7.2 and 7.3) were designed to respond in visual analogue form to allow finer comparisons between participants. The first section included four questions that comprised demographic information followed by the GHQ-12, the LTE-R, the WAYS-R, the Empowerment Scale, and the TSC-40 impact on psychotherapy practice. At the end of the questionnaire was section eight, followed by a statement of thanks for answering the questionnaire, a paragraph asking if they were willing to participate in further research, a form and way to contact them, and a statement of consent to use the information in future publications, assuring that non-identifying information only would be used. The final back page was blank. The final instrument has eight sections (See Table 4.6).

[1] Silvia Pimentel-Aguilar, Profr Digby Tantam and Mrs.Carol Saul
[2] Silvia Pimentel-Aguilar, Profr Digby Tantam and Mrs.Carol Saul

The questionnaires were send in a brown A4 envelope that included: (1) an informed research letter (2) the questionnaire (3) a return pre-paid envelope, (4) a little white paper bag containing one sachet of soluble coffee, one tea-bag and two sachets of white sugar. The questionnaires were sent from the researcher directly to the participants who did agree to participate in the research, following receipt of the agreement from participants. Both, the main survey –and reminders- and the pilot study followed the same mailing procedure.

4.4. Pre-piloting the questionnaire

The pre-pilot study was conducted on five independent psychotherapists or counsellors. Based on their feedback, the final questionnaire was refined for use in the main study.

A working draft questionnaire was developed and presented to five judges[3] who answered it and reviewed the instrument question by question, in order to ensure clarity; find any possible typing errors, to avoid ambiguity and to give feedback for the questionnaire, especially for sections seven and eight designed by the researchers. Some questions were re-worded for clarity, other were refined in the option response. Other questions were redesigned in visual analogue form to allow for finer comparisons between participants.

4.5. Pilot results

A pilot study of 10 participants recruited through the membership list of the members of Universities Psychotherapy and counselling Association (UPCA) was conducted. The latter is a voluntary organization and is not connected with the NHS. Some psychotherapists with the UPCA are also employed by the NHS but,

[3] Psychotherapists or counsellors who worked independently from each other.

that employment is not related to their membership of the UPCA or to their recruitment for this study. This research did not involve the NHS system.

The pilot study was conducted in the light of the comments received from the previous phase (the pre-pilot study). This pilot comprised a mail-shot with a small sample of ten psychotherapists, selected from the list of the UPCA. The results of the pilot study were examined before a final version of the postal questionnaire was decided. Very few corrections were necessary. The pilot study ascertained how well the questionnaire worked; what questions could be eliminated to make it shorter; whether questions in section seven needed to the reworded or did not work; and what general improvements on administration could be made. An analysis was made of the responses to help with the estimation of the sample size for the main study.

4.6. Conclusion

Instruments for the assessment of childhood trauma, ways of coping, general health, power and recent life events with demonstrated reliability and validity for use in this study were found after a search of the literature. The questionnaires were carefully chosen to fully cover childhood traumatic events: physical abuse, emotional abuse, sexual abuse and neglect, applicable to adults.

The data obtained was compared in 2003 with a search of the CRD website to update the review and it was found that there were no other instruments to be analysed. The methodology recommended by the CDR is a very reliable and systematic structure that helps to achieve the selection of instruments in the wide literature available.

The methodology of this review was based on the research methods of the CRD Report No. 4 (Khan et al. 2000). The review objective was reached and the ideal instruments were identified for each topic.

These instruments exhibited the necessary qualities of quality of validity and reliability, and with quick terms of practicality (*i.e.*, 50 minutes on average to complete the whole questionnaire).

The findings of this literature review draw upon systematic reviews techniques, as a very useful method to identify and to ensure a high quality level of questionnaire design composed by consistent and reliable questionnaires previously identified. The terms used in the search helped to retrieve references of the questionnaire and its psychometric characteristics. An update up to 2007 was performed and confirmed the selection of the questionnaires (please refer to Section 3.2.6 of Chapter 3). The inclusion criteria identified the best available sources, which helped select key questionnaires. They also included professional mental health and childhood abuse trauma components inclusive of the measurements. These were used for the qualitative study in the survey.

The next chapter presents the results of the survey. It explains the statistical analysis of each factor. It also analyses the interactions of the variables and it shows the results of the discriminant factor analysis, and finally, it presents the results of regression analysis to know what the factor that moderates resilience is.

CHAPTER 5

Results of the Survey

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5. RESULTS OF THE SURVEY

This Chapter reviews the results of the questionnaire applied in the survey[1]. Initially, it reviews the general characteristics of the sample and it discovers the prevalence of child abuse in the whole cohort. Secondly, it describes the results of each variable that the different questionnaires of the core research tool measure. Thirdly, it analyses the interaction of the variables with the intention of discriminating between resilient and non-resilient groups. Then, it looks at the confounding variables and analysis that helped to identify them. Subsequently, it tests the hypothesis between the resilient and the non-resilient groups. Finally, conclusions of the findings are presented. The key research questions that led to this survey were: What the participants did whilst actually being abused as a child, and what are the contributing factors in resilience?

5.1 Introduction

This quantitative approach of the research uses a core questionnaire previously described in Chapter Three, which was piloted and then applied in the survey. The results of the core questionnaire were captured and cleaned. The data collected were double entered and matched using the two entry files of the software 'EpiInfo version 6.01b; identifying data typing errors. Missing values were marked with a number 9. All the values were visually checked to detect any possible outliers (i.e. number much lower or higher than the rest of the data). The inconsistencies, which were found were re-checked against the responses in the original questionnaires and corrected if necessary. Then, numerical data were checked to identify the normality of the data using histograms. After a final validated data file was produced, statistical analyses were carried out. Non-parametric analysis was also

[1] Many thanks to the Statistician Jean Russell for her support with the SPSS (Statistical Package for Social Sciences) and the understanding of the data.

used for analysing the two different groups from the sample. Linear and multiple regression analysis and correlation were also used. A total of 103 psychotherapists took part in the study.

This next section offers a general description of the survey population, such as socio-demographic characteristics and the prevalence of childhood abuse. Then, it presents the findings of each questionnaire included in the core research tool[2] of this research plus the analysis of the two sections[3] specifically designed for this investigation.

5.2 General description of the participants

The socio-demographic characteristics are shown in Table 5.1 Most of the respondents were married or cohabiting. Just over one third of the respondents were men and nearly two thirds were women. The age range was between 31 to 73 years, the average being 49 years. It varied as follows: 15.5% for 31-40 years, 34.9% for 41-50, 42.7% for 51-60 years and 6.7% for 61 or above. The median age was 49.08 years.

Table 5.1: Socio-demographic characteristics of the whole cohort (n=103)

Variable		No.	% of respondents
Gender	Male	36	35%
	Female	67	65%
Marital Status	Single	8	8%
	Married/cohabiting	76	74%
	Widowed/divorced/separated	19	18%
Parent or not	Yes	68	66%

[2] The scales that compose the research tool measures: general health (GHQ-12 Goldberg and Williams, 1988); The List of Threatening Experiences that measures recent life events (LTE-Q, Brugha, et al, 1985; Brugha and Cragg, 1990); ways of coping (WAYS-R, Lazarus and Folkman, 1988); childhood abuse trauma symptoms (CTQ-40, Briere and Runtz, 1989) and empowerment (the Empowerment Scale, Rogers, et al. 1997).

[3] The two sections are: (a) Impact on psychotherapy practice (Silvia Pimentel-Aguilar, Profr Digby Tantam and Mrs.Carol Saul) and (b) Dominance power practice (Silvia Pimentel-Aguilar, Profr Digby Tantam and Mrs.Carol Saul)

The Universities Psychotherapy and Counselling Association (UPCA) comprises 65% of women and 35% of men. Therefore the selection process produced a sample that exactly reflected the gender distribution of the UPCA, showing no gender bias in selection. A sample of 124 participants volunteered to take part in the study. This was the sample size required to give a reliable representation for the UPCA population size of 390. Of these 124, only 103 actually completed the questionnaire. This figure of 103 only represents a confidence level of 95%.

5.3 Results of each variable

This section examines the results of different variables involved in the process of overcoming childhood abuse (see Table 5.2). These are:

(a) Emotional health -measured by the GHQ-12 (Goldberg, 1978a).

(b) Recent life events -measured by the RLE-Q (Brugha and Cragg, 1990).

(c) Coping strategies -measured by the WAYS-R (Folkman, and Lazarus, 1988).

(d) Power -measured by the Empowerment Scale (Rogers, *et al.*, 1997).

(e) Post-traumatic symptoms caused by childhood abuse -measured by the TSC-40 (Elliot, and Briere, 1991)

(f) The impact of psychotherapy practice, and

(g) Dominance power.

Table 5.2 Sections of the research tool

Section	Measurement
1	Socio-demographic characteristics
2	General Health Questionnaire - 12 (Goldberg, 1978a).
3	RLE-Q Recent Life Events Questionnaire (Brugha and Cragg, 1990).
4	Ways of Coping Questionnaire-Revised (Folkman, and Lazarus, 1988).
5	The Empowerment Scale (Rogers, Chamberlin, Langer, and Crean, 1997).
6	Childhood Trauma Questionnaire - 40 (Elliot, and Briere, 1991).
7	Impact on psychotherapy practice (Pimentel-Aguilar, Tantam and Saul).
8	Dominance power (Pimentel-Aguilar, Tantam and Saul).

5.3.1. Childhood abuse prevalence

This study showed that 57% of the 103 respondents reported that they had been abused in childhood with a higher proportion of women reporting abuse. See Table 5.3.

Table 5.3: Abuse by gender

	Men	Women	Total
	N (%)	N (%)	N (%)
Abuse	16 (27)	43 (73)	59* (100)
No abuse	20 (45)	24 (55)	44 (100)
Total	36 (35)	67 (65)	103 (100)

* Error

An error signifies that an informant stated that she/he did not consider herself/himself abused as a child even though she/he did tick which type of abuse (neglect) she/he had suffered. Respondents who reported any of the types of abuse (physical, sexual, emotional, neglect, or witnessing domestic violence) were assigned to the relevant abused group.

Table 5.4: Type of abuse, by respondents and those reporting abuse (n = 103)

	N	%	% of All respondents	% of those reporting abuse
Abused*	58	57		
Type of Abuse**				
Sexual	22		21.4	37.9
Physical	21		20.4	36.2
Neglect	21		20.4	36.2
Emotional	41		39.8	70.6
Witnessing Domestic Violence	15		14.5	25.8
Not abused	44	43		
*Error- not reported **Some people have more than one type	1			
Total	103	100		

Table 5.4 shows that questionnaire respondents had experienced abuse of some type (physical, sexual, neglect, emotional or witnessing of domestic violence). The majority of respondents reported more than one type of abuse. Of the respondents who reported witnessing domestic abuse, none reported this abuse on its own. For

more information, please refer to section 'Type of abuse and combinations of abuse reported' in this Chapter.

Table 5.5 Abuse by a family member

	Frequency	Percent
Yes	49	83.1
No	8	13.6
Not reported	2	3.3
Total	59	100

Within those who experienced abuse, 83% reported abuse by a close family member (see Table 5.5).

5.3.1.1. Types of childhood abuse prevalence by gender

In order to investigate the prevalence of childhood abuse for each gender and whether or not there is any difference in the experience of abuse between males and females (Figure 5.1) a comparison was made between the responses of males and females to the following question: *Do you consider that you were abused as a child?* Two measures were used to determine if there was an association between gender and different types of abuse. A 2 x 2 contingency table and a chi-square as a statistical test were used with a significance level of 0.05.

Figure 5.1 Gender and abuse relationship

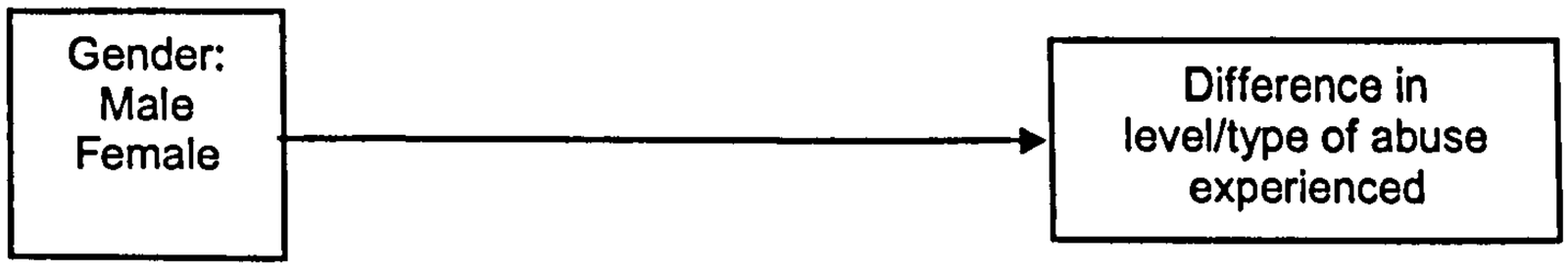


Table 5.6 shows that a total of 56.9% of respondents affirmed that they were abused as a child. More female respondents (63.3%) reported abuse in childhood compared with male respondents (44.4%). Although the difference was not quite statistically significant (p = .061), it was on the borderline. Wherever a value is

missing, this means that a participant may have ticked several types of abuse but may not have considered using the term her/himself.

Table 5.6. Prevalence of childhood abuse experienced by psychotherapists and counsellors by gender.

	Male	Female	Chi square Statistic	p-value
ANY ABUSE				
YES 58/102 (56.9%) *	16 (44.4%)	42 (63.6%)	3.50	0.061
NO 44/102 (43.1%) *	20 (55.6%)	24 (36.4%)		
SEXUAL ABUSE				
YES 22/58	5 (13.9%)	17 (25.4%)	1.84	0.175
NO 81/103	31 (86.1%)	50 (74.6%)		
PHYSICAL ABUSE				
YES 21/58	7 (19.4%)	14 (20.9%)	0.03	0.862
NO 82/103	29 (80.6%)	53 (79.1%)		
CHILD NEGLECT				
YES 21/58	4 (11.1%)	17 (25.4%)	2.93	0.087
NO 82/103	32 (88.9%)	50 (74.6%)		
EMOTIONAL ABUSE				
YES 41/58	10 (27.8%)	31 (46.3%)	3.34	0.068
NO 62/103	26 (72.2%)	36 (53.7%)		
WITNESSING DOMESTIC VIOLENCE				
YES 15/58	3 (8.3%)	12 (17.9%)	1.72	0.189
NO 88/103	33 (91.7%)	55 (82.1%)		
TOTAL	36 (35%)	67 (65%)		

*One missing value

The different categories of child abuse considered in this study were analyzed. In proportion, more women than men reported abuse. In the analysis by category approximately twice as many women as men reported sexual abuse in childhood but this difference was not statistically significant (p-value 0.175). Fewer men (19.4%) experienced physical abuse compared to women (20.9%). The difference was not statistically significant. Regarding child neglect, twice as many women (25.4%) experienced this compared to men (11.1%), with borderline statistical significance (0.087). With regard to emotional child abuse, the results show that more women (46.3%) than men (27.8%) experienced this type of abuse, with borderline statistical significance (0.068). The number of men who witnessed

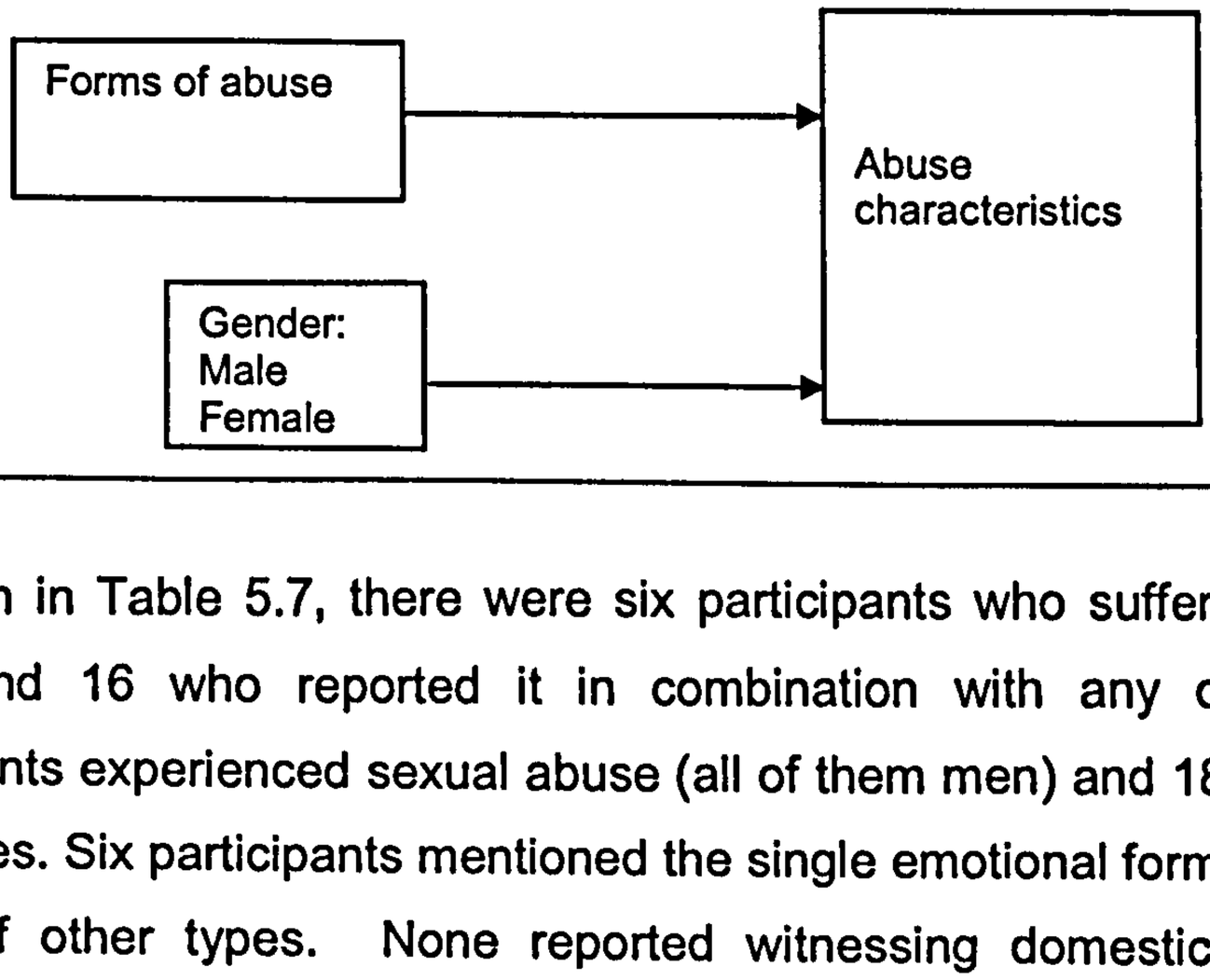
domestic violence was lower than of women (8.3% and 17.9% respectively). The difference was not significant (chi square 1.72, p= 0.189).

Overall, it can be concluded there were more female than male psychotherapists reporting childhood abuse. There is no significant difference ($p \leq 0.05$) or borderline significance between men and women across the specific different types of abuse.

5.3.1.2. Type of abuse and combinations of abuse reported

Abuse can take one or more of several forms. Therefore, it was of interest to examine the different types of combinations of abuse that were reported by the sample, illustrated by Figure 5.2 below.

Figure 5.2 Combination of abuse and abuse characteristics



As shown in Table 5.7, there were six participants who suffered single physical abuse and 16 who reported it in combination with any other form. Three respondents experienced sexual abuse (all of them men) and 18 reported this with other types. Six participants mentioned the single emotional form and 35 suffered a variety of other types. None reported witnessing domestic violence *per se*, although 15 did when combined with other abuse categories.

Table 5.7 Type of abuse and combinations of abuse reported

			Male (N=16)		Female (N=42)		Total
			Number	%	Number	%	N
Other abuse: NO	physical	Yes (physical abuse only)	2	12.5	4	9.	6
		No abuse	7	43.7	7	16	14
Other abuse: YES		Yes (and other types of abuse)	3	18.7	13	31	16
		No (but other types of abuse)	4	2.5	19	44	23
Other abuse: NO	sexual	Yes (sexual abuse only)	3	18.7	0	---	3
		No abuse	6	37.5	11	26	17
Other abuse: YES		Yes (and other types of abuse)	4	25	14	33	18
		No (but other types of abuse)	3	18.7	18	41	21
Other abuse: NO	neglect	Yes (neglect abuse only)	0	---	5	11	5
		No abuse	9	56.2	6	14	15
Other abuse: YES		Yes (and other types of abuse)	4	25	12	28	16
		No (but other types of abuse)	3	18.7	20	47	23
Other abuse: NO	emotional	Yes (emotional abuse only)	4	25	2	5	6
		No abuse	5	31	9	20	14
Other abuse: YES		Yes (and other types of abuse)	6	38	29	68	35
		No (but other types of abuse)	1	6	3	7	4
Other abuse: NO	Witness DV	Yes (Witnessing D V only)	0	---	0	---	0
		No abuse	9	56	11	25	20
Other abuse: YES		Yes (and other types of abuse)	3	18.7	12	28	15
		No (but other types of abuse)	3	18.7	21	49	24

These results suggest that witnessing domestic violence is a very vulnerable experience for a child.

5.3.2. General Health Questionnaire – 12 (Goldberg, 1978a).

The General Health Questionnaire (GHQ) is an international scale of general psychiatric morbidity (here using the 12-item version) and was designed for self-completion by the sample. The scoring system is a 4 option Likert type method of severity. In this study the method for counting problems was 0, 0, 1, 1. More normal distributions score 0. The scale scores are summed to produce the total score. The GHQ has been extensively used and tested for reliability, validity and sensitivity and the results were considered comprehensive (Goldberg 1972, Goldberg and Huxley 1980; Goldberg and Williams 1988).

Respondents were asked to indicate their general health over the past few weeks when answering the questionnaire. This related to present and recent complaints.

Table 5:8 General Health Questionnaire - 12

Question	Categories More usual or About same than usual %
1. Have you been able to concentrate on whatever you're doing?	81.6
3. Have you felt that you are playing a useful part in things?	85.5
4. Have you felt capable of making decisions about things?	86.4
7. Have you been able to enjoy your normal day-to-day activities?	85.4
8. Have you been able to face up to your problems?	91.3
12. Have you been feeling reasonably happy, all things considered?	88.3
	'Not at all' or 'No more than usual'
2. Have you lost much sleep over worry?	81.6
5. Have you felt constantly under strain?	65.1
6. Have you felt you couldn't overcome your difficulties?	91.3
9. Have you been feeling unhappy and depressed?	81.5
10. Have you been losing confidence in yourself?	84.4
11. Have you been thinking of yourself as a worthless person?	96.1

As Table 5.8 shows, almost the whole sample stated that they think of themselves as worthwhile as well as being able to face problems. A high percentage of the whole cohort reported that they could overcome present and recent difficulties. In

addition, a high percentage felt capable of making decisions about things and also playing a useful part in things. Moreover, respondents reported being able to enjoy their normal day-to-day activities. A high proportion of the participants said they had been feeling reasonably happy, all things considered.

Slightly more than 80% of the respondents said that they had been able to concentrate, whilst none reported a concentration level worse than usual. In the same way, respondents said that they had not lost any more sleep as a result of any worries.

About one third of the respondents felt constantly under strain. A very small percentage of the participants reported that they had been feeling unhappy and depressed. Whilst more than three quarters of the participants stated that they had not been losing confidence in themselves 14.6% reported that they had more than usual, (for more details see Appendix 20).

Table 5.9. GHQ-12 Frequencies of the whole sample

Items marked	Frequency	Percent
0	54	52.4
1	9	8.7
2	11	10.7
3	7	6.8
4	5	4.9
5	6	5.8
6	4	3.9
7	1	1.0
8	2	1.9
9	3	2.9
11	1	1.0
Total	103	100

As can be seen in Table 5.9, the analysis of frequencies shows that half of participants reported no symptoms and only one person scored 11 items. Goldberg and Williams (1988) report that in random samples a range between 35 and 47% scored zero, whereas in consulting samples a 25% score zero. Therefore comparatively, this sample shows a healthier emotional state.

Table 5.10. Scores of General Health Questionnaire -12

	Frequency	%
Not case (score 0-3)	81	78.6
Case (score 4+)	22	21.4
Total	103	100

Each item in GHQ-12 was scored as 0 if a response was 1 or 2; and 1 for responses 3 or 4. These scorings summed give a possible score range of 0 to 12. A person was classified as being a case if they scored 4 or more on the summated score. Goldberg and Williams (1988) suggest a threshold scoring of 5, but to make results analysable it was decided to drop this to 4, as only a very small percentage had 5 or more. This measure helps to decrease a tendency to underestimate prevalence. As Table 5.10 shows, a quarter of the participants who scored indicated that they had problems. In other words, overall, 21.4% of the respondents suffered problems with emotional health. It is therefore concluded that an important proportion of professionals in the sample have a good mental health since high levels of good health (78.6%) were detected by the questionnaire.

5.3.3. Recent Life Events measure

The List of Threatening Experiences (LTE-Q) in its questionnaire version (Brugha, *et al.*, 1985; Brugha and Cragg, 1990) measured recent life events. This is a subset of twelve life events that measures recent life events with substantial long-term associated threat (Brugha, et al, 1985). Initially, the scoring is binary. Participants ticked in either of two columns alongside each of the twelve items. The columns gave the option of 'yes in the last three months' and 'still affects me'. (i.e. participants reported if an event had occurred in the last three months and indicated whether or not the event was still affecting them). The scoring was: 1 if a life event had happened and 0 if it had not. Secondly, the number of events that the respondent estimated to be still affecting her or him was then counted. The questionnaire does not have a cut off point.

Most of the respondents to this questionnaire showed that they were not affected by recent life events. Overall, in the whole cohort only very few (28%) were affected by recent life events. However, amongst those few who experienced recent life events, almost half of them felt they were still being affected by their experiences.

Table 5.11 shows the incidence of the effect of recent life events. The highest rate reported was 9.7%. In this category respondents said that they had had a serious problem with a close friend, neighbour, or relative in the last three months. Less than half of them said that they were still affected by this problem.

Table 5.11: Detail of items of recent life events

	Yes in the last three months		Still affects me	
	N	(%)	N	(%)
You had a serious problem with a close friend, neighbour, or relative.	10	(9.7)	4	(3.9)
A close family friend or another relative (aunt, cousin, grandparent) died.	8	(7.7)	2	(1.9)
A serious illness, injury or assault happened to a close relative.	5	(4.9)	1	(1.0)
Something you valued was lost or stolen.	4	(3.9)	3	(2.9)
You had a major financial crisis.	4	(3.9)	2	(1.9)
You yourself suffered a serious illness, injury or an assault	4	(3.9)	1	(1.0)
You became unemployed or you were seeking work unsuccessfully for more than one month.	4	(3.9)	1	(1.0)
Your parent, child or spouse died.	2	(2.0)	1	(1.0)
You broke off a steady relationship.	1	(1.0)	1	(1.0)
You had a separation due to marital difficulties.	1	(1.0)	1	(1.0)
You had problems with the police and court appearance.	1	(1.0)	1	(1.0)
You were sacked from your job.	1	(1.0)	1	(1.0)

Only six people reported they had not suffered a serious illness, injury or an assault happening to a close relative. A small number (4) of the participants stated that 'something they valued was lost or stolen', three of whom said that this was still affecting them. Very few (4) of the participants stated that they had a major financial crisis, although two of them said that this situation was still affecting them. Few of the participants (4) reported that they became unemployed, or had been unsuccessfully seeking work for more than one month. However, none of the respondents reported being sacked from their jobs. Few respondents experienced

that a parent, child or spouse had died in the last three months, and one of them reported still being affected by this.

Only 1% of the respondents stated having had a separation due to marital difficulties, which was still affecting them. Similar results were found in the cohort with regard to the breakdown of a steady relationship.

Only 1 person reported having had problems with the police and had had a court appearance within the last three months, and still being affected by it. (For more detail see Appendix 21).

5.3.4. Coping Skills

The Ways of Coping questionnaire (revised version – WAYS-R) was applied to measure the coping strategies used by participants in this study. It has 66 items scoring on a 4-point Likert scale, indicating the frequency with which each strategy is used: 0 indicates "does not apply and/or not used", 1 indicates "used somewhat", 2 indicates "used quite a bit", and 3 indicates "used a great deal". The coping scale is designed to measure how people think and what they do in order to deal with a stressful situation. There are different coping styles and these are important facets of health outcomes because they regulate emotions or distress. These coping styles can manage the problem that initially caused the distress. The way in which people handle stressful situations may be crucial in influencing and moderating the detrimental effects of these events on their health (Lazarus and Folkman, 1984).

The questionnaire has eight subscales that are denominated by Lazarus and Folkman as dimensions. These are: *Confrontive*, *Distancing*, *Self-controlling*, *Seeking social support*, *Accepting responsibility*, *Escape-avoidance*, *Planful*

problem solving, and *Positive reappraisal*. These dimensions are explained in more detail in the 'coping skills dimensions' section.

Table 5.12 Independent Samples Test. (Scores comparison of those who answered the WAYS-R questionnaire considering a situation as one where they were being abused).

Mean scores	Mean	t	p-value	Mean difference	Standard Error difference
Confrontive		1.013	.314	.178	.176
Situation involved being abused	1.103				
Not involving being abused	.924				
Distancing		-1.287	.201	-.249	.194
Situation involved being abused	.436				
Not involving being abused	.686				
Self-controlling		.171	.865	.030	.176
Situation involved being abused	1.308				
Not involving being abused	1.278				
Seeking social support		2.459	.016	.589	.239
Situation involved being abused	2.000				
Not involving being abused	1.411				
Accepting responsibility		.155	.877	.030	.198
Situation involved being abused	.750				
Not involving being abused	.719				
Escape-avoidance		1.183	.240	.155	.131
Situation involved being abused	.793				
Not involving being abused	.636				
Planful problem solving		-1.092	.277	-.183	.168
Situation involved being abused	1.167				
Not involving being abused	1.350				
Positive reappraisal		.660	.511	.121	.183
Situation involved being abused	1.176				
Not involving being abused	1.054				

There are two methods of scoring the Ways of Coping Questionnaire, namely Raw and Relative. In this study both scores were used. The Raw scores is the most used research method (Folkman and Lazarus, 1988). Raw scores describes coping effort for each of the eight types of coping. Raw scores are the sum of subject's responses to the items that comprise a given scale, and provide a summary of the extent to which each type of coping was used in a particular encounter. In this case the participant was asked to tick a box if an encounter was an abusive situation. 12.6% of respondents stated that they imagined the situation as one where they were being abused (see Appendix 3 for more details). Comparison between the scores of that 12.6% (n=13) with those respondents who did not tick 'Yes' to this response is given in Table 5128.

The purpose of this analysis is to explore what specific coping strategies are used in a situation of abuse, and it is recommended by Folkman and Lazarus in order to understand coping strategies for specific situations (Folkman and Lazarus, 1988). Results of the independent t-test show that there is a significant difference in the use of the strategy 'seeking social support'. However, because this is one of seven comparisons, this result should be regarded as tentative.

Table 5.13: Ways of coping (Specific Strategies)

Strategy	Used		Does not apply or not used		Total
	n	%	n	%	n
I just concentrated on what I had to do next - the next step.	94	92.2	8	7.8	102
I tried to analyse the problem in order to understand it better .	94	92.2	8	7.8	102
I talked to someone about how I was feeling.	91	90.1	10	9.9	101
I tried to keep my feelings about the problem from interfering with other things.	89	88.1	12	11.9	101
I tried to see things from the other person's point of view.	86	84.3	16	15.7	102
I went over in my mind what I would say or do.	85	83.3	17	16.7	102
I accepted sympathy and understanding from someone.	83	81.4	19	18.6	102
I made a plan of action and followed it.	83	81.4	19	18.6	102
I rediscovered what is important in life.	81	79.4	21	20.6	102
I tried not to burn my bridges, but leave things open somewhat.	48	76.5	24	23.5	102
I talked to someone to find out more about the situation.	77	75.5	25	24.5	102
I told myself things that helped me feel better.	75	73.5	27	26.5	102
I changed or grew as a person.	74	72.5	28	27.5	102
I wished that the situation would go away or somehow be over with.	74	72.5	28	27.5	102
I was inspired to do something creative about the problem.	73	71.6	29	28.4	102
I knew what had to be done, so I doubled my efforts to make thinks work.	72	70.6	30	29.4	102
I prepared myself for the worst.	66	64.7	36	35.3	102
I went along with fate; sometimes I just have bad luck.	29	28.7	72	71.3	101
I generally avoided being with people.	28	27.7	73	72.3	101
I prayed.	22	22.2	77	77.8	99
I slept more than usual.	21	20.8	80	79.2	101
I took a big chance or did something very risky to solve the problem.	19	11.6	83	81.4	102
I refused to believe that it had happened.	12	11.9	89	88.1	101

According to the manual, relative scores describe the contribution of each coping scale relative to all of the scales combined. This technique controls the unequal numbers of items within the scales and the individual differences in response rates (Folkman and Lazarus, 1988).

Table 5.13 shows that the highest used coping strategies (for more than 90% of respondents) were: concentrating on the next step, trying to analyse the problem in order to understand it better, and talking to someone about how they were feeling.

The next highest used strategies (80-89%) were accepting sympathy and understanding from someone, making a plan of action and following it, letting feelings out somehow, trying to keep feelings about the problem from interfering with other things, thinking this over about what to say or do in the same circumstances, and trying to see things from the other person's point of view.

The strategies least used by the respondents were as follows: Acceptance of the situation, believing it derives from bad luck, avoiding being with other people, praying, sleeping more than usual, doing something very risky in order to solve the problem, and refusal to believe that it had happened. For more details please see Appendix 22.

5.3.4.1. Coping Skills Dimensions

As it was explained before, the coping skills questionnaire has eight dimensions: *Confrontive*, *Distancing*, *Self-Controlling*, *Seeking Social Support*, *Accepting Responsibility*, *Escape-Avoidance*, *Planful Problem Solving* and *Positive Reappraisal*. According to the reference manual, the *Confronting* dimension describes aggressive efforts to change, and suggests some degree of hostility and risk-taking. The *Distancing* dimension describes cognitive efforts to detach oneself, and to minimize the significance of the situation. The *Self-Controlling* dimension measures efforts to regulate one's feelings and actions. The *Seeking Social*

Support dimension looks at efforts to seek informational support, tangible support, and emotional support. The *Accepting Responsibility* dimension acknowledges one's own role in the problem with a concomitant theme of trying to put things right. The Escape-Avoidance dimension describes wishful thinking and behavioural efforts to escape or avoid problems. The questions for the *Astute Problem Solving* dimension help to describe deliberate problem-focussed efforts to alter the situation, coupled with an analytic approach to solving the problem. Finally, the *Positive Reappraisal* dimension describes efforts to create a positive meaning by focussing on personal growth. It also has a religious dimension (Folkman and Lazarus, 1988).

Table 5.14 Scores of each dimension of the WAYS-R results –Survey-

	N	N of items	Raw scores			Average scores		
			Mean	Std. Deviation	Median	Mean	S. E. of average scores	Median
Confrontive	101	6	5.68	3.555083	5.00	.94	0.353744	.83
Distancing	100	6	3.92	3.930405	3.00	.65	0.39304	.50
Self-Controlling	100	7	8.97	4.144986	8.00	1.28	0.414499	1.14
Seeking Social Support	101	6	8.92	4.957183	9.00	1.48	0.493258	1.50
Accepting Responsibility	102	4	2.89	2.665908	2.00	.72	0.263964	.50
Escape-Avoidance	99	8	5.24	3.41393	5.00	.65	0.343113	.62
Planful Problem Solving	101	6	7.96	3.399767	7.00	1.32	0.338289	1.16
Positive Reappraisal	97	7	7.49	4.308721	7.00	1.07	0.437484	1.00

It can be seen from Table 5.14 that the highest mean of the raw scores was highest for *Self-Controlling* and *Seeking Social Support* dimensions, followed by *Astute Problem Solving* and *Positive Reappraisal* dimensions. For *Confrontive* dimension and *Escape-Avoidance* the mean was 5.68 and 5.24 respectively. The coping strategies least used were the *Distancing* and *Accepting Responsibility* dimensions.

Regarding the average scores, the highest mean score obtained by the respondents corresponds to *Seeking Social Support*, followed by *Astute Solving Problem*, *Self-Controlling*, *Positive Reappraisal*, *Confrontive* and *Accepting Responsibility*. *Distancing* and *Escape-Avoidance* scores had the lowest scores.

Because WAYS-R measures coping processes and these are variable, reliability can be evaluated by examining internal consistency of the coping measures estimated with Cronbach's coefficient alpha, (see Table 5.15).

Table 5.15 Psychometric properties of Coping scales averaged over five occasions (N=150) on the WAYS-R (Table from Folkman and Lazarus, 1988)

Subscale	N of items	Mean	SD	Alpha
Confrontive	6	3.94	2.09	.70
Distancing	6	3.05	1.78	.61
Self-controlling	7	5.77	2.87	.70
Seeking social support	6	5.40	2.40	.76
Accepting responsibility	4	1.87	1.44	.66
Escape-avoidance	8	3.18	2.48	.72
Planful problem solving	6	7.25	2.34	.68
Positive reappraisal	7	3.48	2.96	.79

According to Lazarus and Folkman (1988), "the *Distancing* dimension illustrates cognitive efforts to detach oneself and to minimize the significance of the situation". Items on the subscale of *Escape-Avoidance* contrast with those on the *Distancing* scale that suggest detachment and it can be observed that in the sample of study both *Distancing* and *Escape-Avoidance* subscales scores are in contrast. The *Escape-Avoidance* subscale has a higher mean (5.24) than the *Distancing* subscale (3.92). Please refer to Table 5.10.

Figure 5.3 (below) shows the differences between the scores obtained by Folkman and Lazarus (1988) and the results obtained in the present survey. The graph shows a higher use of coping strategies in all the subscales, particularly in *Positive Re-Appraisal*, *Self-Controlling* and *Seeking Social Support* followed by *Escape-Avoidance* subscale.

Figure 5.3 Comparison of WAYS-R with this survey

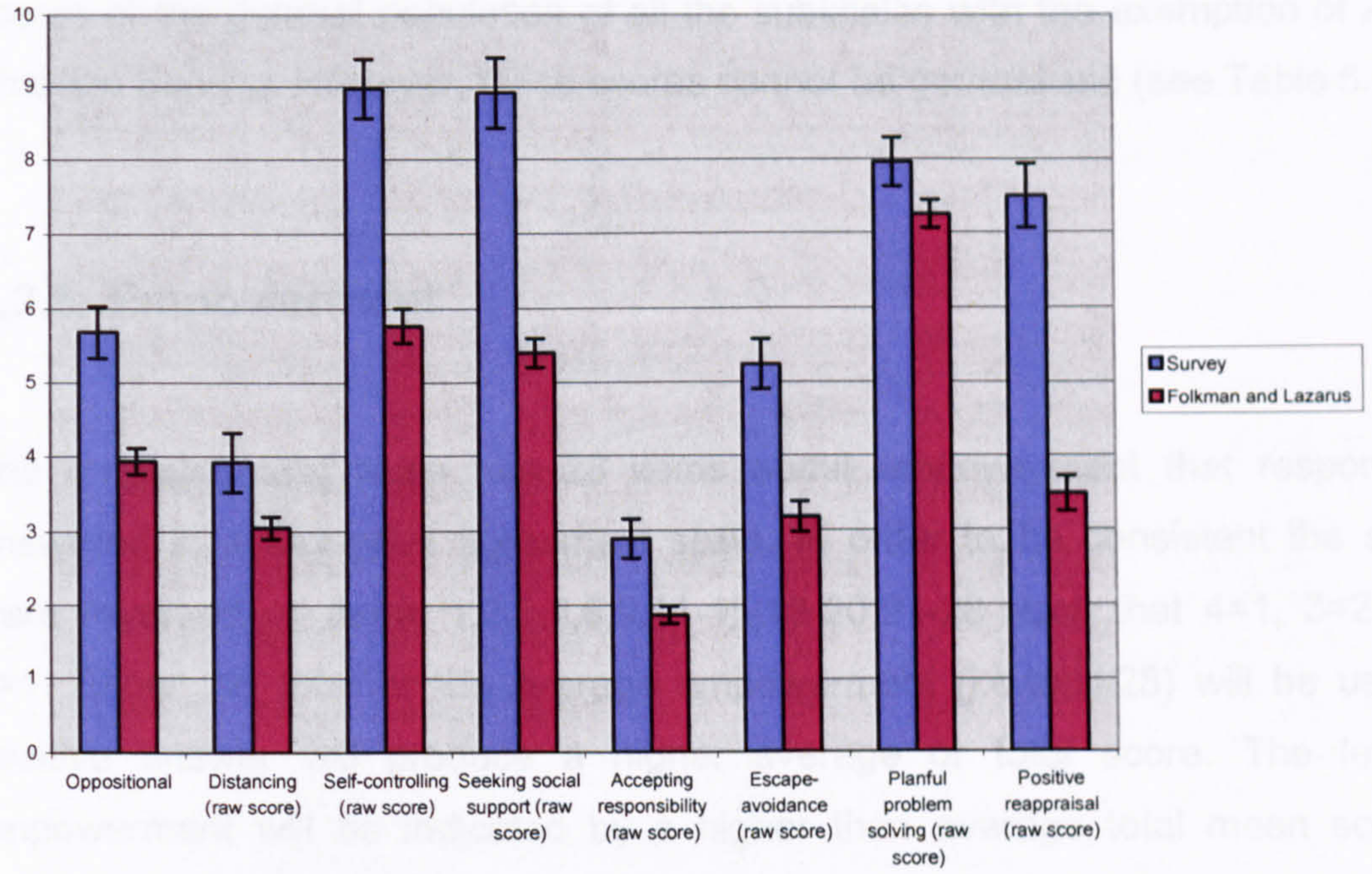


Table 5.16 shows the scores obtained comparing the results of Folkman and Lazarus (1988) and the results of the present survey. All the differences were highly significant.

Table 5.16 WAYS-R scores comparison*

Subscale	S.E (comp)	t- value	Significance
Confrontive	0.217356	8.019889	< 0.001
Distancing	0.186435	4.666502	< 0.001
Self-controlling	0.302791	10.56836	< 0.001
Seeking social support	0.26468	13.30208	< 0.001
Accepting responsibility	0.145744	7.013358	< 0.001
Escape-avoidance	0.256061	8.054417	< 0.001
Planful problem solving	0.244209	2.90897	< 0.004
Positive reappraisal	0.314342	12.77223	< 0.001

**Folkman and Lazarus (1988) and this survey*

Table 5.16 shows that all the differences were highly significant. It can be seen, that in comparison to the scores obtained by Folkman and Lazarus (Please refer

Table 5.11) the mean scores obtained by this sample are clearly higher than the scores of the general population of all the subscales with the exemption of *Astute Problem Solving*. However, these scores cannot be generalised (see Table 5.12).

5.3.5. Empowerment

The empowerment scale has 28 items about empowerment that respondents answered in a four-point agreement scale. In order to be consistent the scores were reversed on items 1,2,3,5,6,9,11-15,18-20,24-28 such that 4=1, 3=2, 2=3, 4=1. Either the total or the average empowerment (i.e.total/28) will be used. A positive answer will produce a higher average or total score. The level of empowerment will be indicated by a higher than average total mean score of 2.94±.32 reported in Rogers, *et al.*, (1997), out of a possible score of 4. A high score on this scale factor score represents a high endorsement of this factor.

The scale has five factors: *Self-Esteem-Self-Efficacy*, *Power-Powerlessness*, *Community Activism* and *Autonomy*, *Optimism And Control Over The Future*, and *Righteous Anger*.

The factor of ***Self-Esteem-Self-Efficacy*** comprises a "sense of self-worth and a belief that one can control one's destiny and life events" (Rogers *et al.*, 1997). This is one of the strongest factors of the empowerment scale, and describes in some way the idea of internal locus of control and self-efficacy. The ***Righteous Anger*** factor implies "the ability and willingness to harness anger into action" and the ***Community Activism and Autonomy*** factor defines a person who has a socio-political component.

The total scores of the scale gather evidence about the personal power and show how empowered a person is. It is an 'equal opportunity' construct with no influence by socio-demographic variables (Wowra and McCarter, 1999). It shows that an

empowered person has "sense of self worth and self-efficacy". It also "recognizes the use of anger as a motivating force to instigate social change and is optimistic about the ability to exert control over his or her life". It values autonomy as well as recognizing the importance of group or community to produce change. (Rogers, Chamberlin, Ellison and Crean, 1997).

Table 5.17. Empowerment scale (summary)

	Scores Percent
Factor 1: Self-esteem-self efficacy	
I feel I have a number of good qualities	100.0
I feel I am a person of worth, at least on equal basis with others	99.1
I see myself as a capable person	98.1
I am able to do things as well as most other people	98.1
I am often able to overcome barriers	96.1
I generally accomplish what I set out to do	96.1
When I make plans, I am almost certain to make them work	90.3
I have a positive attitude towards myself	89.2
I am usually confident about the decisions I make	88.4
Factor 2: Power-powerlessness	
Most of the misfortunes in my life were due to bad luck	5.9
Making waves never gets you anywhere	10.7
People have no right to get angry just because they don't like something	14.6
You can't fight City Hall	10.8
Experts are in the best position to decide what people should do or learn	66.6
Usually I feel alone	38.3
When I am unsure about something, I usually go along with the rest of the group	23.3
I feel powerless most of the time	3.9
Factor 3: Community activism and autonomy	
People working together can have an effect on their community	98.1
People have the right to make their own decisions, even if they are bad ones	97.1
Working with others in my community can help to change things for the better	96.0
People should try to live their lives the way they want to	95.1
Very often a problem can be solved by taking action	92.2
People have more power if they join together as a group	82.2
Factor4: Optimism and control over the future	
I am generally optimistic about the future	93.2
I can pretty much determine what will happen in my life	73.5
People are only limited by what they think is possible	62.1
Very often a problem can be solved by taking action	92.2
Factor 5: Righteous anger	
Getting angry about something is often the first step towards changing it	79.6
Getting angry about something never helps	18.5
People have no right to get angry just because they don't like something	14.6
Making waves never gets you anywhere	10.7

Table 5.17 analyses the percentages of the specific items of the different components of the empowerment scale. The particular factors that comprise this scale are as a follows. (For more detail see appendix 23)

5.3.5.1. Factor 1:Self-Esteem-Self Efficacy

With regards to *Self-Esteem-Self-Efficacy* the most noticeable result was that none of the respondents disagreed or strongly disagreed with the item 'I feel I have a number of good qualities'. Also, 89.2% of the respondents said that they had a positive attitude toward themselves, 88.4% also concurred they felt usually confident about the decisions they make, 98.1% indicated that they saw themselves as capable people, 96.1% reported feeling that they were often able to overcome barriers, 90.3% stated that 'when I make plans, I am almost certain to make them work', 98.1% thought that they were 'able to do things as well as most other people', 96.1% indicated that they generally accomplished what they set out to do, 99.1% of the participants considered themselves being of worth 'at least on an equal basis with others'.

5.3.5.2. Factor 2: Power-Powerlessness

Regarding *Power-Powerlessness*, the highest average number of participants marked thought the following:

- 85.42% of the participants disagreed that 'people have no right to get angry just because they don't like something',
- 94.1% disagreed that 'most of the misfortunes in my life were due to bad luck',
- 89.3% disagreed with 'making waves never gets you anywhere',
- 66.6% of the respondents did not usually feel alone,
- 66.7% agreed that 'experts are in the best position to decide what people should do or learn',

- 89.2% said they felt it was possible to 'fight City Hall',
- 3.9% of the participants felt 'powerless most of the time' (none strongly disagreed with this statement),
- 76.7% disagreed that 'when I am unsure about something, I usually go along with the rest of the group'.

5.3.5.3. Factor 3: Community Activism And Autonomy

The highest averages stated by respondents for community activism and autonomy factor were:

- Demonstrating agreement that 'people have more power if they join together as a group' (82.2%).
- Agreeing with the statement that 'people working together can have an effect on their community' (95.1%).
- Also agreeing with 'people should try to live their lives the way they want to' (95.1%),
- Very few respondents disagreed that 'people have the right to make their own decisions, even if they are bad ones' (2.9%),
- Concurring with the item 'very often a problem can be solved by taking action' (92.2%).
- Finally, agreeing or strongly agreeing that 'working with others in their community can help to change things for the better' (96%).

5.3.5.4. Factor 4: Optimism and Control Over The Future

Responses for this factor were as follows:

- Approximately three quarters of the participants reported that they concurred that they 'could pretty well determine what would happen in their lives'.

- More than half of the participants were in agreement that 'people are only limited by what they think is possible',
- A high proportion of participants (93.2%). said that they agreed or strongly agreed with 'feeling generally optimistic about the future'.
- Only 7.8% of respondents disagreed that 'very often a problem can be solved by taking action'.

5.3.5.5. Factor 5: Righteous Anger

Most of the respondents did not agree that 'getting angry about something never helps' (81.5%),

- Similarly, most participants disagreed that 'people have no right to get angry just because they don't like something' (85.5%),
- Also, 89.3% disagreed that 'making waves never gets you anywhere',
- Finally, just over three quarters of respondents (79.6%) agreed that 'getting angry about something is often the first step toward changing it'.

5.3.5.6. Overall empowerment score

The overall mean score for the empowerment scale was 3.11. This total mean score indicates that the survey was above the midpoint (2) for the instrument (out of a possible score of 4) and shows a high level of empowerment.

Figure 5.4: Empowerment raw score

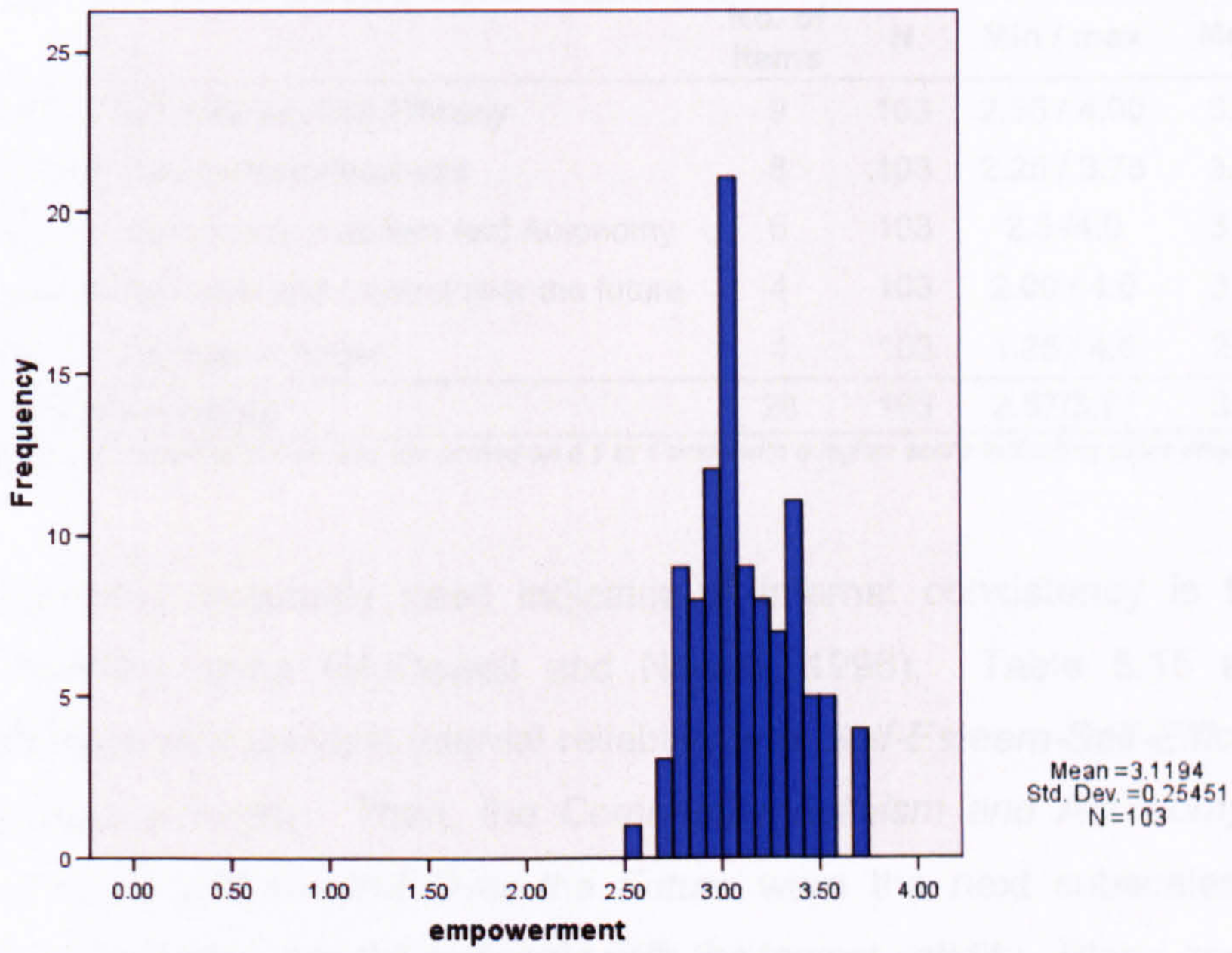


Figure 5.4 shows that the scores of the whole sample are in the range from empowered to very empowered (i.e. between 2.5 and 4).

5.3.5.1. Empowerment subscales

As Table 5.18 shows, the empowerment scores were the highest for the *Community Activism And Autonomy* factor, followed by *Self-Esteem-Self-Efficacy*. The *Power-Powerlessness* factor was third. *Optimism And Control Over The Future* and *Righteous Anger* showed the lowest range of scores. However, in general, the scores were high.

Table 5.18 Empowerment scale results

	No. of items	N	Min / max	Mean	Std Deviation
Factor 1 Self-Esteem-Self-Efficacy	9	103	2.56 / 4.00	3.21	0.363
Factor 2: Power-Powerlessness	8	103	2.25 / 3.75	3.05	0.271
Factor 3: Community Activism And Autonomy	6	103	2.5 /4.0	3.24	0.348
Factor4: Optimism and Control over the future	4	103	2.00 / 4.0	3.00	0.411
Factor 5: Righteous Anger	4	103	1.25 / 4.0	2.95	0.492
Overall mean score	28	103	2.57/3.71	3.11	0.254

Note: Empowerment dimensions are scored on a 1 to 4 scale with a higher score indicating more empowerment

The most frequently used indicator of internal consistency is the Cronbach's coefficient alpha (McDowell and Newell, 1996). Table 5.15 shows that the subscale with greatest internal reliability was *Self-Esteem-Self-Efficacy* followed by *Righteous Anger*. Then, the *Community Activism and Autonomy* subscale and *Optimism and Control Over the Future* were the next subscales, while *Power-Powerlessness* was the subscale with the lowest validity. Bland and Altman (1997) suggest that for comparing groups, scores of 0.7 to 0.8 are regarded as satisfactory, whereas for separate scores, a score from 0.61 to 0.88 gives a satisfactory internal validity. Thus, it is important to bear in mind that the Factor 2 in this case is not very reliable, whereas both the *Self-Esteem-Self-Efficacy* factor and the *Righteous Anger* factor have a satisfactory internal validity.

Table 5.19: Empowerment - Cronbach's Alpha results

Empowerment subscale	Cronbach's Alpha	
Factor 1 Self-Esteem-Self-Efficacy	0.886 (N=101)	
Factor 2: Power-Powerlessness	0.504 (N=100)	(6 items)
Factor 3: Community Activism And Autonomy	0.675 (N=100)	
Factor4: Optimism And Control Over The Future	0.623 (N=101)	(3 items)
Factor 5: Righteous Anger	0.731 (N=103)	

Factors 2 and 4 of the empowerment scale did not have reliability in this study. Few items of the whole scale demonstrate able to be considered due to the response rate of the specific subscales. Streiner and Norman (1995) suggest that a way to increase reliability is to have more items. Therefore, if the number of items

included greater, possibly Cronbach's Alpha would have been higher. Rogers *et al.* (1997:123) reported, *"as long as the test items are not perfectly correlated, the true variance will increase as the square of the number of items, whereas the error variance will increase only as the number of items".*

5.3.6. Dominance Power Indicators

This section of the questionnaire comprises four items (see Table 5.16). The first item is an open question. The remainder use a four-point frequency scale of the Likert type. The latter indicates agreement with items from 'strongly disagree' to 'strongly agree' (1 indicates strongly disagree, 2 disagree, 3 agree and 4 strongly disagree).

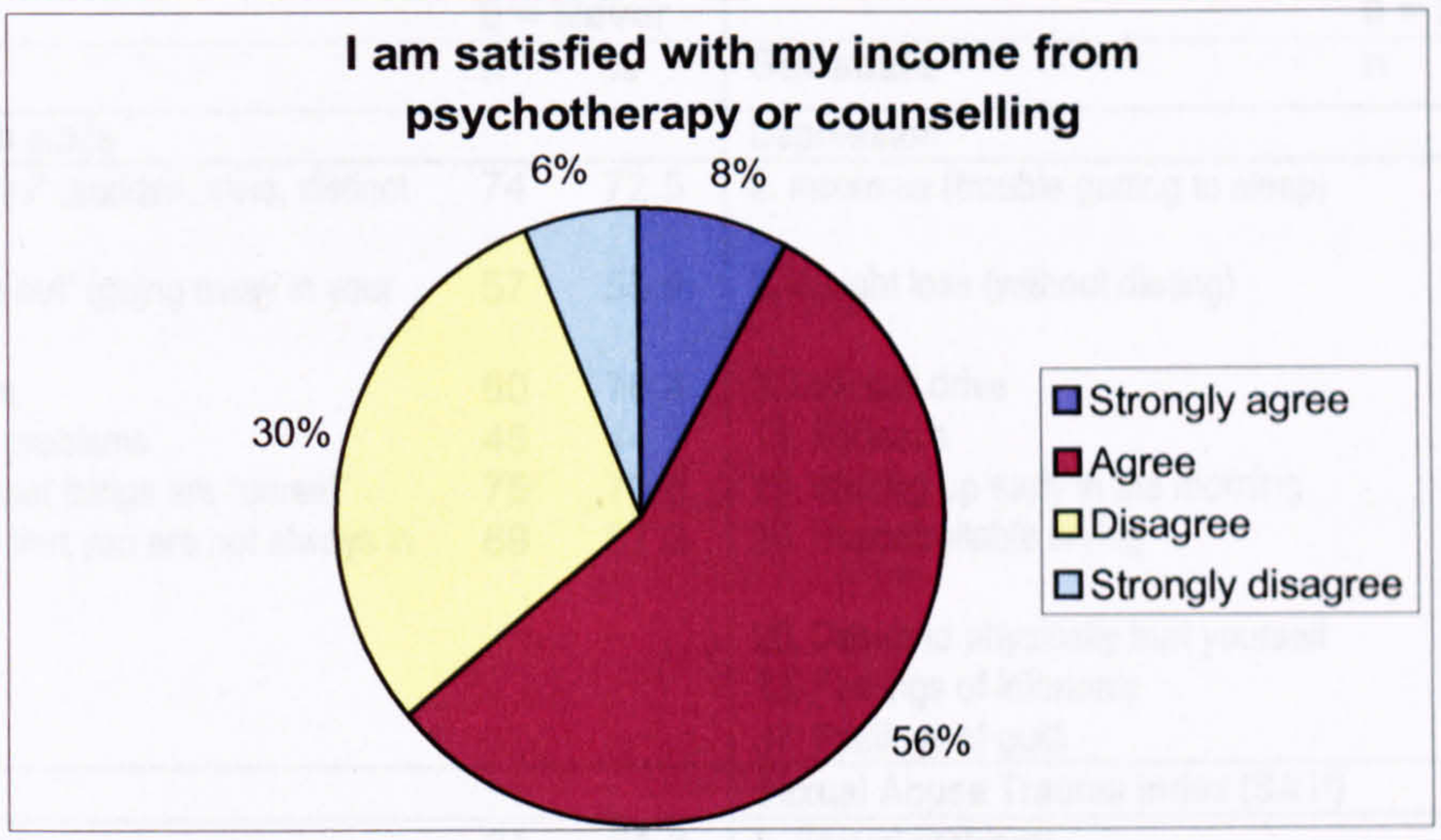
Table 5.20 Dominance power indicators

	Results
How many people work for you?	
0	68%
0 - 75	32%
I am satisfied with my income from psychotherapy or counselling	56% agree
I feel confident in myself	75%
Other psychotherapists respect my work	89%

Dominance power indicates how much power the participants had over the others. The number of people each psychotherapist was in charge of varied widely from none to 75. Out of 103 respondents 68% reported that no-one worked for them – presumably because they worked independently. 32% of the respondents had subordinates.

As Figure 5.5 shows, more than half of the psychotherapists/counsellors were satisfied with their income from professional practice. Few of them strongly agreed with this. However, almost 30% disagreed, and 6% strongly disagreed.

Figure 5.5: Satisfaction with income from psychotherapy or counselling



- Almost three quarters of psychotherapists and counsellors felt confident in themselves.
- Few strongly agreed with feeling confident in themselves (20%).
- 89% of the survey agreed that other psychotherapists respected their work.
- 8% strongly agreed that other psychotherapists respected their work.

More than half of the respondents were willing to be contacted by the researcher whereas about a third were not.

5.3.7. Childhood Abuse Trauma

The Trauma Symptom Checklist-40 (TSC-40) is a scale that helps to evaluate symptomatology in adults associated with childhood or adult traumatic experiences.

Table 5.21 Childhood Abuse Trauma – 40

	0 = Never			0 = Never	
Subscale	**n**	**%**	**Subscale**	**n**	**%**
Dissociation scale			**Depression**		
7. "Flashbacks" (sudden, vivid, distinct memories)	74	72.5	2. Insomnia (trouble getting to sleep)	41	40.2
14. "Spacing out" (going away in your mind)	57	55.9	3. Weight loss (without dieting)	90	88.2
16. Dizziness	80	78.4	9. Low sex drive	39	37.9
25. Memory problems	45	44.1	15. Sadness	15	14.6
31. Feeling that things are "unreal"	75	73.5	19. Waking up early in the morning	40	39.2
38. Feelings that you are not always in your body	89	87.3	20. Uncontrollable crying	84	84
			26. Desire to physically hurt yourself	97	95.1
			33. Feelings of inferiority	51	50
			37. Feelings of guilt	44	43.1
Anxiety			**Sexual Abuse Trauma Index (SATI)**		
1. Headaches	31	31.3	5. Sexual problems	61	61
4. Stomach problems	56	54.9	7. "Flashbacks" (sudden, vivid, distinct memories)	74	72.5
10. Anxiety attacks	66	64.7	13. Nightmares	72	70.6
16. Dizziness	80	78.4	21. Fear of men	85	83.3
21. Fear of men	85	83.3	25. Memory problems	45	44.1
27. Fear of women	83	81.4	29. Bad thoughts or feelings during sex	82	81.2
32. Unnecessary or over-frequent washing	97	95.1	31. Feeling that things are "unreal"	75	73.5
34. Feeling tense all the time	52	51			
39. Having trouble breathing	84	82.4			
Sleep disturbance			**REMAINING ITEMS**		
2. Insomnia (trouble getting to sleep)	41	40.2	6. Feeling isolated from others	41	39.8
8. Restless sleep	27	26.5	12. Loneliness	43	42.2
19. Waking up early in the morning	40	39.2	18. Trouble controlling your temper	50	49
22. Not feeling rested in the morning	22	21.6	24. Trouble getting along with others	58	56.9
28. Waking up in the middle of the night	36	35.3	30. Passing out	99	97.1
Sexual Problems			36. Desire to physically hurt others	92	90.2
5. Sexual problems	61	61			
11. Sexual overactivity	85	83.3			
17. Not feeling satisfied with your sex life	29	28.2			
23. Having sex that you didn't enjoy	66	64.7			
29. Bad thoughts or feelings during sex	82	81.2			
35. Being confused about your sexual feelings	81	79.4			
40. Sexual feelings when you shouldn't have them	73	73			

As Briere (2001) explains, the TSC-40 questionnaire "*measures aspects of post-traumatic stress and other symptoms found in some traumatized individuals*". It was originally developed to assess child abuse–related symptoms present in adult survivors.

This checklist has 40 items. It makes use of a 4-point frequency rating scale to obtain a score ranging from 0 to 120 scoring 0 = never to 3 = often. It has six subscales: anxiety, depression, dissociation, post sexual abuse trauma (SATI), sleep disturbance and sexual problems. The SATI subscale measures symptoms that are often found in survivors of child sexual abuse.

The most frequent symptoms of trauma reported by the respondents, given in Table 5.21, were:

- Sadness (85.4%).
- Not feeling rested in the morning (78.4%).
- Not feeling satisfied with their sex life in the last two months (71.9%).
- Almost three quarters of respondents experienced restless sleep (73.6%).
- More than half of respondents reported the presence of headaches (68.7%).
- More than half of the participants woke up early in the morning (60.8%).

Some of the symptoms occurred rarely:

- Passing out' (97.1%).
- Unnecessary or over-frequent washing 95.1%, and
- Never having the desire to physically hurt themselves (95.1%).
- 90.2% reported never 'having the desire to physically hurt others'.
- None reported often 'having the desire to physically hurt others'.
- Weight loss (without dieting) occurred in 88.2%.
- 87.3% of cases answered they 'never have feelings that you are not always in your body'.
- 84% reported never having uncontrollable crying'.
- Few said that they had 'experienced sexual over-activity'.
- 83.3% admitted 'experiencing fear of men'.
- 82.4% confessed to 'have trouble breathing'.
- None reported that this happened often.
- 81.4% experienced 'feeling fear of women'.
- 81.2% replied that they 'experienced bad thoughts or feelings during sex'.

Any more details are given in Appendix 24.

Table 5.22 TSC-40 scores

Subscales (Mean scores)	No items	Mean of each item		Overall Mean	Median	N
		Minimum	Maximum			
Dissociation	6	.00	.4224	.4224	.3333	101
Anxiety	9	.00	.4147	.4147	.3333	97
Depression	9	.00	.6533	.6533	.5556	100
Sexual abuse trauma index	7	.00	.4286	.4286	.2857	99
Sleep disturbance	6	.00	.9367	.9367	.8333	100
Sexual problems	8	.00	.5528	.5528	.5000	97

Table 5.22 shows the results of the whole cohort. The scores are very small, showing very few symptoms of trauma in the whole sample. The scale with the highest score was *Sleep Disturbance* (mean 0.94), followed by *Depression* (mean 0.65), and *Sexual Problems* (mean 0.55). The lowest was *Anxiety* (mean 0.41).

5.3.8. Impact of childhood abuse on the psychotherapy practice

This section was the seventh section of the questionnaire. It contained questions with different forms of answer. The request "*Please estimate the approximate percentage of your clients that have been abused*" was an open item for completion with a number. The questions "*How difficult are most of your clients who have not been abused?*" and "H*ow difficult is it for you to work with most of your clients who have been abused?*" used a visual analogue form of response, where the response was marked on a line of 10cm with *"Not difficult"* to *"Extremely difficult"* on each extreme of the line. It was measured with a rule and the measure from left to right was annotated with a number of one digit and one decimal (up to number 10). This facilitates finer comparisons between respondents (details in Table 5.19).

Table 5.23 The impact of childhood abuse on the psychotherapy practice

Question	Mean	Median	Range	Minimum/maximum
Please estimate the approximate percentage of your clients that have been abused	51.08	50	(1 –100)	1 / 100
How difficult are most of your clients who have not been abused?	4.2	4.3	(0 – 10)	0 / 10
How difficult is it for you to work with most of your clients who have been abused?	4.4	4.7	(0 – 10)	0 / 8.8

As show in Table 5.23, the psychotherapists/counsellors who were surveyed estimated that 51% of clients were abused. In their opinion, there is little difference between working with clients who have not experienced abuse (mean 4.2 on a scale of difficulty 0 to 10) and working with clients who have been abused (mean 4.4).

The question *"In your experience, what factors help people surmount child abuse?"* had five options with a 'Yes' or 'No' to select (see Table 5.20).

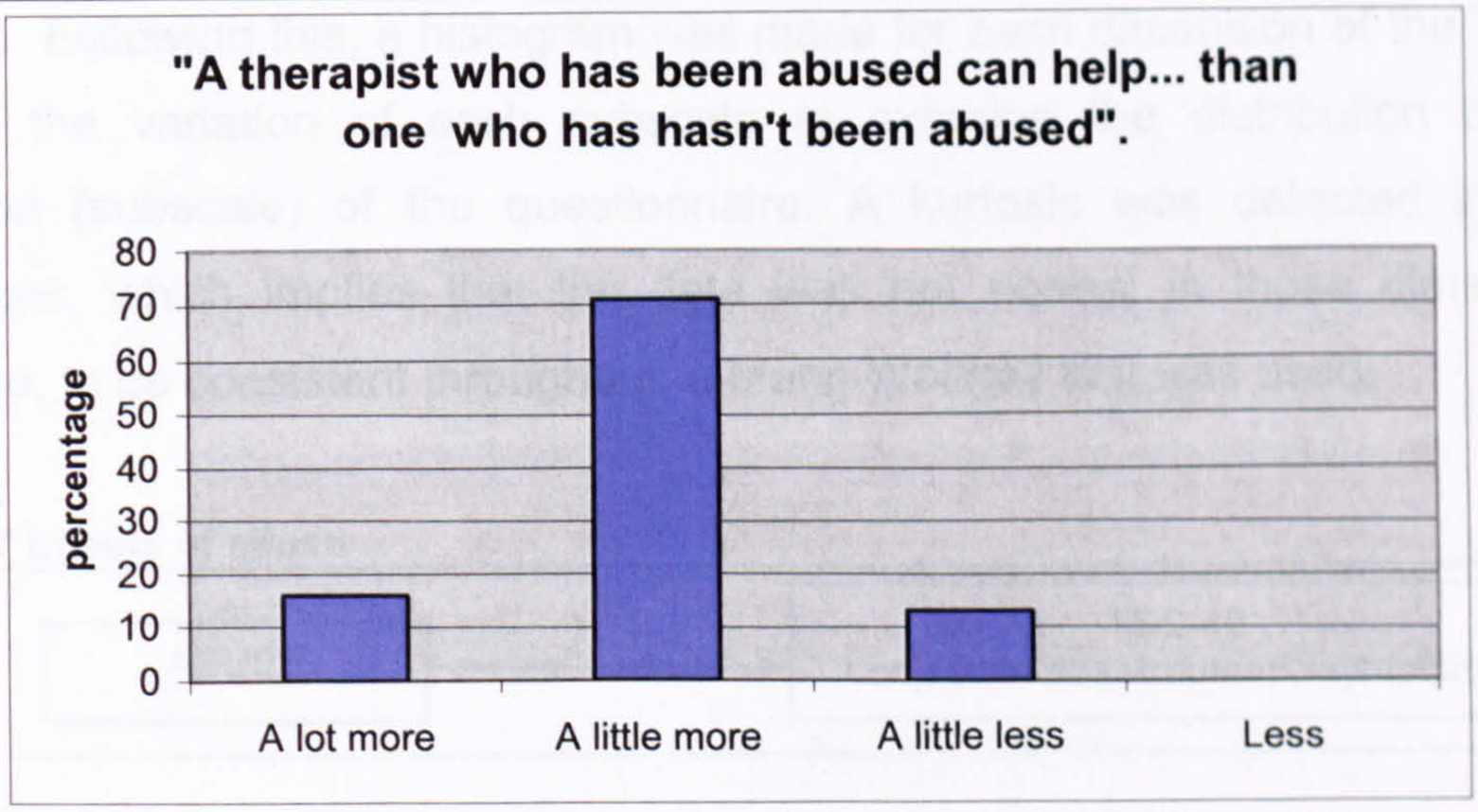
Table 5.24 Factors reported as helping people surmount child abuse

Factors	Percent	Percent of missing values
Self control	40	18
Family support	81	9
Information about the causes and effects of child abuse	88	6
Taking account of your own feelings	99	4
Expressing your anger	89	36
Other factors reported by the participants	Psychotherapy, Finding support from others, Refusing to be the victim, Accepting that it was not your fault.	

Table 5.24 shows that in the experience of the study's participants, the factors that help to overcome childhood abuse are mainly 'Family support' (81%), Information about causes and effects of child abuse (88%), Expressing anger (89%) and particularly Working with one's own feelings (99%). Self-control was reported as not so helpful (40%). Psychotherapy, 'Finding support from others', 'Refusing to be the victim' and 'Accepting that it was not your fault' were reported as other factors.

The statement "*A therapist who experienced abuse can help"* had four Likert type options: 'A *lot more'*, 'A *little more'*, *'A little less'* and *'Less'*. As shown in Figure 5.6 below, 71% of the survey's participants reported that a therapist who had been abused could help clients a little more (33 of the cases were unanswered). Few of them considered that it helped a lot more (16%), whilst 13% considered that it 'helped a little less'. However, none of the psychotherapists responded with 'less'.

Figure 5.6: Therapists' opinions regarding practitioners who had experienced abuse (n=70)*



*33 missing values.

In the next section, the impact of the Childhood experience and Confounding variables of the research questions are analysed. Then, analyses to find the factors that help to achieve resilience are explained. Finally, an integration of the results and comparison with other studies are explained in the discussions at the end of this Chapter.

5.4 Interaction of variables

In order to understand how the different variables are combined, analyses between the different variables relevant to this study were done.

5.4.1. Childhood abuse trauma symptoms

In order to discover if there is an on-going psychological trauma as a result of the experience of abuse a Mann Whitney test was used. This enabled us to determine if there was a higher score of TSC-40 within the respondents who experienced child abuse than within those who did not. (Figure 5.7) The variable "Do you consider that you were abused as a child?" was defined for the 'Yes' and 'No' answers. Following this, a histogram was made for each dimension of the TSC-40 showing the variation of each subscale to examine the distribution of each dimension (subscale) of the questionnaire. A kurtosis was detected in some dimensions, which implies that the data was not normal in those dimensions. Therefore, to be consistent throughout, a Mann Whitney test was used.

Figure 5.7 Effects of abuse

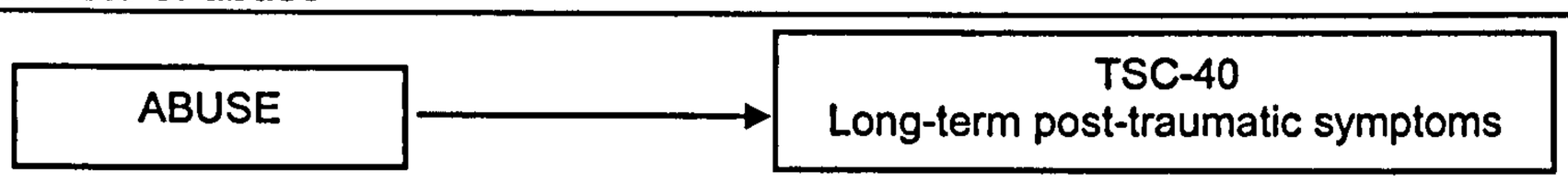


Table 5.25 below summarises the 'Trauma Symptoms Checklist-40' for abused and non-abused respondents. The TSC-40 consists of six subscales: *Dissociation*, *Anxiety*, *Depression*, *Sexual Abuse Trauma Index* (SATI), *Sleep disturbance*, and *Sexual Problems*.

The results show that, in general, there is a highly significant difference between those who experienced abuse in childhood and those who did not. The Table shows that there is a higher score of symptoms of child abuse trauma within the group of respondents who experienced child abuse than in those who did not ($p<.001$). In general the p-values are lower than 0.001 except for the scale of sleep disturbance. Therefore, for all the subscales, the difference was highly significant between participants who reported abuse and those who did not. Those who reported experience of child abuse scored higher on the different subscales of the TSC-40, reporting more symptoms of trauma as a result of the child abuse. For

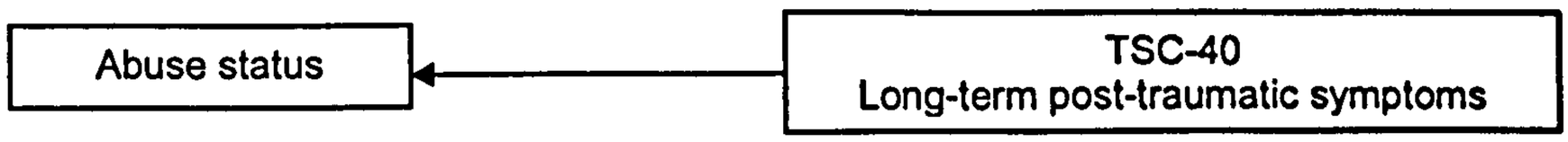
the other subscales, the sleep disturbance scale was particularly highest on the participants who experienced childhood abuse.

Table 5.25 TSC-40 values for Abused *vs.* Not Abused

TSC-40 subscales (Mean score)	Child abuse: YES N	YES Mean	YES S. E.	Child abuse: NO N	NO Mean	NO S. E.	p value
Total score	52	.6769	0.049	41	.3598	0.028	**< .001**
Dissociation	56	.5923	0.063	44	.1894	0.030	**< .001**
Anxiety	54	.5514	0.050	43	.2429	0.030	**< .001**
Depression	55	.7636	0.050	44	.5051	0.041	**.001**
Sexual Abuse Trauma Index (SATI)	55	.6130	0.066	44	.1981	0.029	**< .001**
Sleep disturbance	56	1.089	0.101	43	.7326	0.074	**.009**
Sexual problems	54	.7083	0.075	43	.3576	0.045	**< .001**

In order to assess whether or not there is a relationship between participants who reported child abuse (*i.e.* having a high score of TSC-40) and respondents with no experience of child abuse (*i.e.* having a low score), Figure 5.8.

Figure 5.8 Relationship between Abuse and long-term post-traumatic symptoms



Univariate analysis of variance was conducted with the TSC-40 total score mean as dependent variable, with fixed factors of sex and abuse, age was the covariate of this statistical analysis. This analysis of variance was chosen because sexual abuse were categorical responses and are handled better than by using dummy variables in regression analysis.

Figure 5.9 Plots of TSC-40 values for Abuse/No Abuse

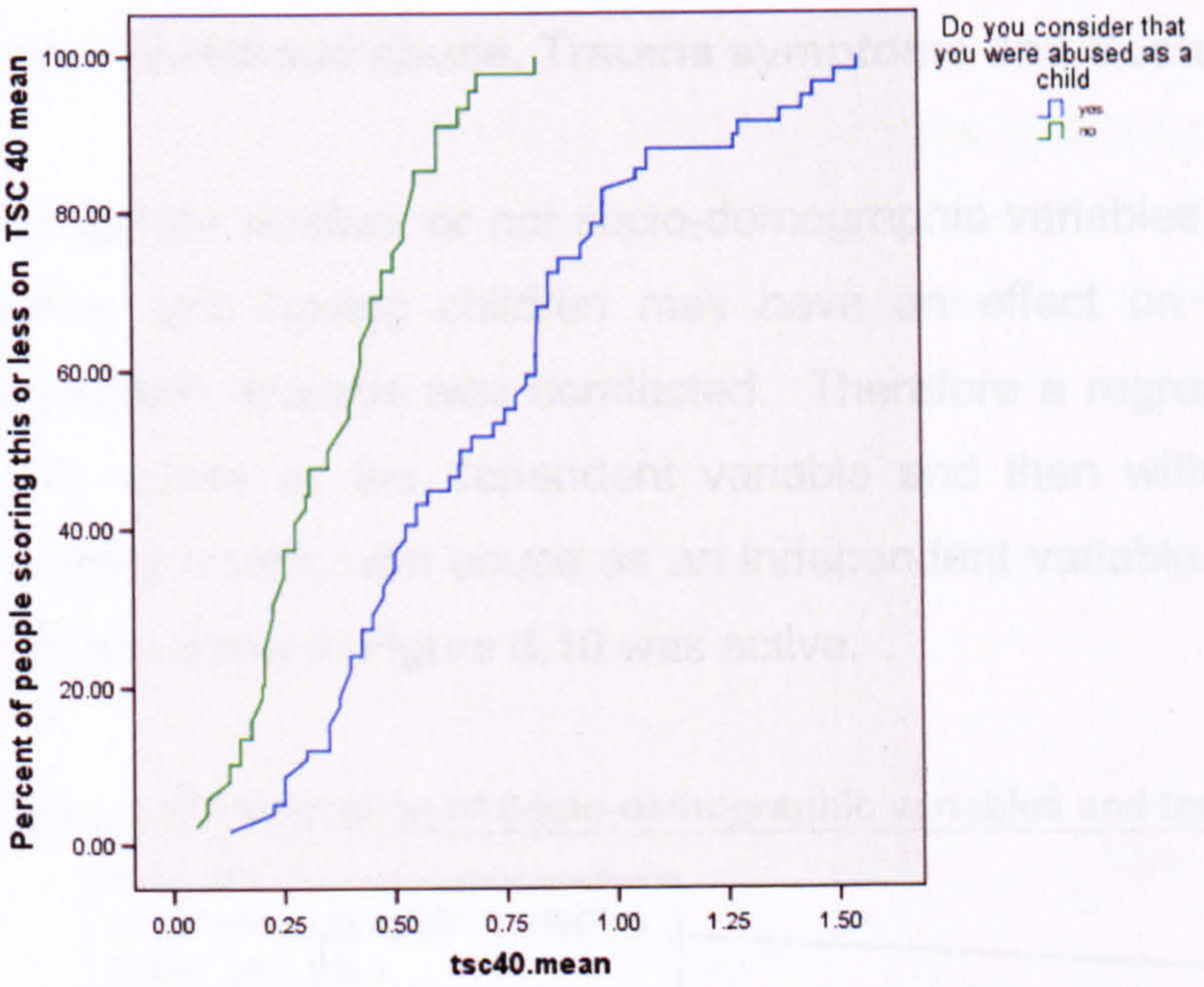


Figure 5.9 illustrates the results of the TSC-40 total scores where participants with no abuse tended to have lower scores of trauma than people who reported childhood abuse. This difference was significant (p-value of 0.001).

Table 5.26: Analysis of Variance (ANOVA) table for TSC-40 and child abuse

	Mean	(95% CI)	Std Error
Experience of child abuse	.659	(0.571; 0.747)	.044
Did not experience child abuse	.357	(0.261; 0.452)	.048

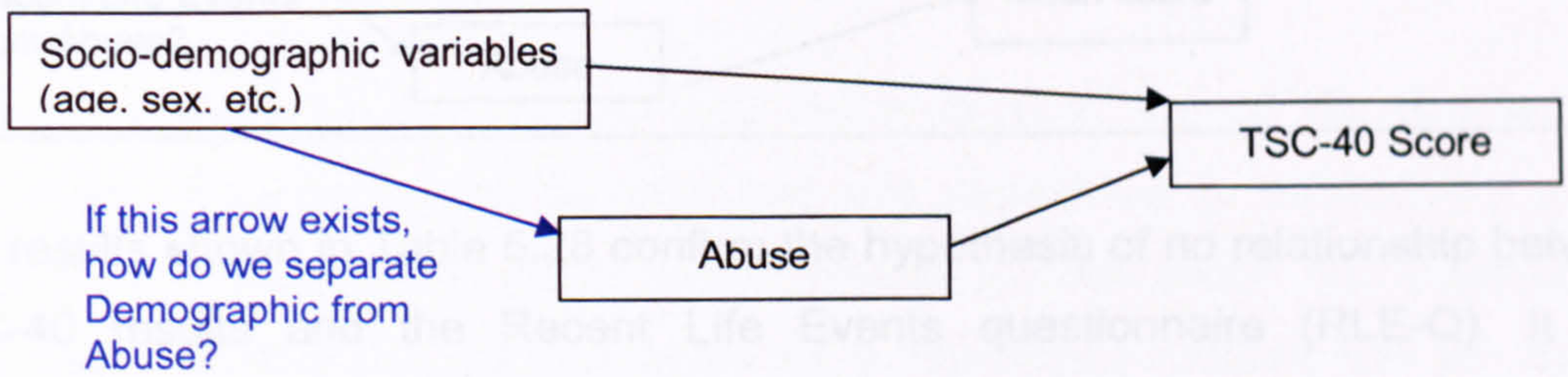
**F (1.98) = 22.291 p < .001*

Table 5.26 shows the results of the analysis of variance, where the means of the TSC-40 scores that do not reflect trauma are very small in both groups. However, the mean for those respondents who experienced child abuse is higher than the mean for those who were not abused in childhood. This suggests that individuals who experience child abuse are more likely to have trauma. The TSC-40 scores were significantly higher (about double) for the abused as opposed to the non-abused. ($F=22.291$, $p < .001$).

5.4.2 Childhood abuse, Trauma symptoms and Socio-demographic variables

To explore whether or not socio-demographic variables such as sex, age, marital status, and having children may have an effect on the trauma symptoms, a regression analysis was conducted. Therefore a regression was carried out with TSC scores as the dependent variable and then with each socio-demographic variable in turn, with abuse as an independent variable. This was to determine if the blue arrow in Figure 5.10 was active.

Figure 5.10 Exploration of Socio-demographic variables and trauma



If this analysis found a relationship between being abused and the Socio-demographic variable, then the TSC-40 score cannot be ascribed only to whether a person has been abused.

Table 5.27 Regression analysis on the inclusion of Socio-demographic variables and the effect of having abuse has on TSC-40 score

Covariate	Abuse coef. B	p-value	Covariate coef. B	p-value
None	12.687	.000	n/a	n/a
Sex	12.249	<.001	2.197	.080
Age	12.469	<.001	-0.87	.537
***Marital status**	12.987	<.001	n/a*	.373
Childrearing	12.752	<.001	-973	.706

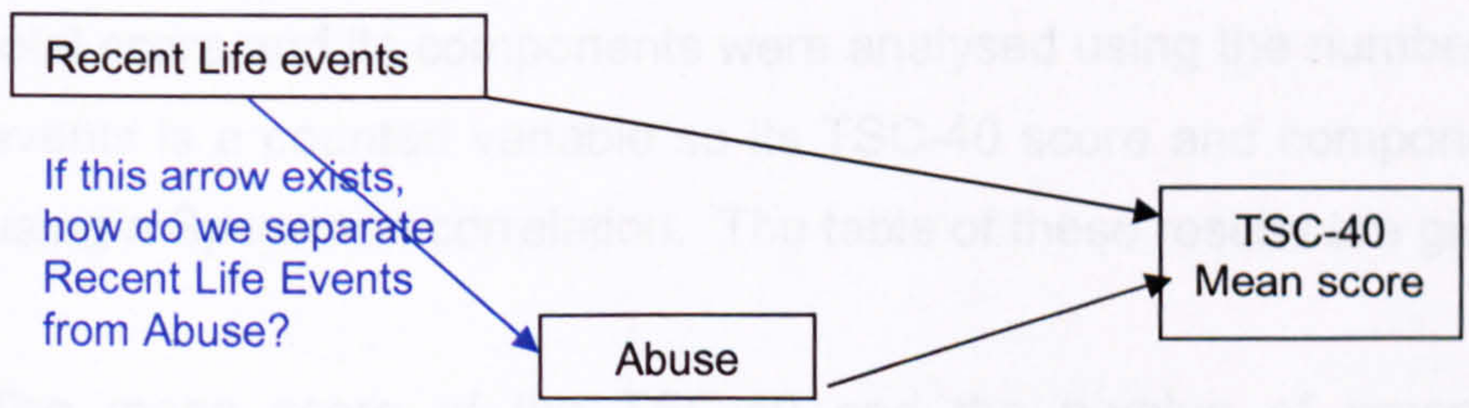
**Marital status is a multifactor covariate (i.e. has 2 d.f.) These were split into never married/been married and never lost spouse/lost spouse then the covariate coefficients are 4.441 and –4.100.*

Table 5.27 shows that either sex, age, marital status or childrearing have no effect on how abuse is related to traumatic symptoms (TSC-40 score).

5.4.3. Childhood abuse, Trauma symptoms and Recent Life Events

A correlation was conducted using the sample of child abuse and the TSC-40. This was to discover any difference between the TSC-40 score, which measures psychological trauma, to try to find if there was a relationship between these variables (Figure 5.11).

Figure 5.11 Possible relationships between Trauma, Recent Life Events and Childhood Abuse



The results shown in Table 5.28 confirm the hypothesis of no relationship between TSC-40 results and the Recent Life Events questionnaire (RLE-Q). It was calculated using the mean TSC-40's score and the p-value.

Table 5.28 Partial Spearman Correlation between RLE-Q and TSC-40

Spearman's rho*	N	Rank of Recent Life events	p-value
Disassociation	90	.109	.302
Anxiety	90	.178	.089
Depression	90	.206	.048
Sexual Abuse Trauma Index	90	.121	.249
Sleep disturbance	90	.125	.235
Sexual problems	90	.150	.154
Total TSC-40	90	.225	.031

**by abuse group*

Results shown in Table 5.28 indicate that only depression (p .048) and the total score (p .031) on post-traumatic symptoms are significant, but not the other variables of TSC-40.

5.4.4. Dimensions of trauma subscales and their relationships to Recent Life Events

As commented before, the TSC-40 measures trauma, and it has several subscales that provide information of different post-traumatic symptoms related to child abuse. The TSC-40 total score is made up of six subscales: *Dissociation*, *Anxiety*, *Depression*, *SATI*, *Sleep Disturbance* and *Sexual Problems*. The data in the survey allowed us to see if a respondent had recently had a major life event, and how many of them. Life event is a binary score (present or absent) so the TSC-40 total score and its components were analysed using the number of life events. Life events is a counted variable so its TSC-40 score and components were analysed using a Spearman correlation. The table of these results are given in Table 5.29.

The mean score of the TSC-40 and the p-value of recent life events were calculated. An independent samples test was carried out to determine if a high score of trauma symptoms are or are not related to a life event. The analysis was conducted with the TSC-40 total score as a dependent variable and the Recent Life Events as an independent variable.

Table 5.29 Spearman correlations of TSC-40 and Recent Life Events

Covariable	TSC- 40 Subscales						
	Total Score	Dissociation	Anxiety	Depression	SATI	Sleep disturbance	Sexual Problems
Had a life event	0.144	0.487	0.210	0.061	0.258	0.883	0.149
Number of life events	0.223	0.958	0.108	0.075	0.434	0.812	0.105

The results were not significant in any way. This means that there was no recent life event or number of life events that affected the score of the TSC-40 (see Table 5.29). It can therefore be concluded that there is no relationship between the TSC-40 and whether a person had had a recent life event.

5.4.5. Relationship between child abuse and coping

With regard to the distribution of *Ways of Coping* dimensions, a histogram for each of the eight dimensions of the Ways of Coping Questionnaire (WAYS-R) was used. It was decided that a t-test for independent samples of child abuse would be conducted.

Table 5.30 below shows the results of the WAYS-R in terms of abused and not abused respondents.

Table 5.30Independent Samples Test of Child abuse and Ways of Coping Questionnaire

	n=58 Mean ABUSED	n=44 Mean NOT ABUSED	Mean difference	p-value
Confrontive	0.9394	0.9494	0.010	.945
Distancing	0.7302	0.6329	-0.097	.548
Self-controlling	1.4740	1.2271	-0.2469	.084
Seeking Social Support	1.2778	1.5417	0.2639	.194
Accepting Responsibility	0.8295	0.6938	-0.1358	.400
Escape-Avoidance	0.7102	0.6396	-0.071	.496
Planful Problem Solving	1.1439	1.3776	0.2337	.087
Positive Reappraisal	0.9500	1.1020	0.1520	.328

The results show that there was no significant difference in the ways of coping between people who were abused and people who were not.

5.4.6. Relationship between child abuse, trauma symptoms, and coping

A correlation test was performed with the aim of determining the coping strategies used by the abused respondents through TSC-40, and to see if there was a clear relationship in the use of coping strategies (Table 5.29).

Table 5.31 Correlation between Ways of Coping and TSC-40

TSC-40 Total score (mean score) (Rho)	Confronti ve (mean score)	Distancin g (mean score)	Self-controlli ng (mean score)	Seeking social support (mean score)	Accepting responsibil ity (mean score)	Escape - avoida nce (mean score)	Planful problem solving (mean score)	Positive reapprais al (mean score)
Correlation	.041	.121	.090	-.023	.202	.256	-.075	-.024
p-value	.697	.255	.401	.832	.054	.015	.481	.822
N	91	90	90	91	92	89	91	87

Table 5.31 shows that people with a high score on TSC-40 also have a higher score in *Escape-Avoidance* (.256) and in *Accepting Responsibility* subscales (.054). This suggests that the more helpful ways of coping are accepting responsibility and problem solving.

In order to answer the question "Is there any difference between the different coping skills of people who experienced child abuse with no emotional trauma, and those who were abused and have trauma?", various statistical tests were done. Firstly a scatter plot was done to detect the number of symptoms that could make a case for the existence of trauma. The scatter plot showed that five items marked as moderate or severe would be registered as a case for trauma. This gave the results of 42 (41%) of the population (N=103) who scored as a case for trauma due to abuse. See table 5.32 below.

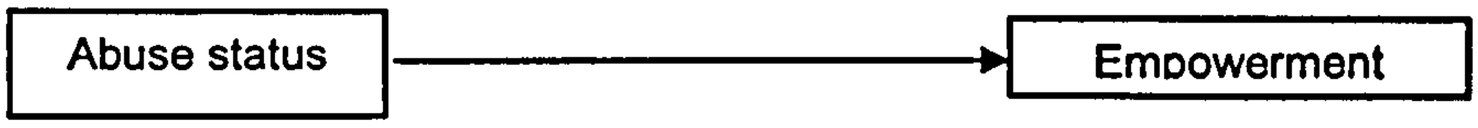
Table 5.32 Frequencies of 5 or more moderate or severe symptoms (TSC-40).

	Frequency	%
No more of 5 symptoms	61	59.2
More of 5 symptoms	42	40.8
Total	103	100

5.4.7. Relationship between child abuse and empowerment

The effects of childhood abuse could be related to the way power is experienced (see Figure 5.12, for more details see section 5.3.5).

Figure 5.12 Is abuse status affecting power?



Therefore a t-test was carried out with the results of empowerment questionnaire by participant between the different types of Abuse considered in this thesis and Not abuse variables (that has been previously explained in section 5.35). The results are shown in Table 5.33.

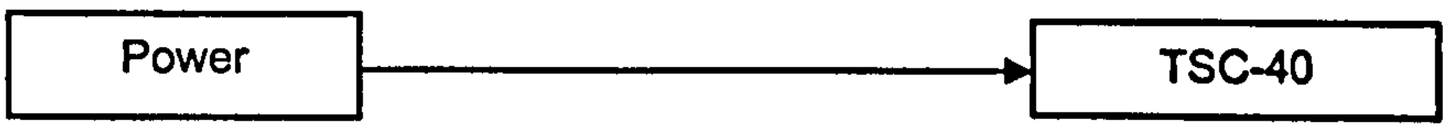
Table 5.33: t-test on the Abuse-Empowerment relationship –different types of abuse-

	Empowerment						
	N (yes)	N (no)	df	Mean Difference	Standar d error	t-test	p-value
Sexual Abuse	22	81	101	.082	0.061	1.352	0.179
Physical Abuse	21	82	101	-.082	0.062	-1.320	0.190
Neglect	**21**	82	101	.098	0.061	1.598	0.113
Emotional Abuse	**41**	62	101	.027	0.051	.529	0.598
Witnessing Domestic Abuse	**15**	88	101	-0.000	0.071	.000	1.000
Overall Abuse	**58**						

The results show that there is no relationship between the type of abuse and empwerment but both groups (abused and non abused) have empowerment.

It is necessary to consider whether or not power is related to resilience, and what type of power facilitates resilience. The relationship below can be given (see figure 5.13).

Figure 5.13 How power affect trauma scores



Power, is represented by Empowerment and its subscales (Rogers *et al.*, 1997), while resilience was represented by TSC-40 (Briere, 2001). As both power and

resilience were represented in the data set by scale variables a correlation is the appropriate test (see Table 5.34 below).

Table 5.34: Power and its relationship to trauma

	TSC – 40 SCORES		
	N	**Pearson correlation**	**p-value**
Empowerment total	58	-0.118	0.377
Factor 1 Self-esteem-self-efficacy	58	-0.058	0.666
Factor 2: Power-powerlessness	58	-0.105	0.434
Factor 3: Community activism and autonomy	58	-0.163	0.222
Factor4: Optimism and control over the future	58	-0.064	0.635
Factor 5: Righteous anger	58	-0.102	0.448

From Table 5.34 it was concluded that there was no significant relationship between power and trauma. This analysis includes to the entire sample, this is affecting the significance of this analysis, therefore important to consider what might be interfering (see confounding factors).

Figure 5.14. Prediction between empowerment and trauma (TSC-40)

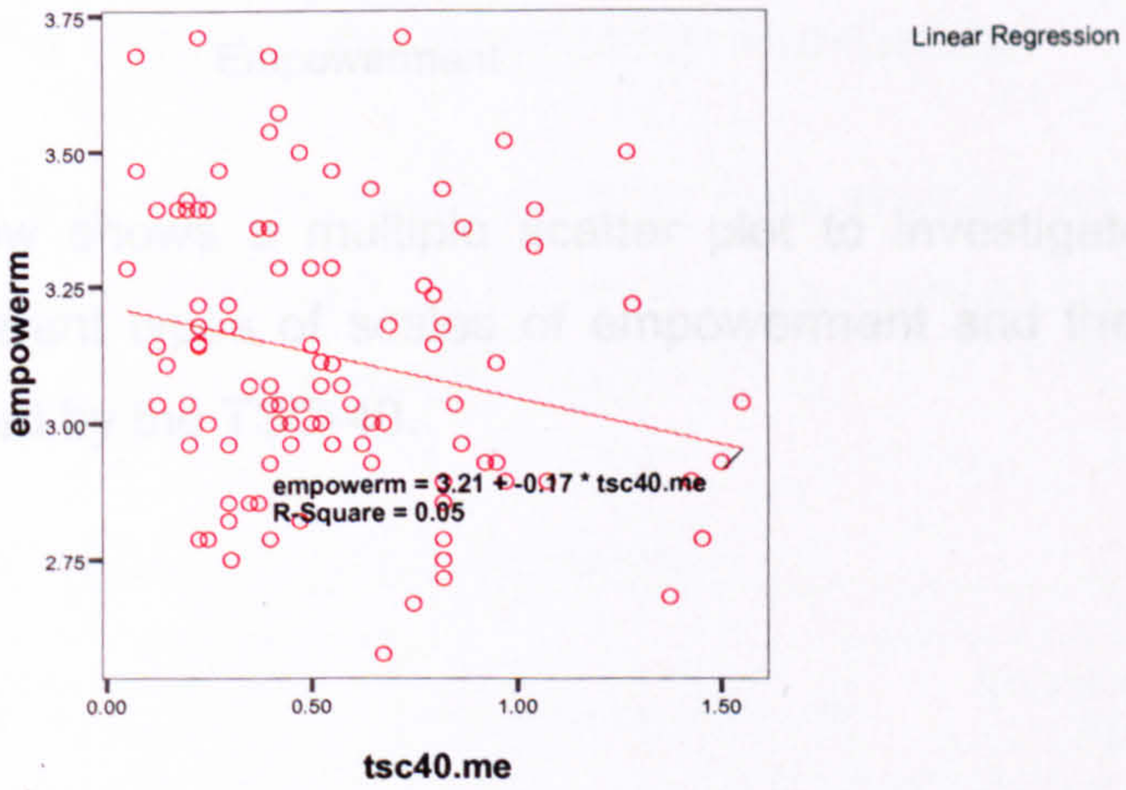


Figure 5.14 shows that the less trauma participants have, the more power they show, but there was a considerable scatter.

Figure 5.15 below shows that there is a certain pattern in the way the different types of power relate to the trauma scores of the TSC-40. The empowerment *Self-*

Esteem-Self-Efficacy occurs more often and appears more related to the highest scores of empowerment, whereas the *Righteous Anger* and *Optimism* scores are at the lower part of the spectrum. However, the majority of the results were related to the lowest trauma scores of the TSC-40.

Figure 5.15 Scatter graph for empowerment and trauma

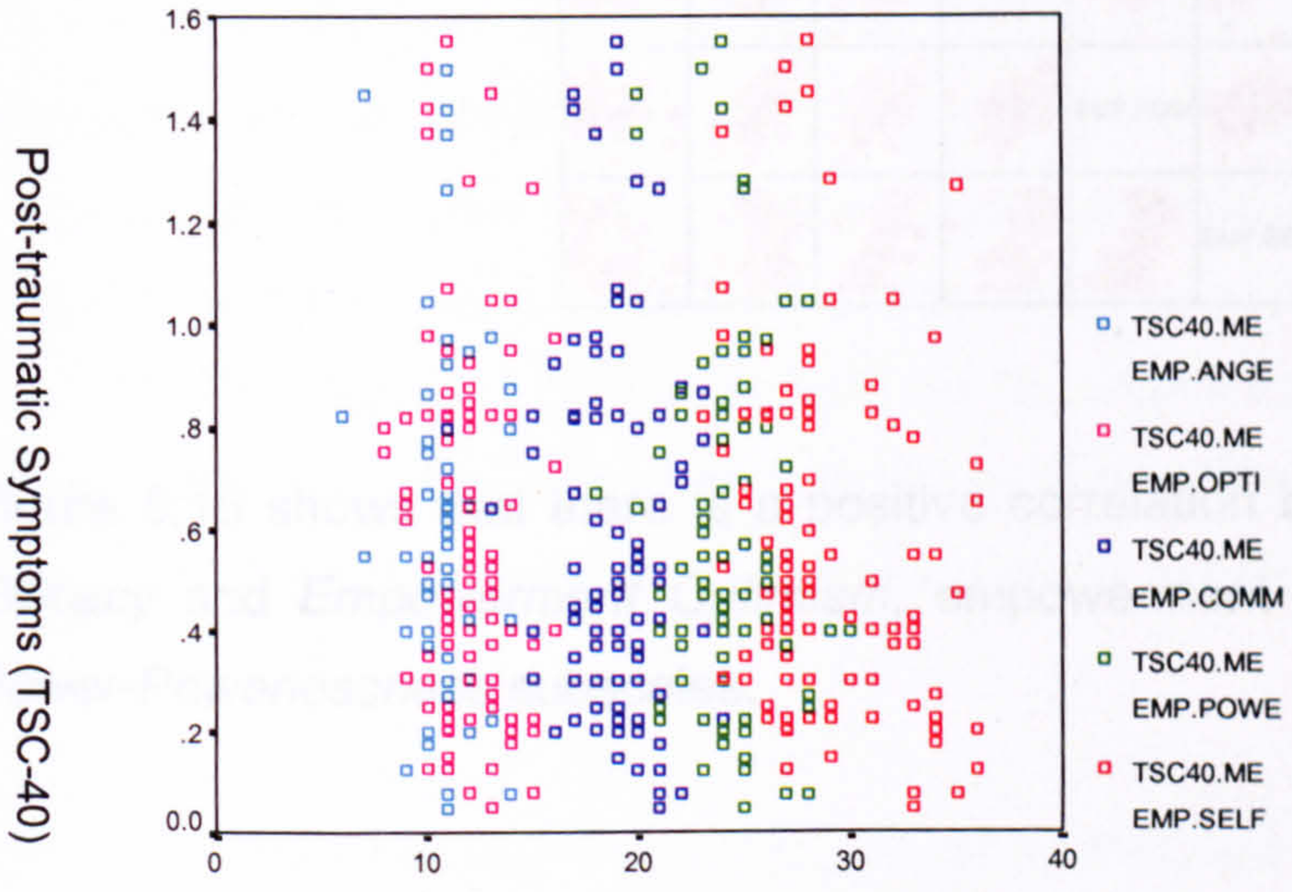


Figure 5.16 below shows a multiple scatter plot to investigate the relationship between the different types of scales of empowerment and the mean of trauma symptoms reported by the TSC-40.

Figure 5.16 Multiple scatter graph for TSC-40 and Empowerment scales

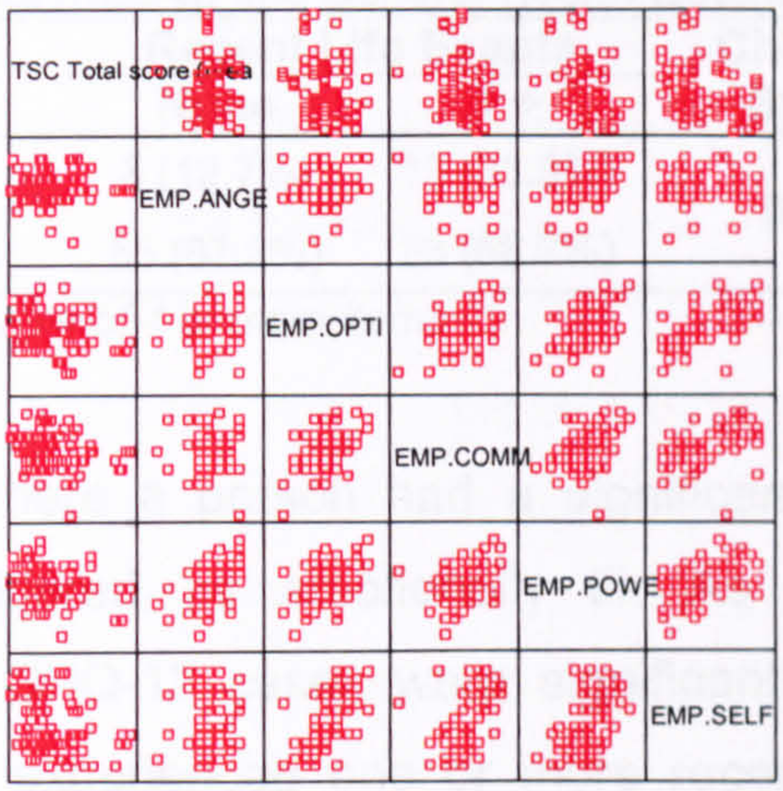
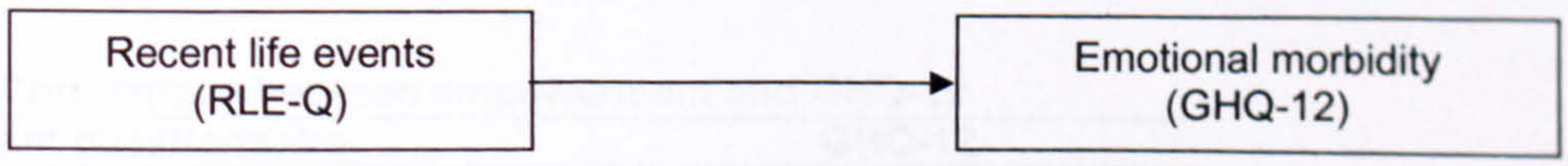


Figure 5.15 shows that there is a positive correlation between *Self-Esteem Self-Efficacy* and *Empowerment Optimism*, empowerment *Community Activism*, and *Power-Powerlessness* subscales.

5.4.8. Recent life events and emotional morbidity

To better understand the emotional state of respondents, an investigation was carried out to determine whether or not recent life event(s) had an effect on the respondents' general emotional health (Figure 5.17).

Figure 5.17 Recent life events and emotional morbidity



A correlation test was made using the Recent Life Events (RLE-Q) as the dependent variable and the General Health Questionnaire-12 (GHQ-12) as the independent variable.

Table 5.35. Recent Life Events (RLE-Q) and General Health Questionnaire (GHQ– 12)

GHQ-12 case*	Recent Life Events		Chi square Statistic	p-value
	None	1 +		
Case (Threshold of 4+)	8 (12.7%)	13 (33.3%)	6.27	0.012
Non case (Threshold of 0–3)	55 (87.3%)	26 (66.7%)		

**Case is when a person has score of 4 or more items*

A case is a situation where a person had a significant number of psychiatric symptoms to be considered as emotionally ill. As shown in Table 5.33, respondents who were GHQ-12 cases were significantly more likely than non GHQ-12 cases to have experienced one or more recent life events (x^2= 6.27, p=0.012). The Recent Life Events and the General Health questionnaires are not independent variables, but rather associated variables. It can be seen that the Recent Life Events variable can affect the general health of the participants.

5.5. Discriminating the function of variables

A series of tests such as correlations and means comparisons were done in order to discriminate the function of the different variables (questionnaires).

In order to examine whether or not empowerment is related to emotional morbidity, a correlation between the scores of the empowerment questionnaire and the GHQ-12 was carried out (Table 5.36).

Table 5.36. Correlations between empowerment and GHQ-12

Empowerment questionnaire	GHQ-12
Self-Esteem-Self-Efficacy	-.296**
Power-Powerlessness	-.156
Community Activism and Autonomy	-.253**
Optimism and Control Over the Future	-.259**
Righteous Anger	-.009
Total Empowerment	-.294**

***p < .01*

The results showed that *Self-Esteem-Self-Efficacy*, *Community Activism* and *Autonomy*, *Optimism* and *Control Over* the *Future*, and *Total Empowerment* are highly correlated to emotional morbidity (Table 5.36). It can be seen that the GHQ-12 scores and Empowerment are interdependent, *i.e.* correlations could go both ways: it could be that participants who have low empowerment are likely to be depressed, or that when people are depressed they perceive themselves as lacking power. In this case, this situation indicates that GHQ-12 is not an outcome variable but a confounding variable. This situation highlights the importance of carrying out a 'Discriminant Function Analysis', which will be explained later in this Chapter.

To investigate whether or not empowerment and coping strategies could be related, a correlation test was done between them two (Table 5.37).

Table 5.37. Correlations between Empowerment and Coping Strategies

	Confrontive	Distancing	Self-controlling	Seeking social support	Accepting responsibility	Escape-avoidance	Positive reappraisal	Planful problem solving
Self-esteem-self efficacy	.250*	.170	.146	.049	.045	-.064	.308**	.159
Power-powerlessness	.047	-.251*	-.125	.013	-.170	-.321**	.194	.138
Community activism and autonomy	.058	0165	.160	.075	.048	.022	.188	.132
Optimism and control over the future	.253*	.053	.097	.089	.014	-.123	.240*	.284**
Righteous anger	.101	-.432**	-.273**	-.010	-.142	-.160	-.44	-.003
Total Empowerment	.208*	-.013	.048	.084	-.045	-.183	.285**	.207*

*$p < 0.05$, ** $p < 0.01$

The results show that there is a positive correlation. In general it can be seen that there was a highly significant correlation between the *Positive Reappraisal*, *Escape-Avoidance*, *Distancing*, *Self-Controlling*, *Planful Problem Solving* subscales, and Empowerment. Specific examination of these relationships led to the following conclusions:

- The higher that subjects scored for *Confrontive*, the higher they scored for *Self-Esteem-Self-Efficacy*.
- The higher participants scored for *Positive Reappraisal* the higher they scored for *Self Esteem-Self-Efficacy*.
- The lower they scored for *Distancing*, the higher they scored on *Power-Powerlessness*.
    - People who used *Distancing* tended to feel less powerful. People who used *Distancing* less, tended to feel more powerful.
- Lower scores on *Escape-Avoidance* the higher corresponded to *Power-Powerlessness*.
    - People using *Escape-Avoidance* tended to feel less powerful, with those using *Escape-Avoidance* less, feeling more powerful.
    - Avoidance-*Distancing* seemed to be a preferred technique amongst people who felt powerless, whereas those who felt powerful tended to use this technique less.
- The higher the score on *Positive Re-Appraisal*, the higher was the score on *Optimism and Control Over the Future, and Self-esteem-self-efficacy*.
- *Planful Problem Solving* scores were found to correlate with higher scores on *Optimism and Control Over the Future*.
- A lower score on *Righteous Anger* coincided with a higher likelihood of using *Distancing* as a means of coping. The opposite was also found to be true.
- The more respondents used *Confrontive* approaches, *Positive Reappraisal*, and *Planful Problem Solving*, the higher was the *Total Empowerment* score.

It was of interest to see if there was any relationship between *Empowerment* and *Recent Life Events*, Table 5.38 shows the results of a correlation analysis, which was therefore carried out between these two variables.

Table 5.38. Correlations between Empowerment and Recent Life Events

Empowerment type	Recent Life Events✧	Still affected by some Recent Life Events
Self-esteem-self-efficacy	.041	.053
Power-powerlessness	-.177	-.133
Community activism and autonomy	-.035	-.024
Optimism and control over the future	-.041	-.003
Righteous anger	-.199*	-.122
Total Empowerment	-.057	-.005

*$p < .05$ ✧*In the last three months, for more detail please refer to Table 5.11.*

The results in Table 5.38 show that the higher the number of recent life events the lower tends to be a person's feelings of righteous anger. It could be seen that life events show little correlation except regarding righteous anger

In order to examine whether or not there was a relationship between *Empowerment* and *Dominance Power*, a correlation was made (see Table 5.39).

Table 5.39. Correlations Empowerment and Dominance Power

	How many people work for you?	I am satisfied with my income from psychotherapy or counselling	I feel confident in myself	Other psychotherapists respect my work
Self-esteem-self-efficacy	.181	.133	.322**	.145
Power-powerlessness	.11	.108	.372**	.247*
Community activism and autonomy	.204*	-.095	.150	.259**
Optimism and control over the future	.041	-.115	.297**	.159
Righteous anger	-.184	.104	.014	.023
Total Empowerment	.135	.063	.368**	.242*

Table 5.39 shows that the subscales *Self-Esteem-Self-Efficacy*, *Power-Powerlessness*, *Community Activism* and *Autonomy*, and the *Total Empowerment* scale highly correlate to the item 'I feel confident in myself' which reflects a good self-esteem. The *Community Activism* and *Autonomy* highly correlates with the item 'Other psychotherapists respect my work'. Similarly, '*Power-Powerlessness*' and the *Total Empowerment* scale correlates with the item 'Other psychotherapists respect my work'.

The relationship could be explained in more detail as follows:

- The more self confident a person feels, the higher his or her reported *Self-Esteem-Self-Efficacy*, and *Total Empowerment.*
- Higher *Community Activism and Autonomy* was found in those participants who had more people working for them.
- The more the person feels respected by other psychotherapists, the greater was the reported *Community Activism and Autonomy, Power,* and overall *Empowerment.*
- People with higher self respect felt more optimistic and positive about the future, and showed higher overall empowerment.

According to Giles (2002:41), 'Discriminant function analysis' or 'Discriminant analysis' is an exploratory analysis related to a variety of multivariate techniques. It uses MANOVA and ANCOVA comparisons to screen the function of different groups of variables. It is the researcher's job to identify those functions which make theoretical sense of what predicts group membership. *"Helps to clarify what appears to be the case from simply examining the univariate effects and the various multiple comparisons"* (Giles, 2002:41). *He also states that "It is used when we have several dependent variables and we wish to use these to sort our cases, or participants, into a small number of discrete groups on the basis of their pattern's response*" (Giles, 2002:52). It is usually used as an exploratory and interpretive technique to find the patterns of the data (Giles, 2002).

A classification of the participants into five groups was conducted to understand and isolate the different interactions of the variables and their effects (Table 5.40).

Table 5.40. Categorization of participants

	Frequency	Percent
Group 1 (No Abuse, no Recent Life Events)	29	28
Group 2 (No Abuse, Recent Life Events)	16	16
Group 3 (Abuse, No Recent Life Events, Low score on GHQ)	28	27
Group 4 (Abuse, No Recent Life Events, High score on GHQ)	7	7
Group 5 (Abuse, Recent Life Events)	23	22
Total	103	100

Group 3 is the group identified as of participants who are resilient to child abuse, and compared to Group 4 is the group of those who are not.

An Analysis of Variance was done comparing the means between the identified groups with the TSC-40 subscales, and total scores, as independent variables (details in Table5.41). This was to identify the different ways that abuse could emotionally affect participants, and to isolate these effects from the possibility of being the result of other causes such as *Recent Life Events*.

Table5.41. One way Anova between identified groups and TSC-40

Subscales Mean Scores)	Group 1 Mean (Std dev)	Group 2 Mean (Std dev)	Group 3 Mean (Std dev)	Group 4 Mean (Std dev)	Group 5 Mean (Std dev)	Total	p-value
Dissociation	.2241 (.2719)	.1875 (.2097)	.4464 (.3456)	.9444 (.5837)	.6818 (.5392)	.4224 (.4349)	.000
Anxiety	.2469 (.2028)	.2361 (.1982)	.4762 (.3859)	.6852 (.4182)	.6167 (.3213)	.4147 (.2728)	.000
Depression	.4866 (.2728)	.5764 (.3174)	.6584 (.3709)	.9074 (.4467)	.8535 (.4246)	.6533 (.3778)	.003
SATI	.1888 (.1946)	.2143 (.1951)	.4949 (.4196)	.9048 (.6367)	.6871 (.5202)	.4286 (.4405)	.000
Sleep disturbance	.7184 (.4652)	.7889 (.5472)	.9524 (.6771)	1.0000 (.5374)	1.2879 (.8836)	.9367 (.6736)	.040
Sexual problems	.3148 (.2928)	.4297 (.3026)	.6157 (.5129)	.8333 (.5682)	.7917 (6051)	.5528 (.4887)	.004
TSC-40 Total Score	.3308 (.1830)	.4100 (1817)	.5538 (.2900)	.8958 (.3411)	.7713 (.3968)	.5371 (.3330)	.000

The results of this analysis show that all subscales are highly significant (p= <0.05).

- Regarding the *Dissociation* subscale, the group 4 scored the highest.

- With regard to *Anxiety* subscale, the group 4 had the highest score, followed by survivors with trauma from suffering recent life events (Group 5).

- For the Depression subscale, the group of survivors of child abuse with low score on GHQ-12 (Group 4) scored the highest, and the group of respondents

without experience of abuse and no recent life events (Group 1) scored the lowest.

- The *Sleep Disturbance* subscale was the subscale with the highest of all the mean scores, being the highest for those who were abused and had *Recent Life Events* (Group 5).

- Regarding the scale of *Sexual Problems*, the group of those reporting abuse *No Recent Life Events* and high *GHQ* (Group 4) were the group that scored the highest.

- Considering the overall score, Group 4 are the ones who scored the highest, followed by those who reported abuse and had *Recent Life Events* (Group 5).

To investigate coping strategies used in the different group conditions, an ANOVA analysis was carried out (Table 5.42).

Table 5.42 One way Anova between identified groups and Coping strategies

(Raw scores)	Group 1 Mean (Std dev)	Group 2 Mean (Std dev)	Group 3 Mean (Std dev)	Group 4 Mean (Std dev)	Group 5 Mean (Std dev)	p-value
Confrontive	4.52 (2.798)	5.93 (3.936)	6.81 (4.105)	5.57 (3.309)	5.70 (3.363)	.204
Distancing	2.52 (2.293)	6.80 (5.710)	4.04 (4.176)	1.50 (1.378)	4.32 (3.272)	.005
Self-controlling	7.82 (3.528)	9.47 (4.941)	10.22 (4.136)	6.86 (5.429)	9.22 (3.605)	.149
Seeking social support	7.28 (4.720)	10.00 (5.581)	10.07 (4.624)	8.29 (3.773)	9.13 (5.311)	.239
Accepting responsibility	2.28 (2.034)	2.73 (2.764	3.29 (3.017)	3.86 (2.035)	3.00 (3.030)	.537
Escape-avoidance	4.43 (2.949)	6.33 (3.266)	4.96 (4.087)	5.71 (3.039)	5.76 (3.208)	.422
Planful problem solving	8.03 (3.448)	8.13 (3.563)	9.07 (3.562)	5.57 (1.988)	7.17 (3.040)	.103
Positive reappraisal	7.21 (3.614)	6.93 (4.818)	8.92 (5.276)	7.14 (1.864)	6.62 (3.943)	.392

To identify the empowerment strategies between different groups, a further ANOVA test was done Table 5.43.

Table 5.43. One way Anova between identified groups and Empowerment

Empowerment subscales	Group 1 Mean (Std dev)	Group 2 Mean (Std dev)	Group 3 Mean (Std dev)	Group 4 Mean (Std dev)	Group 5 Mean (Std dev)	Total Mean (Std dev)	p value
Self-esteem-self-efficacy	29.172 (3.1743)	30.187 (3.6188)	28.571 (3.4257)	26.142 (2.1930)	28.695 (3.1828)	28.8544 (3.3325)	.100
Power-powerlessness	29.1875 (2.0263)	30.1875 (1.6520)	28.5714 (2.5850)	26.1429 (2.5166)	28.6957 (2.0108)	24.3689 (2.1692)	.477
Community activism and autonomy	19.8966 (1.9150)	19.8125 (2.3443)	19.1786 (2.1439)	18.2857 (.7559)	18.6068 (3.0709)	19.2913 (2.3289)	.191
Optimism and control over the future	11.9655 (1.6579)	12.3125 (1.2500)	12.0714 (1.9037)	11.8571 (1.2149)	11.5652 (1.9731)	11.9515 (1.7114)	.735
Righteous anger	11.5862 (1.1500)	10.4375 (1.8246)	11.0714 (1.5617)	11.5714 (1.1338)	11.1739 (1.4970)	11.1748 (1.4847)	.145
Total Empowerment	3.1632 (.2394)	3.1585 (.2090)	3.1078 (.2962)	2.9853 (.2043)	3.0918 (.26099)	3.1194 (.2545)	.483

As can be seen from Table 5.43 for empowerment, the Analysis of Variance shows no significant differences between the means of the groups or its own subscales *i.e.* p-value was not less than 0.05.

Due to consideration of the possibility that Recent Life Events and GHQ-12 were interfering in the results shown in Table 5.41, an analysis was carried out. This was done using Analysis of Covariance (ANCOVA). The statistical model used tested:

(1) The difference between those who had and had not been abused.

(2) The effect of *Recent Life Events*.

(3) Whether the effect of RLE-Q differed between groups.

(4) The effect of the GHQ-12 score, and

(5) Whether that differed between groups.

The differences in means are reported in Table 5.42 for the groups Abuse and Non abuse, with adjusted average scores on RLE and GHQ-12. Also, in the same Table can be seen the significance p-values of all terms, except ANCOVA coefficients for terms involving covariates (see Table 5.44).

Table 5.44. ANCOVA Analysis of TSC-40 adjusted for Non Abused and Abused, with RLE-Q and GHQ-12 as covariates

TSC-40 Subscale	Non Abused Mean (std error)	Abused Mean (std error)	Abuse effect	RLE-Q	RLE-Q* Abuse	GHQ-12	GHQ-12 Abuse
			p-values for terms in model				
Dissociation	.191 (.051)	.555 (.051)	.040	.951	.000	.997	.001
Anxiety	.248 (.047)	.536 (.041)	.011	.843	.068	.649	.297
Depression	.500 (.053)	.743 (.047)	.129	.196	.218	.733	.025
SATI	.202 (.057)	.585 (.050)	.009	.847	.009	.936	.033
Sleep disturbance	.724 (.102)	1.062 (.088)	.409	.232	.529	.591	.177
Sexual problems	.368 (.072)	.703 (.064)	.010	.262	.417	.947	.848
Total Score	.364 (.044)	.653 (.038)	.009	.240	.014	.922	.049

* *Abuse effect*

The results of Table 5.44 are as follows:

- For *Dissociation* 'the Abused' group scored significantly higher than the Non-Abused, but the *Dissociation* score for the Abused group was also affected by both *Recent Life Events* and GHQ-12 score. The Non-Abused showed no such effects.
- For *Anxiety*, 'the Abused' group scored significantly higher than the 'Non-Abused'.
- For *Depression*, there was no overall difference, but those with a high GHQ-12 in the 'Abused' group, scored higher. In the Non-Abused group no difference was noted.
- For *SATI* 'the Abused' group scored significantly higher than the 'Non-Abused' group, but the 'Abused' *SATI* score was affected by both *Recent Life Events* and GHQ-12, while the 'Non-Abused' showed no such effects.
- For *Sleep Disturbance*, the 'Abused' group scored higher than the 'Non-Abused' group. However, it was non significant.
- For the *Sexual Problems* subscale, the 'Abused' group scored higher than the Non-Abused.
- For the *Total Score* of the TSC-40, the 'Abused' group scored significantly higher than the 'Non-Abused' group.

A similar statistical analysis was done, but this time with *the Coping scale* (see Table 5.45).

Table 5.45. Analysis of Covariance of Ways of Coping (WAYS-R) for Non Abused and Abused, with RLE-Q and GHQ-12 as covariates

Subscale (Raw scores)	Non Abused Mean (std error)	Abused Mean (std error)	Abuse effect	RLE-Q	RLE* Abuse	GHQ-12	GHQ-12 Abuse
			p-values for terms in model				
Confrontive	5.093 (.550)	6.207 (.476)	.040	.557	.430	.230	.647
Distancing	4.220 (.558)	3.972 (.514)	.147	.003	.892	.046	.354
Self controlling	8.627 (.645)	9.374 (.551)	.083	.326	.694	.551	.171
Seeking social support	8.332 (.779)	9.445 (.674)	.962	.153	.723	.282	.110
Accepting responsibility	2.558 (.415)	3.162 (.356)	.283	.707	.107	.373	.633
Escape avoidance	5.322 (.521)	5.166 (.451)	.659	.175	.017	.367	.866
Planful problem solving	7.966 (.530)	8.048 (.459)	.181	.252	.835	.506	.422

* *Abuse effect*

Results of the analysis showed in Table 5.45 are reported as follows:

- For the *Confrontive* subscale the 'Abused' group scored significantly higher than the 'Non-Abused' group.
- For *Distancing*, there was no significant overall difference, but those with *Recent Life Events* and GHQ in the 'Non-Abused' group scored higher than the Abused group with the same conditions.
- For the *Escape-Avoidance* scale there was no significant overall difference. However, those who had been 'Abused' and had had *Recent Life Events* scored significantly lower than the 'Non-Abused' group who had also had *Recent Life Events*.

To examine how the *Empowerment* factor interrelates with the same groups as above, an ANCOVA analysis was performed and its results are reported in Table 5.46.

Table 5.46. ANCOVA analysis of Empowerment for Non-Abused and Abused, with RLE-Q and GHQ-12 as covariates

Subscale	Non Abused Mean (std error)	Abused Mean (std error)	Abuse effect	RLE-Q	RLE-Q* Abuse	GHQ-12	GHQ-12 Abuse
			p-values for terms in model				
Self-Esteem-Self-Efficacy	29.364 (.492)	28.466 (.427)	.177	.104	.002	.873	.414
Power-Powerlessness	24.641 (.334)	24.220 (.290)	.269	.204	.276	.409	.892
Community Activism and Autonomy	19.721 (.350)	18.938 (.304)	.335	.990	.057	.809	.811
Optimism and Control Over the Future	12.018 (.261)	11.914 (.227)	.962	.860	.015	.311	.541
Righteous Anger	11.152 (.228)	11.162 (.198)	.155	.050	.903	.076	.454

In the Analysis of Covariance for *Empowerment*, there was no overall significant difference between 'Abused' and 'Non-Abused' groups for the *Self-Esteem-Self-Efficacy* subscale. However there was a difference between those who had had *Recent Life Events*, and who had reported been abused as a child.

For *Community Activism and Autonomy* there was no overall significant difference between 'Abused' and 'Non-Abused' groups. In contrast, there was a higher score for survivors of child abuse and those who had had *Recent Life Events*.

The *Righteous Anger* subscale, showed no overall significant difference, but lower score for those who had 'No Abuse' and a *Recent Life Event*.

To test whether or not the statement "A therapist who has been abused can help..." is valid when considering post-traumatic symptoms of childhood trauma, a correlation test was done. Results are shown in Table 5.47 for female psychotherapists and counsellors and in Table 5.48 for their male counterparts.

Table 5.47 Correlation between "A therapist who has been abused can help" and TSC-40

Females

"A therapist who has been abused can help"	Dissociation (mean score)	Anxiety (mean score)	Depression (mean score)	SATI (mean score)	Sleep disturbance (mean score)	Sexual problems (mean score)	TSC-40 Overall Score (mean score)
Correlation	-.119	-.102	-.135	-.286	-.416	-.012	-.246
p-value	.518	.587	.471	.119	.018	.949	.197
N	32	31	31	31	32	30	29

The results in Table 5.47 show that the female psychotherapists and counsellors who believe that "A therapist who has been abused can help a little more" sleep better.

Table 5.48 Correlation between "A therapist who has been abused can help" and TSC-40

Males

"A therapist who has been abused can help"	Dissociation (mean score)	Anxiety (mean score)	Depression (mean score)	SATI (mean score)	Sleep disturbance (mean score)	Sexual problems (mean score)	TSC-40 Overall Score (mean score)
Correlation	-.028	-.133	-.317	-.365	-.052	-.431	-.224
p-value	.926	.665	.292	.220	.865	.141	.462
N	13	13	13	13	13	13	13

When Male psychotherapists and counsellors who reported having been abused, considered the statement "A therapist who has been abused can help a little more" less sexual problems and trauma were reported. The score is not significant; this may be the result of the small size of this group (Table 5.48).

Further analysis was necessary to examine whether or not *Empowerment* influences the impact of trauma. This was made by an analysis of controlled confounding factors which may also affect the results, as explained in the following section, 5.6.

5.6. Towards an answer to the key hypothesis

The hypothesis is that empowerment is the entity which may make the difference between being 'Abused' and suffering traumatic symptoms. In other words, if a person is powerful enough she/he may overcome abuse and not develop traumatic symptoms.

If GHQ-12 and *Recent Life Events* scores are removed would trauma still be associated in those people reporting childhood abuse? How would power influence this? What types of power protect individuals? Is power the factor that changes having symptoms of trauma?

The parametric nature of the data having being ascertained, a regression analysis was done. A regression analysis controlling for GHQ-12 and Recent Life Events was carried out to investigate whether or not empowerment is a mediator of resilience in childhood abuse trauma. The aim was to predict if powerful survivors would not have trauma symptoms, and which type of coping strategy is related to resilient survivors.

Table 5. 49 Regression analysis of TSC-40 high and low scores of abused participants* controlling for GHQ-12 and Recent Life Events, with the subscales of Empowerment and Coping Strategies as covariates.

	TSC-40		
Covariates	**Beta**	**Std. Error**	**Significance**
Constant	142.000	26.278	.000
Self-Esteem-Self-Efficacy	-2.420	1.048	.027
Power-Powerlessness	2.570	1.515	.099
Righteous Anger	-3.281	1.645	.054
Confrontive (raw scores)	2.150	.710	.005
Distancing (raw scores)	1.076	.687	.126
Seeking Social Support (raw scores)	-1.681	565	.005

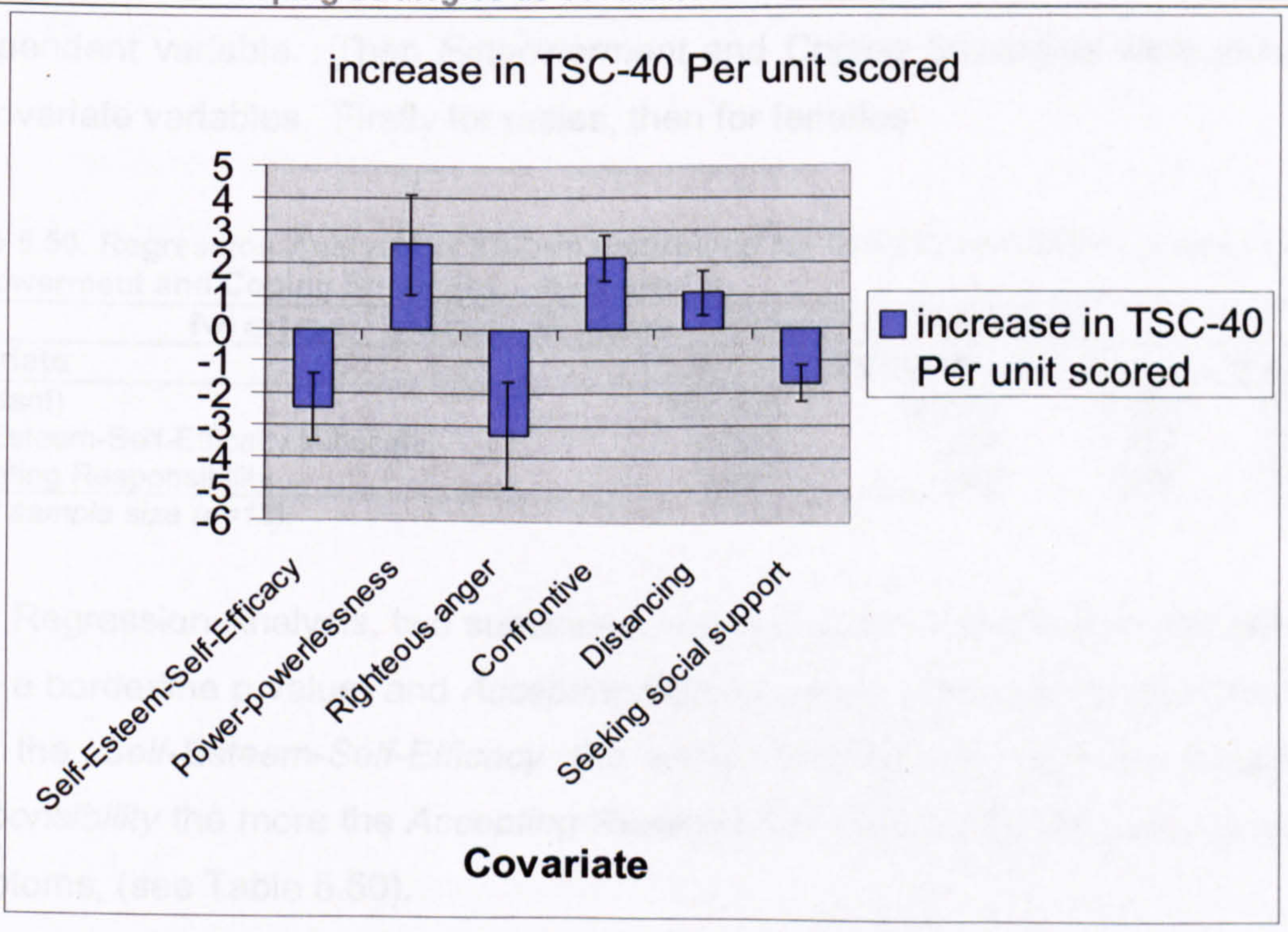
**as dependent variable*

Table 5.49 shows the results of the regression analysis of participants who suffered abuse, to discriminate whether or not empowerment moderates between abuse and having symptoms of trauma. The results show that the subscales

Power-Powerless, *Confrontive*, and *Distancing* are positive empowerment mediators of trauma. *Self-Esteem-Self-Efficacy, Righteous Anger* (subscales of empowerment) and *Seeking Social Support* on the other hand, are the negative coping mediators for trauma. However, *Power-Powerlessness* and *Distancing* are not significant, as its p-value more than 0.05 shows, and *Righteous Anger* is a borderline subscale.

High scores in trauma (Beta) were associated with high scores in *Confrontive* coping strategy and *Distancing*. Conversely, low scores of trauma were associated with high scores of *Self-Esteem-Self-Efficacy, Seeking Social Support*, *Righteous Anger* (borderline) and *feeling powerful* (borderline). This suggested that self-reliance and confrontation increased peoples trauma, power obtained from support from others, and 'Acknowledged Anger' led to lower levels of trauma (negative values of Beta in the table). See also Figure 5.18.

Figure 5.18 Graph of Regression analysis of TSC-40 high and low scores of abused participants* controlling for GHQ-12 and Recent Life Events, with the subscales of Empowerment and Coping Strategies as covariates.



Considering the inclusion criteria of $p<0.05$, from Table 5.49 it can be seen that *Distancing* and *Power-Powerlessness* (*PP*) do not meet the inclusion criteria because they are not statistically significant. Therefore they may not be included in the model. Additionally, Table 5.49 shows that Self-Esteem-Self-Efficacy (*SESE*), Righteous Anger (*RA*) and Seeking Social Support (*SSS*) have a negative value. This is due to the fact that linear regressions were performed and it means that the slope is negative. Therefore the statistical model of Empowerment could be represented as follows:

$$\text{Empowerment} = 142.000 - 2.42\, SESE_t + 2.57\, PP_t - 3.281\, RA_t + 2.150\, C_t + 1.076\, D_t - 1.681\, SSS_t$$

To investigate whether or not there were different predictors of resilience for males of females, the same statistical procedure was done independently for each gender.

A regression was conducted by, a Discriminant Factor Analysis, having the TSC-40 as dependent variable, with the GHQ-12 and the *Recent Life Events* as independent variable. Then *Empowerment* and *Coping Strategies* were included as covariate variables. Firstly for males, then for females.

Table 5.50. Regression Analysis of TSC-40 controlling for GHQ-12 and RLE-Q, moderated by Empowerment and Coping Strategies. –Male gender.

Males Who Experienced Abuse				
Covariate	**B**	**Std. error**	**t**	**p-value**
(constant)	137.464	23.089	5.954	.000
Self-Esteem-Self-Efficacy subscale	-1.457	.797	-1.827	.078
Accepting Responsibility	1.897	1.085	1.748	.091

Small sample size (n=13).

After Regression Analysis, two subscales were selected: *Self-Esteem-Self-Efficacy* (with a borderline p-value) and *Accepting Responsibility*. The results show that the less the *Self-Esteem-Self-Efficacy* the more the trauma, and for *Accepting Responsibility* the more the *Accepting Responsibility*, the higher the post-traumatic symptoms, (see Table 5.50).

Then Regression Analysis was then repeated, but this time for females.

Table 5.51. Regression Analysis of TSC-40 controlling for GHQ-12 and RLE-Q, moderated by Empowerment and Coping Strategies –Female Gender.

Females Who Experienced Abuse

	TSC-40			
Covariates	**B**	**Std. error**	**t**	**p-value**
Constant	153.103	18.817	8.136	.000
Self-Esteem-Self-Efficacy subscale	-2.011	.66	-3.017	.004
Confrontive	1.017	.590	1.723	.093
Self-Controlling	.987	.482	2.045	.047
Seeking Social Support	-.938	.461	-2.033	.049

After Regression Analysis, one subscale of the *Empowerment* questionnaire and three subscales of the *Ways of Coping* questionnaire remained in the regression. Table 5.51 shows that post-traumatic symptoms were higher with low *Self-Efficacy-Self-Esteem* and low *Seeking Social Support* (negative values of beta in the table). Between the more *Confrontive* (of borderline significance) and *Self Controlling*, the higher was the score in post-traumatic symptoms.

Based in the results of Tables 5.50 and 5.51, the statistical model of empowerment for males and females could be represented as following:

Males Empowerment = $137.464 - 1.457\ SESE_i + 1.897\ AR_i$

Females Empowerment = $153.103 - 2.011\ SESE_i + 1.017\ C_i + 0.987\ SC_i - 0.938\ SSS_i$

The next section will seek to discuss the findings of the survey and its relationships with other studies on survivors of childhood abuse.

5.7. Discussion

Taking into the account the socio-demographic characteristics of the whole cohort, which comprised only psychotherapists and counselors, more than half of the people in the sample, reported being abused as a child. The results of this research contrast considerably with the findings of Nuttall and Jackson (1994), who

found that 17% had experienced sexual abuse and 7.1% had experienced physical abuse in their study. It should be noted that their survey was conducted amongst professionals responsible for evaluating child abuse allegations. Comparatively, they had a 42% response rate while the survey currently being researched had an overall response rate of 26.4%. Possibly, the present survey has a higher prevalence of child abuse due to the participants' self-selection, and because of the inclusion of more types of abuse than in the survey of Nuttall and Jackson (1994).

In this thesis 56.9% of respondents suffered child abuse. The incidence was 44% in males and 63% in females, with a borderline significant difference (p .061) - possibly because of the size of the sample. With a bigger sample the significance may become higher. Emotional abuse was dominant probably because it is a common feature of any type of abuse. The percentages of sexual abuse, physical abuse and neglect were very similar (about a fifth of the whole sample). However, approximately 40% reported emotional violence and approximately 15% witnessed domestic violence as a child. Witnessing domestic abuse was not found present on its own, it was always combined with other type of abuse.

Respondents ranged in age from 31 to 73 years. This is similar to Nuttall and Jackson's study. They found that 17% reported sexual abuse, but in this present study the figure was 21.4%. Certainly, the population sample used by Nuttall and Jackson was larger (N=656) while in the present study the number was 103.

Regarding the long-term impacts of child abuse, physical abuse was found to be linked to some trauma symptoms detected by the TSC-40 questionnaire. The *Recent Life Events* questionnaire was done to ensure that the trauma symptoms reported were caused by child abuse and not other life events. In this present study, 63% did not report any recent life event. When examining the reports of trauma of those who were abused, there is a higher significant difference with those who did not report abuse.

A useful comparison can be made with the Briere and Runtz (1990) study. In their research they focussed on University women who reported sexual, physical, and psychological abuse and found it was related to three types of psycho-social dysfunction. They found that, psychological abuse was linked to low self-esteem. Physical abuse was linked to aggression towards others, and sexual abuse was related to maladaptive behaviour. In the present research, *Self-Esteem-Self-Efficacy* factor of the Empowerment scale was high. Physical abuse was related to *Righteous Anger* and probably to the *Power-Powerlessness* factor. Sexual abuse was related to the *Sexual Abuse Trauma Index*.

The recruitment in this study was such that it accurately reflected the proportion of men and women in the UPCA. Therefore the results regarding gender could not have been biased by gender consideration.

According to the response of the present study, psychotherapists are generally of the opinion that a therapist who has been abused can be of more assistance than one who was has not. This study showed that the incidence of child abuse was 44% in males and 63% in females, with a borderline significant difference (p=.061).

The main ways of coping with those who experienced abuse were *Self Controlling* followed by *Seeking Social Support* (p=.084 borderline significance) and *Planful Problem Solving* (p=.087 – borderline significance).

There seems to be a correlation between high levels of Empowerment and the use of *Planful Problem Solving* as a coping strategy. If the hypothesis for the qualitative study is correct regarding the use of imagination, it can serve as a tool of people to find ways for empowering themselves. It could also help overcome abuse and the witnessing of domestic violence.

The interaction of variables was then examined and it was found that GHQ is a confounding variable for power and trauma. The GHQ-12 measures depression and anxiety but it was not clear that the source of these symptoms was child abuse trauma and therefore the analysis was leading to a false conclusion (Table 5.41). The analysis in Table 5.46 (One way Anova TSC-40), confirmed the suspicion that the GHQ was confounding the results. Multivariate analysis allowed the confusing elements (Recent life Events and GHQ-12) to be filtered out.

There is an impact on the measures of trauma (see group 3 table 5.46), so there emerged a question "if the GHQ-12 and Recent Life Events are removed, is trauma associated to those reporting childhood abuse? How is power related to such situation? Is this power due to the relationship between trauma and abuse?

Quantitative analysis shows that abuse is significantly related to trauma even when it is taken out of current life events and current mental states (GHQ-12). After checking that the data was parametric, Multiple Regression analysis was used to investigate abuse against trauma. It was found out that three subscales of the Empowerment questionnaire (*Self-Esteem-Self-Efficacy*, *Power-Powerlessness* and *Righteous Anger*) were mediating factors of resilience. Quantitatively speaking, resilience is having not only high *Self-Esteem-Self-Efficacy*, and power but also the ability to control and focus anger into action, even for those who may have depression or anxiety. *Confrontation*, *Distancing* and *Seeking Social Support* are coping mechanisms of gaining empowerment for people who need to do so.

Female psychotherapists reported sleeping better and performing their duties better (*i.e.* Psychotherapy and Counselling) due to their opinion that their profession is useful and their psychotherapy training.

This present thesis concentrates more on female than male respondents since women are more likely to be the victims of abuse, and to reflect a more feminist point of view. This is why the motivation was to explore women's experiences and

use the IPA (Interpretative Phenomenological Analysis) in order to honour the ordeals of the victims, in this case women. Also, feminist theorists have explored how power and control can affect women, and that abuse is a power unbalance in the relationship between adults and children. However, power variables within the study of child abuse have not been thoroughly investigated or reported in the scientific literature. The hypothesis of the researcher suggests that empowerment is a means of gaining control over one's own situation as reported by the feminist literature. There has been very little research into how this empowerment could be psychologically developed within the person. A growing interest for the researcher is the focus on imagination and specifically whether or not active imagination plays any role in boosting one's internal power. It is possible to find ways of resolution and "locus of control" to overcoming the effects and causes of child abuse, and of witnessing of domestic violence.

If the key research question of the interview study regarding imagination was correct, this could show a way in which people could empower themselves.

For this reason, the next stage of the research was to study participants of the survey who were willing to be interviewed. Participants were selected mainly according to their high score obtained in the empowerment scale survey. The aim was to have a sample of each category of child abuse in order to investigate whether or not active imagination could be a means of gaining power and overcoming the experiences of trauma. Further details will be explained in the next chapter.