

Self-Care of Incest Survivor Mothers

by

Christine M. Kreklewetz

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### Abstract

While much is known about the long-term effects of childhood sexual abuse (CSA) on women in adulthood, little is currently known about their self-care efforts. Given the paucity of research on self-care for survivors, particularly those who are also mothers, and the potential importance of self-care for both themselves and their children, the main goal of the present study was to explore these women's perceptions and practices of self-care. A grounded theory approach was chosen for this exploration as it provided a sensitive and open-ended methodology which garnered an in-depth understanding of self-care for survivor mothers. The current study combined classic grounded theory (GT) research methods with photovoice methods to explore self-care from the perspective of CSA survivor mothers. Analyses of interview and photograph data from 14 survivor mothers resulted in an original basic social process for understanding how these women care for themselves, feel better, and engage in healing in the context of past violence and trauma. Complex interactive behavioural patterns were identified that recreated a whole self out of damaged fragments; these were conceptualized as "reconstituting a damaged self". This basic social process was comprised of three main stages, including: *emotional de-paining*, *safetying*, and *authenticating and returning to self*. Several substages within each of these main stages were also identified. Findings were discussed in relation to four theoretical frameworks. Future research directions and clinical implications for this neglected population were suggested. Reconstituting a damaged self can be a long process for sexual abuse survivor mothers involving taking small safe steps, for the most part, on one's own.

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## **Chapter 1: Introduction**

### **Thesis Overview**

The present thesis contains five chapters. The introduction contains the purpose of the study and its importance. In chapter 2, an overview of the current literature in the areas of childhood sexual abuse (CSA), self-care, and parenting and several theoretical frameworks for understanding self-care are provided. In chapter 3, an overview of the two data collection methods used in the current study: classic grounded theory (GT) and photovoice methods, followed by the rationale for choosing these methods is included. The procedures for sampling, recruitment, data collection and ethical considerations are provided. An overview of how GT methods were used to conduct data analysis and to develop the theory is also included. In chapter 4, results are described in detail, specifically how the basic social process and core concept of reconstituting a damaged self are identified. In chapter 5, the present findings are discussed, followed by the main conclusions of this research.

### **Purpose and Significance of the Study**

Although CSA has received major attention in the literature, the self-care of trauma survivors has not. While research is beginning to recognize the necessity of self-care for professionals working with survivors of violence and trauma (Richardson, 2001; McKegney, 1993), self-care for mothers who themselves are survivors of violence or trauma, (e.g., childhood sexual abuse) has not been widely investigated.

To address this gap, self-care of survivor mothers of incest was examined in the present study. Self-care was defined as a process in which one performs specific behaviours aimed at improving one's physical, emotional, spiritual, or social sense of well-being.

### **The Imperative to Discuss CSA Within the Family**

Even though most research neglects to differentiate incest as a unique form of CSA, there is strong argument for not losing sight of incest as a unique form of CSA and studying incest survivors specifically. First, the characteristics of CSA within the family are unique when compared to extrafamilial CSA. Fischer and McDonald (1998) found that intrafamilial CSA often involves younger age of onset, longer duration, multiple assaults, quick progression to more intrusive sexual behaviours, and less physical or verbal force.

Second, family environments where incest occurs are often filled with little nurturing and safety. Instead, research supports that incest often co-occurs within a multi-problem family environment including substance abuse and addictions, violence towards the mother, numerous family stresses, multiple forms of abuse, and psychiatric and psychological problems (Dong, Anda, Dube, Giles, & Felitti, 2003; Armsworth & Stronck, 1999). Only 10% of the survivors in Newman and Peterson's (1996) sample reported no other childhood trauma than incest. Similarly, in Armsworth and Stronk's (1999) study, incest survivors also reported physical abuse (93%), emotional abuse (55%), and CSA outside of the family (75%). The above arguments point to survivors of incest being particularly vulnerable for not acquiring healthy models of self-care or feeling worthy of later self-care as adults. These dysfunctional family environments also provide few positive parenting role models and practices for later parenting.

Third, the relationship to the perpetrator (on which the victim is often emotionally dependent) appears to be a key variable. Abuse by a parent or father figure is associated with greater distress, higher levels of trauma, poorer long-term outcomes and adjustment, and higher risk for the development of psychiatric disorders (Bulik, Prescott & Kendler, 2001; Trickett, Noll, Reiffman & Putman, 2001; Russell, 1986; Browne & Finkelhor, 1986; Herman, Russell & Trocki,

1986) and self-harm behaviours (Turrel & Armsworth, 2005). Sexual victimization by a sibling (i.e., brother–sister incest) has also been revealed to be as serious as parental abuse (Cyr, Wright, McDuff, Perron, 2002; Rudd & Herzberger, 1999).

A fourth reason for focussing on incest in this research is one of language and politics. In the early 19th Century incest as evidenced by gonorrhoea infections, was largely ignored by medical professionals (Sacco, 2002). In the 1970s, along with rape and wife-battering, feminists began discussing incest. A review of the research by Olafson, Corwin and Summit (1993) revealed that incest was frequently discussed and researched in the 1970s. By the mid 1980s and 1990s, however, only a handful of studies spoke about incest directly and it became obscured under the larger umbrella of CSA, sexual assault, trauma, and other terminology or used synonymously with CSA (Kelly, 1988a). Ward (1985) wrote, “Women everywhere need to start talking about father-daughter rape” (p. 206). This discussion, however, has not continued. Hamer (2002) stated that people have a “common blindness” towards incest and tend to dissociate from it. Others have suggested that “sexual abuse” is preferred to the term “incest” because, “It [is] easier to cope with the thought of what is implied when the act is sanitized by calling it something less direct than incest” (Renvoize, 1993, p. 32). Butler (1996) contends that incest is a “toxic subject” that is met with silence, anxiety, and denial (p. 9) by medical professionals and others. The more “normative” the discussion of CSA becomes in society (e.g., social discussions, in the media, and through policy making), the greater the risk of diminishing or diluting the serious nature and harmful effects of this trauma. Therefore, research focussing specifically on incest is imperative.

Ford, Ray and Ellis (1999) stated that while CSA is being discussed widely, the public remains less aware that a large number of the acts are perpetrated within the family. Research focussing on incest needs to be preserved and encouraged, not because it only happens within the

family but because of the above mentioned reasons and because focussing on CSA outside the family tends to lessen its perceived severity. “Although all sexual abuse is abhorrent, incest reflects important distinctions from abuse involving a non-relative that make it especially pernicious” (Ford, Ray & Ellis, 1999, p. 139). Thus, incest is the focus of the present research, even with the existing definitional challenges and limitations in the literature.

Definitions are a continuing challenge in this field. The terms incest and child sexual abuse (CSA) are frequently interchanged and used synonymously within the literature. Incest (i.e., intrafamilial child sexual abuse) is considered a form of CSA; therefore, for clarity, the term CSA will be used in this study to refer to incestuous sexual victimization unless research studies specifically mention incest. For brevity, “survivor mothers of incest” are referred to hereafter as ‘survivor mothers’ or ‘survivors’.

### **Rationale for Studying Self-Care Among Survivor Mothers**

There are several important reasons for studying self-care among survivor mothers. The trauma of CSA carries numerous long-term negative physical, interpersonal, and mental health effects which affect not only how survivors care for themselves, but also how they care for their children. As a group, survivor mothers often experience unique challenges in parenting which are in part due to their history (Armsworth & Stronck, 1999; O’Brien, 1998; Kreklewetz, 1995; Cohen, 1987). One of the most common effects of CSA is depression (Putnam, 2003; Browne & Finkelhor, 1986), which has been clearly linked to decreased or absent self-care. Other effects of CSA (e.g., substance abuse, lowered self-efficacy, poor self-concept, trust issues, self-harm and revictimization behaviours and long-term health effects) may also impede women’s ability to take care of themselves. Clearly, the self-care of survivor mothers needs to be better understood. What has not been answered in the research thus far is how these key components of abuse translate

into self-care or the lack thereof. It is unknown how these women overcome the negative effects of their past trauma and exercise agency in caring for themselves and their children. Self-care may be an important factor in answering this question. Indeed, self-care may be crucial in overcoming long-term effects of past abuse trauma.

Childhood sexual abuse survivors are a vulnerable population. A number of studies have found that CSA survivors are at risk for revictimization (physical or sexual assault) and self-harm behaviour in adulthood. (Barnes, Noll, Putnam, & Trickett, 2009; Koenig, Doll, O'Leary, & Pequegnat, 2004; Yates, 2004; Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003.) This body of work raises the question of how self-care relates to self-protection, and whether it may play a role in strengthening women's ability to protect themselves from further risk. To date, the literature has not addressed the self-care practices of survivors, the role self-care plays in either preventing or reducing revictimization, or survivors' overall wellness.

A particular shortcoming of the CSA literature is that mothers have often been blamed for their own abuse and their children's subsequent abuse. The accompanying feelings of guilt, shame, and anger may undermine or interfere with self-care practices. Thus, a final reason for studying self-care in this population is the effects and implications of mother blame that may influence self-care.

Research has identified CSA as a risk factor for having a child who becomes abused even though mothers are, for the most part, not the perpetrators (Hiebert-Murphy, 1998; Oates, Tebbutt, Swanston, Lynch & O'Toole, 1998; Goodwin, McCarthy and Divasto, 1981). Not all children of survivor mothers are victimized; however, the mechanisms by which intergenerational transmission of sexual abuse occurs are not clearly understood. Perhaps mothers' own self-care also plays a

role in protecting their children from sexual victimization. In this study, the question raised is whether self-care may be one of these unexplored mechanisms.

Another reason for examining self-care in survivor mothers is the potential influence and benefit in transmitting healthy self-care values and practices to their children. Research on the intergenerational transmission of parenting is useful in underscoring the long-term implications of parental self-care and raising healthy children who also value and practise self-care. The intergenerational transmission of parenting has been defined as "...the process through which purposively or unintendedly an earlier generation psychologically influences parenting attitudes and behaviour of the next generation" (Van Ijzendoorn, 1992, p. 76-77). Survivor mothers want to protect their children and provide them with a healthy, safe, and secure environment (Kreklewetz & Piotrowski, 1998; Hooper & Koprowska, 2004); however, these mothers may have difficulty doing so because they have not been protected and may not know how to nurture themselves. In support of this, Kreklewetz (1995) found that self-care seemed to be important for healing.

The present study used a strengths-based or assets perspective rather than a deficit-based or risk approach. The majority of past research has focused on the negative long-term effects and difficulties CSA survivors experience, rather than on their resilience. Resilience in mothers is seen as a protective factor in intergenerational transmission of CSA (Leifer, Kilbane & Kalick, 2004). Effective, self-care practices may increase mothers' resilience and their ability to be successful in their daily parenting roles. In contrast, ineffective self-care practices or the lack of self-care may be an area that needs strengthening and supportive efforts. Consequently, it is vital to identify how survivor mothers care for themselves in the context of their daily lives and the meaning of the choices they make.

Therefore, the main goal of this research is to better understand the self-care practices of survivor mothers. By taking a qualitative approach in doing so, theory building around a social process was undertaken that was based on classic grounded theory (Glaser, 1978). This approach allows exploration of how self-care may create a safe place for mothers and ultimately reduce their own and their children's vulnerability to abuse, and promote overall wellness in their lives. A secondary goal is to avoid mother-blame and instead focus on mother empowerment by taking a strengths-based approach to self-care and its importance for women survivors. The main research question guiding this study is: What are the self-care and health promotion practices of survivor mothers of incest in their daily lives?

The research goals are accomplished by offering this neglected population of mothers the opportunity to share their experiences. In doing so, new knowledge about their lives is created. Exploring the daily choices survivor mothers make for themselves and their children represents one small step towards ultimately understanding how to reduce the recurrence of incest in the next generation. This research emphasizes survivor mothers' positive self-care efforts towards wellness and strength by using methodology designed to be sensitive to their self-esteem, self-value and protective capacity over their children.

## Chapter 2: Review of the Literature

### Challenges in Defining Incest and Childhood Sexual Abuse (CSA)

In the current literature, *incest* lacks a consistent universal definition. Since it has often been used interchangeably with CSA, very little research clearly defines or separates incest from CSA. For example, the term incest has been used interchangeably with CSA (Paolucci, Genius & Violato, 2001), or tangled with other terms such as sexual assault (Statistics Canada, 2005), rape, intrafamilial sexual abuse, incestuous abuse (Russell, 1997), extrafamilial sexual abuse, trauma, sexual abuse within the family, sexual molestation, and father-daughter rape (Ward, 1985). Incest has most frequently become subsumed under broad terms such as child sexual assault. Statistics Canada's National Survey on Family Violence (2005), for example, subsumed incest within the category *other sexual crimes*. Some researchers have suggested that even the legal definition of incest is too narrow to be clinically relevant (Draucker, 1992a). Besides adding to the definitional confusion, mislabeling incest, or not labelling it at all, is highly problematic and promotes the underestimation of this trauma.

Over time, incest has been broadened from its traditional definition based on blood ties to emphasize the victim-offender relationship, thereby including father-figures (e.g., step-parents, mother's boyfriends). This is consistent with Draucker (1992a) who states that

Although variables such as the closeness of the relationship and the type of sexual activity involved do seem to be related to the degree of trauma, the adult survivor's perception of the experience as traumatic and a determination of the impact it has had on his or her life are of greatest interest to counselors in defining an abusive childhood sexual experience" (p. 3).

Fisher (2003) states that feminists have redefined incest as CSA by focussing on power imbalances and betrayal of trust in the relationship. Broadening the definition of incest, however, can become problematic when child sexual abuse is substituted for incest even when the abuser is the biological father or stepfather (Renvoize, 1993).

Definitions of incest include a range of behaviours that go beyond sexual intercourse, penetration and genital contact. Feminist discourses which first spoke about incest recognized that sexual violence is not restricted to penile penetration and ejaculation (Russell, 1986, Ward, 1985; Kelly, 1989), thus incestuous acts now include fondling and non-contact behaviours. Russell's (1983) classic definition of incest was: "Any kind of exploitive sexual contact or attempted sexual contact that occurs between relatives (or those in an equivalent relationship such as a live-in boyfriend) before the victim turns eighteen years old" (p. 41). The present study adapted Russell's definition and viewed incest as: sexual victimization of a child or adolescent by a father-figure or caregiver in the family (i.e., biological fathers, stepfathers, grandfathers, older sibling, or other males cohabiting in the family or having access to the child) who held the child's trust.

### **The Prevalence of CSA**

The problem of CSA is no longer seen as a private family issue largely due to feminist writings. In fact, it is now viewed as a public health concern (Dong et al., 2003) and has been declared an issue of epidemic proportions by the U.S. Centres for Disease Control (CDC) (Anderson, Mangels & Langsam, 2004). Few current statistics on the prevalence of incest exist to date. Extrapolating from Statistics Canada's National Survey of Family Violence (2005), prevalence rates in Canada can be approximated. In 2003, of 28,000 sexual assaults reported to 122 Canadian police departments, over one-third (32%) involved a family member. Nearly one in five (17%) of the sexual assaults reported were regarding historical abuse (i.e., abuse which occurred

between 1949 and 1999). Approximately 97% of those sexual assaults were committed by someone known to the victim, and of those, 61% were by family members. Parents were accused in 37% of historical sexual assaults, followed by siblings (34%) and extended family members (29%). Incest was also clearly a gendered crime where the majority of victims of historical sexual assault were female (68%) with male perpetrators. Girls were sexually assaulted more often within the family by family members (70%) and boys were most often sexually assaulted outside of the family (43%). Interestingly, Statistics Canada reported that non-family related (i.e., extrafamilial) sexual assaults have almost doubled those of family related (i.e., intrafamilial) sexual assaults since 1998. This finding could be interpreted as a reporting effect, where incest is reported less frequently than sexual victimization outside the family due to the complex legal issues and ambivalence involved in pressing charges (Cohen & Mannarino, 2000).

Childhood sexual abuse also remains a serious and widespread problem internationally. A recent meta-analysis which looked at 65 articles covering 22 countries (Pereda et al., 2009) showed that 19.7% of women and 7.9% of men had suffered some form of sexual abuse before the age of eighteen. CSA also remains a gendered problem. While it is important to acknowledge male victims, most victims are female with the ratio of 2.5 women for each male victim. One limitation of these reports is that they rely exclusively on sexual victimization reported to authorities. Therefore, prevalence is underestimated since these reports do not capture the majority of men and women or "hidden victims" who do not disclose or report their victimization, or seek treatment.

Research conducted in the United States found that 25 percent of women sampled reported a CSA history (compared to 16% of men) (Dube et al., 2005; Dong et al., 2003). Of these women, 34% described their perpetrator as someone who lived in their home (relative or non-relative) (Dong et al. 2003). One strength of this finding was the large sample size, however,

several limitations can be noted. First, the definition of CSA relied on victim-perpetrator physical contact (as opposed to non-contact behaviours) even though research supports the contention that covert sexual abuse (i.e., non-contact behaviours or unwanted sexual attention such as sexual comments, leering, displaying or viewing pornographic material) can be harmful (Whealin, Davies, Shaffer, Jackson, & Love, 2002; Russell, 1983). A second limitation of the dataset was that the sample was primarily white and highly educated, however, other survey-based studies have shown similar incidence rates of women with a history of CSA between 12% and 38% (Plant et al., 2005; Putnam, 2003; Hume & Agrawal, 2004; Roberts, 1996; Finkelhor, Hotaling, Lewis & Smith, 1990; Lechner, Vogel, Garcia-Shelton, Leichter & Steibel, 1993).

In summary, the actual extent of CSA is difficult to ascertain due to underreporting of cases, differing definitions of abuse and varying reporting requirements (Trocme et al., 2001). Taken together, prevalence reports indicate that there is a large number of women incest survivors today. Incest is a gendered crime which occurs primarily to girls by a parent perpetrator. Given the alarming frequency of CSA, it is important to understand the painful legacy that women survivors carry with them into adulthood. However, in any discussion of the long-term outcomes of CSA, the definitional inconsistencies concerning CSA and incest must be acknowledged.

### **The Long-Term Effects of CSA and Implications for Self-Care**

A long history of research has clearly established the presence of serious long-term outcomes for CSA survivors, across many domains (physical health, mental health, interpersonal) (see Putnam, 2003 for a comprehensive review). The following review focusses on specific long-term effects which may influence self-care, including poor self-concept, lowered self-efficacy, powerlessness, depression and PTSD, revictimization and self-harm, and health risk behaviours.

These effects were selected due to the preponderance of research identifying them as recurrent deleterious effects of CSA, and because they have been linked to self-care behaviours.

**Self-concept disturbances.** To take care of, nurture, and love ourselves, at our core there needs to be a sense of self-value and worth. Research shows that CSA impairs one's sense of self (Putnam, 2003; Harter, 1999). Harter's (1999) work on how abuse affects the construction of the self brings a valuable perspective forward in understanding how CSA may affect later self-care. Her research on childhood trauma shows that child abuse can affect cognitive developmental structures and result in negative development of the self. Harter observed that being abused often produces negative self-evaluations and debilitates a child's self-awareness and sense of agency (i.e., self-efficacy). Other disturbances in the development of the self include, "...feelings of incompetence, low self-worth, a profound sense of inner badness, self-blame, guilt and shame, depression, suicide and other destructive behaviours, as well as the sense that the self that one presents to the world is false or inauthentic." (p. 282).

In describing how a CSA survivor's sense of self is affected differently from survivors who are exposed to single-event acute traumas, Herman (1992) states, "While the victim of a single acute trauma may say she is 'not herself' since the event, the victim of chronic trauma may lose the sense that she has a self." (p. 385). The fact that CSA has been shown to have a negative impact on a victim's sense of self may influence self-care in adulthood if a negative evaluation of self-worth has persisted (Harter, 1999).

**Lowered self-efficacy.** Another path through which CSA may affect self-care in adulthood is by hindering one's sense of control, power, and agency over one's efforts - the development of self-efficacy. Bandura (1977a) introduced the concept of self-efficacy as the belief that one can successfully perform certain behaviours required to produce a successful outcome, and that one's

expectations were a strong predictor of behaviour. "People's levels of motivation, affective states, and actions are based more on what they believe than on what is objectively the case" (Bandura, 1995, p. 2). Harter (1999) described self-efficacy as developing a positive view of oneself as an active agent and having confidence in one's abilities. Research has shown that CSA affects a person's sense of efficacy or agency. High self-efficacy is linked to better emotional health (Saarni, 1999) and lowered self-efficacy is shown through negative self-evaluations and decreased self-awareness skills such as attending to one's own needs (Harter, 1999). Diehl and Prout's (2002) review found that CSA and subsequent post-traumatic stress disorder (PTSD) negatively affects self-efficacy beliefs in childhood.

**Parental self-efficacy.** Closely related to personal self-efficacy is parental self-efficacy (PSE) which describes caregivers' expectations of their ability to parent successfully (Jones & Prinz, 2005). Research shows strong support linking PSE to healthy parent-child outcomes (Jones & Prinz, 2005). In their review of PSE research Jones and Prinz suggested that low parental PSE may be a risk factor for child maltreatment. There is scant research on self-efficacy of survivor mothers. One study that explored how incest related to parenting (Fitzgerald, Shipman, Jackson, McMahon, & Hanley, 2005) found that survivor mothers perceived their parenting abilities more negatively than they actually were. Survivor mothers reported feeling less efficacious in the parental role when compared to a non-abused sample of mothers. Fitzgerald et al. speculate that,

If incest survivors are indeed more doubtful of their parenting capabilities than non-abused mothers, it is possible that they would more often experience frustration, confusion, stress, and less satisfaction in the parental role, which could negatively impact their relationship with their children. (p. 14)

Therefore, it is important to include both personal and parental self-efficacy in the investigations of mothers survivors.

**Powerlessness.** Numerous studies have shown that intrafamilial CSA produces a sense of powerlessness in its victims (Herman, 1992; Neumann, Houskamp, Pollock, & Briere, 1996; Finkelhor & Browne, 1985). Mothers of CSA victims report feelings of powerlessness as well (Russell, 1997). A perceived lack of control over their bodies (due to their abuse) may impede survivors' attempts at being assertive in later relationships and/or protecting themselves from further revictimization (Davis & Petretic-Jackson, 2000). Powerlessness may also be linked to lower self-efficacy with poor self-concept.

In summary, these avenues of research point to self-concept and personal self-efficacy beliefs as possible core determinants of survivor mothers' self-care efforts. Existing research prompts us to believe that survivor mothers may exercise few self-care efforts since they have (or perceive they would have) little or no effect on their lives. Self-concept and self-efficacy may indeed play a crucial role in self-care. Furthermore, according to Bandura (1995), self-efficacy reduces stress and lowers vulnerability to depression. Survivor mothers with compromised self-efficacy and a poor self-concept may also be at risk for depression and PTSD, which may further influence their self-care practices and perceptions.

**Depression and PTSD.** Depression is recognized as a leading health problem and, along with anxiety, is one of the most frequently cited long-term mental health outcomes for CSA survivors (Putnam, 2003; Paolucci et al, 2001; Chapman et al. 2004; Duncan 2004; Banyard, Williams & Siegel, 2004). Two meta-analyses strongly linked CSA with later depression (Putnam, 2003; Paolucci et al. 2001). In one meta-analysis, 37 studies conducted between 1981 and 1995 were analysed and CSA was found to increase risk for PTSD and depression in adulthood

(Paolucci et al. 2001). Surprisingly, no significant difference was found between the type of abuse or nature of the relationship to the perpetrator on negative outcomes regardless of sex and socioeconomic status (SES). There were two limitations to this study, however. First, this meta-analysis did not include unpublished studies. Second, the results may have been biased by the overall low rates of female perpetrated sexual abuse. A second meta-analysis also found CSA was a serious risk factor for depression and substance abuse in adulthood (Putnam, 2003).

**Revictimization and self-harm behaviours.** CSA survivors are at risk for various self-harm behaviours such as cutting themselves, reckless or risk-taking behaviours, burning, hitting, and biting oneself. Child trauma has been shown to be a predisposing factor for self-harm behaviours. Yates' (2004) review of self-harm research showed that between 17% and 58% of CSA survivors (especially cases of parent-child incest) engage in self-harm behaviours. Survivors also show a higher rate of physical and/or sexual re-victimization than the general population where harm by others includes adult partners, acquaintances, and strangers (Noll et al., 2003; Hendricks-Mathews, 1993; McKegney, 1993).

CSA has even been found to predict self-harm behaviours when other forms of child maltreatment are taken into account (Noll et al., 2003). Noll and colleagues (2003) explored both revictimization and self-harm of 70 intrafamilial CSA survivors and found startling results: survivors were twice as likely to report being raped or sexually assaulted, reported more physical victimization (including domestic violence), had almost four times as many incidents of self-harm behaviours and more significant traumas in their life (following CSA) than a non-abused control group. One can speculate that these revictimization rates may be underestimated given that the majority of their sample consisted of young adults. This was the first longitudinal study of CSA survivors to provide empirical support for revictimization, and suggested that poor self-concept may

play a role in later victimization. "The experience of sexual abuse may be associated with strong negative feelings about one's own body such that abused girls may possess an underlying desire to experience pain or bodily disfigurement" (p. 1467). Unfortunately, the study did not address why some survivors did not experience revictimization; a woman's choice, resilience, and agency were not emphasized.

An alternative perspective on women's self harm comes from Shaw (2002) who feels that self-harm is complex and poorly understood. Shaw's interesting historical review places self-injurious behaviour in a cultural context which encourages one to consider alternative truths about women's self-injury. Rather than seeing self-injurious behaviours as pathological, Shaw considers self-injury as an adaptive response to trauma where women "claim back ownership over their bodies; as a symbol of protest" (p. 16). She stated, "Self-injury is women's self-inflicted objectification and destruction in their bodies in the service in reducing symptoms of psychological distress. It is this which is not culturally sanctioned" (p. 16). The discussion of interpreting self harm behaviours through an alternative framework will be further expanded in a harm reduction framework in the next section.

Some efforts at broadening self-harm behaviours have been made by looking at less direct forms of self-harm (e.g., substance abuse, refusing medical treatment). One study which allowed participants to define their self-harm behaviours revealed less commonly studied behaviours such as non-suicidal pill-abuse (Laye-Ginhu & Schonert-Reichl, 2005). This study used adolescents and did not measure abuse history, however, the findings may be relevant to the current study given that CSA has been connected to substance abuse and these behaviours have traditionally been left out of self-harm discussions.

Some research has identified positive consequences of self-harm such as the release of stress and positive affect, which may reinforce these behaviours. Contrary to past thinking about self-harm behaviours, persons who engage in self-harm do not necessarily do so for attention, but rather to reduce negative feelings such as depression, anxiety, or stress, self-hatred and anger, self-punishment, loneliness or alienation, and distraction from problems (Laye-Gindhu, 2005; Briere & Gil, 1998; Ross & McKay, 1979). For trauma survivors, it may also serve as a reconnection with their physical body (Harter, 1999). One specific form of self-harm behaviours called “episodic self-injury behaviours” are usually occasional occurrences and often result in stress release and better mood (Yates, 2004; Simeon & Favazza, 2001).

**CSA and health risk behaviours.** Health risk behaviours are defined as “actions that increase an individual’s risk for illness and health-related problems” (Rheingold, Acierno, & Resnick, 2004, p. 217). Rheingold and colleagues (2004) reviewed the trauma literature and concluded that trauma survivors are at increased risk for engaging in health risk behaviours. CSA was specifically associated with later risk for substance dependence (i.e., smoking behaviours and alcohol abuse), which were thought to reduce negative feelings. Interpretation of these findings must be made cautiously as the authors did not specify the types of past sexual abuse trauma (e.g., intrafamilial or extrafamilial) and used multiple terms (i.e., sexually abused, sexually assaulted, and sexual trauma survivor) that imply different forms of abuse. In addition, many of the studies cited did not include ethnically diverse samples, or ethnocultural differences were not differentiated. Perhaps most importantly, the studies cited were primarily large-scale quantitative studies that did not take the type or frequency of health risk behaviours into account.

**Effects of CSA on parenting.** The long-term negative effects of CSA also have the potential to affect the quality of parenting when survivors become mothers. Several qualitative

studies show how depression and anxiety may be the greatest challenges incest survivor mothers face as parents. All nine survivor mothers in O'Brien's (1998) study reported clinically significant levels of depression at some point in their adult life. Similarly, most mothers in Kreklewetz's (1995) study described earlier periods during which they were emotionally absent (dissociation), and/or physically absent from their young children. These periods included illness, depression, heavy drinking, nervous breakdowns, or when they just couldn't function. Other studies support these findings of survivor mothers experiencing depression, dissociation, anxiety, and difficulty functioning (Hooper & Koprowska, 2004; Douglas; 2000; Armsworth & Stronck 1999; Cohen, 1987). Armsworth and Stronck (1999) found that survivor mothers reported feeling detached, numb, helpless or overwhelmed with the parenting role, and handicapped by the lack of skills and models for parenting. Feelings of being emotionally unavailable to their children was perceived as the most difficult part of parenting. One woman stated, "I was trying to help my daughter develop a self when I didn't even have one" (p. 309). Many women experienced motherhood in a "survival mode." One woman said, "I didn't learn parenting skills - I learned survival skills and that's what I've ended up teaching my child" (p. 308). Survival skills included hiding their children, avoiding relationships, continuously monitoring their children's whereabouts, home-schooling, changing schools, and relocating their families.

Armsworth and Stronck (1999) reported that many of the participants were parentified as children and grew up in homes with insufficient protection, parenting, nurturing or caring. Other mental health problems for survivor mothers have included prolonged postpartum depression (Duncan 2004). Given these findings it seems doubtful that survivor mothers prioritize self-care or find time and energy for nurturing themselves.

Not only have studies found long-term effects of CSA in adulthood, but a strong connection has been drawn in the last few years linking a mother's past CSA with later parenting difficulties and risk to her children (Roberts, O'Connor, Dunn & Golding; 2004). A study by Dubowitz et al. (2001) found that abused mothers who were re-victimized as adults were more depressed and had children with behavioural problems than were mothers who were only victimized as a child or mothers without a history of victimization. Mothers who were both physically and sexually abused had higher levels of depression than other mothers. This research on high-risk families contained no information collected on the larger context of the mothers' depressive symptoms and caution is necessary to avoid mother blaming. Lerner (1999) departs from pathologizing mothers who suffer from depression and suggests that depression might be exacerbated due to other factors related to becoming a parent such as leaving employment to be a mother and loss of social networks. Studies such as these demonstrate the potential importance of promoting self-care for this vulnerable population and for their children.

In summary, research addressing the long-term effects of CSA has convincingly shown that many aspects of women survivors' lives can be profoundly affected by past abuse. Clearly, the long-term legacies of CSA can significantly affect women survivors in their daily self-care activities, interactions with others, and parenting role. The effects of depression, impaired sense of self, and sense of powerlessness will likely affect one's abilities and efforts towards self-care, regardless of other potential consequences (substance abuse, self-harm, revictimization, mental and physical health concerns). The grim findings of the effects of CSA on women would suggest that these women face many challenges in caring for themselves, let alone in the context of parenting.

Unfortunately, definitional problems make it difficult to gather information and generalize findings about incest survivor mothers specifically. While many studies on CSA have been

conducted, the long-term outcomes and prevalence are still unclear due to definitional inconsistencies of incest and CSA, design and measurement problems, biased sampling, absence of control groups and poor outcome measures (Paolucci & Violato, 2001). Research strongly suggests that sexual abuse survivor mothers are prone to long-term negative health and parenting effects. The costs of not attending to this vulnerable population include detrimental effects on these women's children and families, and direct costs to the health care system. Unfortunately, research has typically engaged in blaming mothers for their children's sexual abuse instead of exploring possible ways to strengthen their experience as parents.

### **Mother Blame and its Effects on Self-Care**

There is a strong tendency for victims of abuse to feel responsible and blame themselves for their own abuse. In fact, research has linked CSA to feelings of self-blame, guilt, and shame for one's abuse (Neumann et al., 1996; Finkelhor & Browne, 1985). These findings lead us to wonder whether a woman's abuse-related feelings of guilt and self-blame translate into lowered self-efficacy as an adult and reduced ability to nurture, pamper, and care for herself. For example, a mother survivor may not feel (consciously or unconsciously) that she deserves to spend time or money on self-comfort. An interesting perspective comes from Lerner (1999) who states that feelings of powerlessness and helplessness (i.e., low self-efficacy) are normative for mothers, who frequently feel guilty and blamed by others for their parenting and their children's behaviour. This could especially be the case for survivor mothers who have children who have been sexually abused.

Historically, strong mother-blaming tendencies existed in cases of CSA. Mothers in families with CSA were often blamed for causing the abuse, maintaining it, not stopping it, and pretending they did not know it was happening (Ward, 1985). CSA was often seen as a measure of the

mother's failure in the family, and although mothers were not the perpetrators, they were the primary source of blame. Sadly, this tendency has continued to the present day. Krane (2003) argues that holding mothers primarily responsible for protecting their children is unfair, given that many mothers are already overburdened with multiple parenting roles and other daily concerns.

The discussion of the long-term effects of CSA provides an important context for understanding how mother blame and self-care interact. Illustrating this, Swigart (1998, p. 103) writes,

Our tendency to blame mothers often results from not understanding the context of the mother's experience in the family and in society as a mother and as a woman - not understanding 1) how as a survivor of violence herself, the mother suffers from several long-term emotional and physical health-related debilitating effects; 2) how the mother's home life is commonly coupled with partner violence; 3) how the daily experience of childrearing for even non-survivors is far from ideal and often wrought with limited energy and patience, boredom, loneliness and isolation, and unmet needs related to the unequal giving and receiving and altruism required, especially with young children.

Feminist analyses of mother-blame recognize that women's past sexual victimization trains them to be powerless victims (Cole, 1995; Jacobs, 1990; Russell, 1986). According to this point of view, other theoretical perspectives fail to account for the fact that mothers of incest victims are often victims of past sexual abuse or spouse abuse, which then affects their protective efforts towards their children (Truesdell, McNeil & Deschner, 1986).

Much of the research on CSA strikingly reveals that non-offending mothers are often the targets of blame from helping professionals, legal structures, and their victimized daughters. There is increasing evidence that professional agencies and clinicians treating incest victims hold

negative stereotypes of non-offending mothers. Carter (1999) found that mothers of incest victims felt blamed for their children's sexual abuse by institutions, family members, and society. Similarly, Dietz and Craft's (1980) survey of child protection workers' attitudes found a startling correlation between reading professional literature and negative beliefs about mothers. The workers believed that mothers unconsciously consented to incest and were as responsible as the abusing fathers for the sexual abuse. Societal attitudes have likely improved since 1980, yet, there is evidence that blame towards mothers of CSA victims "...remains solidly entrenched in the conscious and unconscious minds of professionals and the public..." (Carter, 1999, p. 7) and they are perceived as providing little support and help (Hill, 2001). Allan (2004) suggested that rather than being reduced, mother blaming is being practised more covertly by helping professionals. Hill (2001) reported on the long-lasting traumatic impact of mothers finding out about their child's sexual abuse, "...The common core of their experience was an overwhelming feeling of guilt at their sense of their own failure as mothers" (p. 388). Even for many women who rejected the idealized images of motherhood in the study, residual feelings of guilt remained.

Survivor mothers are burdened with feelings of self-blame for their own and their children's abuse, and regrettably, these feelings may be further reinforced by attitudes of professionals and society that can be harmful and disempowering. Subsequently, mother blame may accentuate self-blame which in turn may affect mothers' self-care perceptions and practices. Given the negative long-term consequences of CSA that may be exacerbated by mother blaming attitudes, one of the most stimulating discussions in CSA research has involved survivors who overcome these negative long-term effects and demonstrate resilience.

## **A Resilience Framework**

A resilience framework can be used to understand self-care as a protective factor for CSA survivors and their children and to highlight the capacities and strengths these women demonstrate in their daily lives. While many survivor mothers do suffer negative consequences from CSA, some survivors do not show many or any harmful effects, and instead are well adjusted and high functioning (Banyard, 1999; Himelein & McElrath, 1996). Failing to develop negative effects, achieving positive outcomes and overcoming adversity despite serious risks can be defined as resilience (Wright, Fopma-Loy, & Fischer, 2005).

Glaister and Abel (2001) examined incest survivors who felt that they had successfully healed from their abuse. "Making the decision to heal, taking care of self, and learning new skills and ways of thinking were actions that facilitate healing" (Glaister & Abel, 2001, p. 194). This research found that healing was associated with developing a sense of well-being and acceptance of self and having a positive outlook. Survivors' healing relied on the development of the understanding of abuse through information, supportive relationships, risk-taking (i.e., self-assertiveness behaviours) and inner strengths and beliefs (e.g., "Don't give up").

Hyman and Williams (2001) found that, according to their definition, 18% of their sample of CSA survivors were resilient. Resilience was associated with a variety of characteristics such as: fewer trauma symptoms, high self-esteem, no current substance abuse, presence of biological children living with the woman, female friendships, fewer interpersonal problems with men, and social activity. Resilient women were also more likely to have higher economic status, and more education and fewer arrests. An interesting finding from this study was that the experience of incest predicted lower resilience (when compared to CSA outside of the family). While this point was not

explained more fully, the researchers suggested that having a more stable family environment in childhood (with no incest present) may contribute towards one's later resilience.

**Connecting resilience, self-care and parenting.** Self-care appears to be imperative for better parenting in more vulnerable populations, such as single parents, adolescent mothers, and CSA survivors. Research on healthy successful single parents showed that they were vigilant in recognizing their self-nurturance needs (mental, physical and emotional) even though little personal time was available to exercise these needs (Olson & Haynes, 1993). Several strategies that single parents identified as helping them parent successfully included: garnering interpersonal support from others, exercise, positive thinking, and religious affiliation. Effective parenting also appears connected to having a positive self-concept and self-efficacy beliefs. Black and Ford-Gilboe's (2004) study of resilience in adolescent mothers revealed that a positive self-concept was important in the practice of self-care. Adolescents who used effective coping mechanisms such as self-reliance, self-esteem, social support, positive outlook, and stress reduction were better able to manage crises and challenges.

Wright et al. (2005) found that survivor mothers who used less effective coping mechanisms such as avoidance to cope with stress, were at greater risk for negative outcomes. In this study, romantic partners mediated the relationship between depressive symptoms and parenting competence. This finding underscores the importance of familial influence in the resilience of CSA survivors, especially since a review of the literature reveals CSA as a risk factor for later physical or sexual assault by intimate partners (Dilillo, 2001). Himelein and McElrath's qualitative study (1996) revealed that resilient survivors engaged in four types of cognitive strategies (a) talking about their CSA, (b) minimizing the sexual abuse in their lives (e.g., the abuse really was not that serious), (c) positive reframing, and (d) refusing to dwell and focus on the

experience. Intrafamilial and extrafamilial CSA were combined in this study and the participants were young, single white, university-educated women and are hardly representative of all CSA survivors.

Finally, resilience has been shown to be a protective factor in lessening the risk of intergenerational transmission of CSA (Leifer, Kilbane & Kalick, 2004). In this study, survivor mothers did not differ from non-abused control mothers in terms of trauma symptoms or adult victimization, and they showed secure adult relationships which reflected a positive model of self and others. In addition, these researchers found that survivor mothers whose children had been sexually abused functioned more poorly, had more trauma symptoms, and more severe substance abuse, and were more frequently victimized as adults than survivor mothers whose children had not been abused. There were, however, several limitations of this study. Focussing on maternal factors alone suggests mother blame and that mothers are primarily responsible for preventing (or perpetuating) the abuse of their children. CSA was broadly measured and did not specify the extent of their abuse or relationship to the offender. The sample was also limited to low-income African American mothers, which restricts generalization of the findings.

Taken together, these studies on effective parenting in vulnerable mothers do not address self-care specifically, nor do they investigate if self-care acted as a protective factor which may have enhanced resilient characteristics. The following discussion addresses the nature and role of self-care itself and its potential implications for survivor mothers.

### **Self-Care**

An in-depth review of the literature revealed that self-care is also referred to as: self-help, healing, self-nurturance, self-comforting, wellness lifestyles, self-care agency, health-promoting behaviours, and health-protective behaviours. Specific research on self-care of survivor mothers is

sorely lacking. The majority of information on self-care comes from popular self-help books and feminist therapy discourse.

Self-care in feminist models of therapy. In the feminist therapy tradition, self-care is seen as necessary for nurturing oneself. In fact, a fundamental principle of feminist therapy is self-nurturance (Gurman & Klein, 1980 cited in Miller-Kallenbach, 1994). Inspired by the women's movement and therapeutic literature (Miller-Kallenbach, 1994), self-care has been extended to embrace physical, emotional, and spiritual care. Engel (1989) broadened this definition for CSA survivors to include self-assertion, help seeking, and acknowledgement of rights and freedoms. Miller-Kallenbach (1994) noted that it was only through the context of psychotherapy with women that the notion of self-nurturance entered academia. The Feminist Therapy Code of Ethics (Feminist Therapy Institute, 2000) is the only code that specifically focused on self-care as it related to therapist well being (Wityk, 2002) and it encouraged self-care as an ethical practice relating to one's personal as well as professional health.

**Popular self-help discourse on self-care.** The self-help literature has dominated the majority of writings on self-care. Bibliotherapy is one self-help method which uses written materials to encourage behaviour change through self-awareness and empowerment among individuals. Considerable literature exists supporting the use of self-help reading materials to improve womens' health. For example, bibliotherapy has been used for decreasing health risk behaviours in dating with college students (Yeater, Naugle, O'Donohue & Bradley, 2004). A meta-analysis also found strong efficacy of self-help materials in decreasing at-risk and harmful drinking behaviours (Apodaca & Miller, 2003). Further, using a standpoint feminist approach Anastasiadis Atallah (2003) found that women who read self-help books achieved empowerment, agency, and validation. Women reported that reading self-help literature helped them feel more in control and able to take

action over their lives. Bibliotherapy allowed them to understand their struggles and issues they were facing within the broader context of patriarchy.

Other self-help parenting literature suggests that self-nurturing practices can benefit one's children. Hanson, Hanson and Pollycove (2002) advise mothers that, "...nurturing yourself is the foundation of caring for your children" (p. 58). They encourage daily practices of meditation and journaling to nurture themselves and cope with the ongoing conflict between meeting the needs of others and their own needs. They further stress that, "pursuing healthy wants" provides a positive example for children and decreases stress on the mother's part. Lerner (1999) also emphasized the importance of mothers recognizing and being aware of their own needs since women tend to ignore their needs once they become parents. It is also suggested that self-help for parents is necessary for quality parenting. According to Saunders and McDaniel (2000), "If you want to save your child from drowning, you must first learn how to swim. If you jump into the pool without knowing how to perform this basic task, there will be two drownings instead of one" (p. 35).

Self-care has also been identified as an important tool for dealing with anxiety and depression, one of the most common effects of CSA. Bloch's (2002) popular self-help program for depression and anxiety emphasized self-care as a critical component to healing. It delineated five areas of self-care including: social support, spiritual connection, mental and emotional self-care, lifestyle habits that enhance mood, and physical self-care. However, this model lacks differentiating between self-care and coping strategies, does not separate the cognitive and emotional areas of self-care, nor does it explain behaviours that fall outside of traditional self-care efforts.

Popular writing about self-care illuminates and emphasizes its importance, especially for parents and caregivers. However, this literature was limited by lack of specific reference to survivor mothers, as well as class, race, and gender distinctions. This is important in the study of survivor

mothers as they are often women of colour living in poverty and are among the most disenfranchised members of society.

**Self-care for mothers.** For mothers, self-care is about balancing their own needs and those of their children (Isaacs & Keller, 1979). While few empirical studies have been conducted which build on the notion of self-care for CSA survivors, self-care sometimes appears in the parent education and intervention literature in a discussion of coping. For example, Coleman and Ganong (2004) briefly discussed creative coping strategies for single parents such as extended family, support networks and counselling. Self-care for parents was briefly mentioned within the Head Start program, which includes self-care as part of its curriculum with stress management, nutrition, and dental care (Baydar, 2003). Other parenting handbooks aim to teach parents effective parenting strategies and ways of coping with stress in the context of their child's behaviour problems (Briesmeister & Schaefer, 1998).

The National Extension Parent Education Model (NEPEM) is a core conceptual framework for parent education framework in the United States (Goddard, Smith, Cudaback, & Myers-Walls, 1994) and was one of the few places that discussed "Care for Self" directly in a comprehensive way which highlighted its importance for effective and resilient parenting. One of the model's six categories is "Care for Self" which emphasizes the parent's personal skills (e.g., managing personal stress). The primary focus of the model is on what parents can do to enhance their child's well being. According to this model,

Caring for oneself means knowing and understanding oneself, managing life's demands, and establishing clear direction. Although not impacting children directly, Care for Self provides a backdrop of security, support, predictability, and purpose that indirectly influences the lives of everyone in the family. For example, a parent

who has established a sense of purpose in parenting will be more comfortable establishing criteria for choosing guidance strategies. A parent who is motivated in her or his own life will be more capable of motivating a child. And a parent who feels interpersonally connected and supported will find it natural to nurture a child (p. 132).

The program focused strongly on a parent's needs; it stressed, "Caring for oneself is not only a critical parenting skill, but a skill for life" (p. 82, Goddard et al., 1994). This approach to self-care does not take into account the unique characteristics of CSA survivors or the challenges they experience in their role as mothers.

### **The Importance of Self-Care for Survivor Mothers**

Self-care for survivor mothers has been virtually ignored in the literature. This is most disturbing given that CSA is of epidemic proportions, and survivor mothers' ability to care for their children may be a function of their ability to nurture their own mental and physical health. In her study on women's self-nurturance, Miller-Kallenbach (1994) found that older women who had self-nurturing modeled by their mothers had more positive attitudes towards self-nurturing. It may be that some survivor mothers have also developed positive self-nurturing attitudes through positive role models.

As with other victims of abuse, survivor mothers often lack healthy parenting role models, knowledge, and skills, which make the experience of parenting particularly difficult and daunting. According to Engel (1989) self-care is especially important for parent survivors: "If you can take care of yourself you will be able to move beyond victimization." (p. 162). She further asserts: "Self-care makes it possible for you to truly care for others...(it) does not mean you stop caring about others; it just means you start caring more about you." (p. 160). It is currently unknown what self-

care practices are engaged in by survivor mothers, or what their attitudes or perceptions of self-care are.

**Self-care in the present study.** The review of the literature demonstrated that self-care has been defined and discussed in many ways. It is apparent that there are many components of self-care: physical, social, emotional, and spiritual. Therefore, for the purpose of the present study, self-care is defined as an activity that increases or maintains one's own physical, emotional, social, and spiritual health. Further research identifying spiritual forms of self-care is needed since spiritual domains have been implicated in both positive healing outcomes for sexual abuse survivors (Hall, 2003) and in mothers' resilience (Monteith & Ford-Gilboe, 2002). Thus, this definition serves the purpose of including these potentially significant aspects of self-care. In addition, given the demands of the parenting role survivor mothers also contend with, the definition of self-care in the current study also includes creating balance between caring for others and caring for oneself. Given the large gap in the literature on how CSA may affect self-care, the present research will explore how these characteristics uniquely influence self-care perceptions and practices.

## **Conclusion**

Self-care for CSA survivors is not well understood. It is clear that there are many long-term effects of CSA that have potential impacts on the self-care perceptions and practices of survivor mothers. However, there are large variations in definitions and understandings of "self-care", which are dependent on the discipline in which it is discussed. Self-care for parents is often not addressed in the parenting literature. Although research on vulnerable parents has identified some self-care strategies, these may or may not apply to the unique experiences of survivor mothers.

Further, the lack of theorizing and research on self-care and self-nurturing in the parenting literature leaves the impression that parental self-care is not important for parents or their children.

Self-care discussion regarding parent sexual abuse survivors is conspicuously absent.

Interestingly, there is also a gap in the literature concerning CSA and parenting.

Davis and Petretic-Jackson's (2000) review of CSA research recommended that future research explore CSA and parenting as well as survivors who exhibit few negative after-effects. Self-care may be an important mechanism for explaining why some CSA survivors are more resilient in adulthood, and why the intergenerational cycle of abuse is broken in some families but not in others. The literature suggests that self-care may act as a protective factor for survivor mothers and their children. Consequently, it is important to begin understanding self-care perceptions and practices of survivor mothers. This understanding can be situated within relevant theoretical frameworks which are discussed next.

### **Understanding Self-Care Through Four Frameworks**

While there currently is no specific theory of self-care regarding CSA survivors, four theoretical frameworks are particularly useful for understanding how past CSA may later affect self-care for survivors. These include Finkelhor and Browne's traumagenic dynamics framework, social learning theory, feminist theory, and harm reduction framework.

**Traumagenic dynamics framework.** Finkelhor and Browne's (1985) classic "traumagenic dynamics" model still remains a useful framework for explaining the effects of CSA on survivors (Fabelo-Alcover & Sowers, 2003; Davis & Petretic-Jackson, 2000). Four factors in the model (i.e., traumatic sexualization, betrayal, powerlessness, and stigmatization) capture the experience of CSA that may negatively affect an adult survivor's self-care practices. According to Finkelhor and Browne (1985), "These dynamics alter children's cognitive and emotional orientation to the world, and create trauma by distorting children's self-concept, worldview, and affective capacities" (p. 531).

The first factor of *betrayal* occurs when children realize that a trusted person they depended on caused them harm and that they were not protected or believed. This later appears in adulthood as grief reactions, depression, impaired judgment of the trustworthiness of others, vulnerability to revictimization in relationships, or hostility and anger leading to aversion to intimate relationships (Finkelhor & Browne, 1985). These dynamics would strongly affect a survivor's self-care primarily in the social component, which relies on having a healthy trust in others, openness to relationships with others, and creating, fostering and maintaining supportive interpersonal relationships. O'Brien (1998), for example, found that survivor mothers' impaired trust was significant, and affected trusting their own judgment or trusting the care of their children by others (e.g., babysitters). Self-care may be particularly necessary in this context for survivors who lack trust in others and interpersonal relationships from where they might receive support in their parenting role and personal healing.

The second dynamic of *powerlessness* occurs because a child is unable to stop or escape from the abuse experience(s). This diminishes a child's sense of efficacy and can result in fear and anxiety, PTSD symptoms, impaired coping skills and revictimization in adulthood (Finkelhor & Browne, 1985). These dynamics may affect survivors' emotional self-care in restricting their ability to be assertive in later relationships, or in the physical component by feeling a lack of control over what happens to their bodies. Perceived powerlessness and lowered self-efficacy may also affect these women's perceptions regarding their ability to protect their children and themselves from victimization.

The third traumagenic dynamic of *stigmatization* occurs through messages of worthlessness, shame and guilt which are conveyed to the child. These messages eventually become incorporated into the child's self-image as shame, guilt, low self-esteem and feeling

different from others. While the degree of stigma suffered varies, Finkelhor suggests that the longer term effects may show up in adults as feelings of isolation, poor self-esteem, drug and alcohol abuse, prostitution, guilt and shame with its extreme form of self-mutilation and suicide attempts. These dynamics may also strongly affect a survivor's self-care efforts in all of the four traumagenic components as well as from the central cognitive component, especially in physical self-care.

Finkelhor's traumagenic dynamics model is useful for understanding how the long-term effects of CSA may make it difficult for survivor mothers to engage in self-care. The model describes the effects of CSA on a survivor's sense of self-worth, trust in others and feelings of powerlessness. The theory does not explain, however, resilient survivors who demonstrate few of these negative effects. A social learning model of self-care may fill the gap for explaining how these effects might be mediated for the adult survivor's functioning.

**Social learning theory.** Social learning theory (Bandura, 1977b) has frequently been used to explain socialization within the family. According to this model, children learn behaviours, attitudes and actions primarily through observing parental role models and significant others (e.g., teachers). From this stance, the family environment acts as a critical training ground for modelling pro-social behaviours such as self-care. According to this framework, one might expect to see less self-care in CSA survivors since families of incest are often living in a multi-dysfunctional environment with domestic violence, substance abuse and witnessing violence against their mother. Herman (1981) showed how mothers in incest families were more likely to be victims of domestic violence than those in non-incest families. Studies also have shown that many mothers are physically abused by the same perpetrators responsible for their children's sexual abuse (Deblinger, Hathaway, Lippmann & Steer, 1993; Truesdell et al., 1986). The Violence Against Women Survey (Statistics Canada, 1994) revealed that women in violent relationships were twice

as likely as women in non-violent relationships to have witnessed violence towards their mother by their father. Women were also three times as likely to report that their spouse had witnessed parental violence growing up. Given this family environment, it is unlikely that survivors would have observed and acquired positive models of self-caring behaviours.

A social learning framework lends itself to understanding self-care behaviours that children learn from their parents, but does not account for why these behaviours may persist into adulthood. Social learning theory does not account for the social conditions and societal context present, which may affect and limit a mother's choices of self-care (e.g., spousal violence, poverty, devaluing of self-nurturing in society). Subsequently, this perspective offers a narrow and limited understanding of whether women engage in self-care behaviours and the forms of self-care they choose.

**Feminist theorizing, parenting and self-care.** Feminism is a perspective, philosophy and practice rooted in individual choice and self-determinism (Foss, Foss & Griffen, 1999) which supports women's articulation of their own experiences and their right to determine how their lives will proceed. Feminist theories take into account the broader social structures of patriarchy and political context that may influence self-care. Attention to sociocultural contexts in which self-care occurs is critical. We need to ask, are some forms of self-care efforts (e.g., esthetic services, nights away from family) impeded or less accessible to lower-income single mothers?

Feminist theories also focus on structures that constrain women's lives (e.g., gender roles and socialization). In this regard, it is important to understand incest survivor mother's self-care efforts in the power structure and social context in which they occur. Three areas deserve mention: 1) the socialization of women into caregiving roles, 2) the social organization of parenting, and 3) the prevalence of mother blame and reinterpreting myths associated with motherhood.

***The socialization of women as caregivers.*** From a feminist viewpoint, women are socialized and encouraged to be caregivers to their children, their partners, their aging parents, and friends rather than focussing on themselves. This idea was supported by O'Brien (1998) who found that survivor mothers spent much energy caring for, and meeting the needs of their partner or spouse. In this context, it was not surprising to find few self-care efforts by mothers in this study. Oakley (1981) stated that mothers are selfless caring figures whose existence revolves around their children's needs. The concept of a "good mother" and idealized images of motherhood are very pervasive (Hall, 2000), and feminist theorists argue that the social reality of mothering is one of inequality, social isolation, coercion, blame, stress and reduced economic and political opportunities (Allan, 2004; Fox, 1997; Chodorow, 1978).

***The social, political, and economic climate of parenting.*** Lerner (1999) argued that society values the production of goods and services as opposed to nurturing and private practices of raising and caring for children. This is consistent with the lower wages paid to those caring for our children in formal child daycare centres. Chodorow (1978) critiqued the social organization of parenting in which the mother is the primary caregiver. "The structure of parenting creates ideological and psychological modes which reproduce orientations to and structures of male dominance in individual men, and builds an assertion of male superiority into the definition of masculinity itself" (p. 185). Unequal child rearing often results in women having little time to nurture their self-interests. Fox's study (1997) revealed how gender roles became reinforced in relationships following the birth of children. What is unclear is how these gender roles shape the experience of self-care behaviours for mothers. Fox's interviews with new mothers (1997) found that the increased responsibilities and high pace of the mother's new role resulted in women

reporting that they “had no life” and felt trapped. Increased social distance and lack of contact also were reported.

Most mothers (even if they work outside the home) are the primary nurturers in the family with the fathers as the primary breadwinners. Stay-at-home mothers or those who work part-time have less earning power and contribute less financially. It is questionable therefore, whether these mothers would feel entitled to spend time or money on forms of self-care or avenues to allow them to nurture themselves.

While pointing to the social and cultural conditions of parenting, early gender-role socialization translates into later adult caregiving patterns (Raley & Bianchi, 2006). Rich (1976) argues for the importance of self-nurturing of mothers raising daughters,

The nurture of daughters in patriarchy calls for a strong sense of self-nurture in the mother....A woman who has respect and affection for her own body, who does not view it as unclean or as a sex-object, will wordlessly transmit to her daughter that a woman's body is a good and healthy place to live. A woman who feels pride in being female will not visit her self-depreciation upon her female child. (p. 245)

The strength of a feminist framework is that it highlights societal and cultural roles that affect parenting, mothering, and self-care, and situates self-care within its social structures of patriarchy and political context. One can speculate that this type of climate would strongly affect a woman's self-care efforts. Feminist theory also focusses on structures that constrain women's lives (e.g., gender roles and socialization). It is important to ask what encourages and supports mothers to engage in self-care behaviours and what detracts from them. Acknowledging these social structures provides an important frame of reference for better understanding survivor mothers' self-care efforts.

What feminist theory does not address is the nature of self-care itself, including the wide variety of potential practices and behaviours in which survivor mothers may engage. Their perceptions of self-care and the meaning of their practices may be better captured by a framework that provides a broader definition of self-care that incorporates both health promotion and the reduction of health risk.

**Harm reduction framework.** The harm reduction model “takes a non-judgmental, non-punitive neutral stance, focusses on the immediate goals of reducing harm, and expects the user to take responsibility for choices” (Erickson, Riley, Cheung & O’Hare, 1997). A review of the self-harm, self-care, and CSA literature together raises provocative questions about whether some self-harm behaviours can be viewed as *forms* of or *attempts towards* self-care. On the surface self-harm behaviours appear harmful to the individual, and seem to be the opposite of self-care efforts. An explanatory framework of harm reduction is useful in understanding how some self-harm behaviours may be seen as a form of self-care by survivors. This framework challenges us to look at and understand self-care behaviours in a new innovative way.

When viewed within a harm reduction framework, some self-harm behaviours offer temporary relief and may instead be seen as a form of self-comfort through which negative feelings that are difficult to cope with are released. Snyder and Dinoff (1999) note that coping can be seen quite differently depending on whether the person describing it is the person using the coping strategies, or someone on the outside viewing or judging the coping. The same can be said for self-care efforts. To an outsider (such as a researcher) self-harm behaviours used to deal with past sexual abuse (or stress related to parenting) may appear dysfunctional or harmful. For example, self-injury behaviours have been viewed within a coping framework as strategies to reduce negative feelings (Rodham, Hawton, & Evans, 2004) and have been explained as attempts to

decrease feelings of distress (Laye-Gindhu & Schonert-Reichl, 2005). Thus, while survivors may engage in such behaviours they can be seen as movement and efforts towards self-care within a harm reduction framework.

From its inception in those years HR has posed the notion that self-indulgent behaviour is distributed along a continuum ranging from excess through moderation to abstinence. Although abstinence is a desired goal, *any* movement toward reduced harm is encouraged and accepted.... The more the client can be moved away from excess toward moderation, the greater the reduction of possible harm. Hence, the harm reduction slogan: Any steps toward decreased risk are steps in the right direction. (Laws, 1999, p. 234)

Adopting a harm reduction framework is important in identifying and understanding self-care strategies of incest survivor mothers for three reasons. First, addictive behaviours (alcohol, illicit drugs, overmedicating) are frequently reported as one of the long-term effects of CSA. The meaning of self-care can and will differ across women with different outcomes, and this framework allows for this. Second, no studies have examined self-care on a continuum. A harm reduction framework provides a continuum framework rather than a dichotomous perspective. In this way, women's self-care is not categorized but is viewed instead as degrees or increments towards self-care. Third, use of a harm reduction framework in this study provides the broadest possible definition for self-care designed to encompass all perceptions of self-care provided by survivors. Without a harm reduction framework, some survivors' self-care experiences might be excluded or misinterpreted. Webster and Dunn (2005) cautioned researchers to "remain grounded in the client's experience" rather than controlling and naming women's experiences for them. A harm reduction

framework would thus allow survivors to define their experience in the broadest possible terms of self-care.

In conclusion, the four theoretical frameworks discussed - the traumagenic dynamics model, social learning theory, feminist theory, and harm reduction framework- jointly provide a conceptual frame for understanding the association between the long-term effects of CSA and survivor mothers' self-care. The traumagenic dynamics model provides insight into particular aspects of self-care that survivor mothers may experience challenges, such as establishing trusting supportive networks, help seeking, and self-efficacy. Social learning theory provides understanding into why some common self-care perceptions and practices may be absent for survivor mothers. Feminist theory connects survivor mothers' self-care perceptions and practices into the broader social context, explaining how gender roles and power hierarchies may influence daily lived experience. Harm reduction widens the possible definitions of self-care for survivor mothers, given some of the long-term effects they face. The framework also provides a continuum perspective that is lacking in the literature which broadens the scope for understanding self-care in this vulnerable population. Taken together, these four perspectives provide a useful interdisciplinary conceptual framework for understanding the unique nature of self-care.

Given the paucity of research on self-care for survivors, particularly those who are also mothers, and the potential importance of self-care for both themselves and their children, the main goal of the present research was to explore the perceptions and practices of self-care for these women. A grounded theory approach was chosen for this exploration as it provides a sensitive and open-ended methodology which can garner a deeper understanding of self-care for survivor mothers. This approach is explained in detail in the next chapter.

## Chapter 3: Methodology

### Overview of Data Collection Methods

This chapter provides an overview of the mixed-methods approach used in the current study that utilizes grounded theory and photovoice methods, and provides justification for their selection as appropriate methods. The main goal of the present study is to explore perceptions, practice, and the meaning of self-care for survivor mothers. Grounded theory is a powerful and systematic way of generating theory grounded from empirical data. It is both a design and analysis technique where the emerging theory shapes the data collection.

**Overview of classic grounded theory process.** Numerous remodelings of GT and the mixing of qualitative data analysis and GT methodologies (e.g., Straus & Corbin 1990, Morse, 1994; Charmaz, 2000) have resulted in confusion surrounding the nature of the GT method (Glaser & Holton, 2004). To be clear, the present study used a classic grounded theory (GT) approach based on the groundbreaking work of Barney Glaser (1978). Glaser's method (often referred to as Glaserian or classic GT) is a method based on a concept-indicator model which uses a rigorous set of procedures to reveal the grounded data. The rationale for GT research is,

to get through and beyond conjecture and preconception to exactly the underlying processes of what is going on in the resolving of the participant's main concern... [which] has to be allowed to emerge from the systematic collection and treatment of data during the research process...The methodology is for the generation of a theory directly from the data that explains as much as possible with as few concepts as possible, and what are explained are the behaviour patterns of those being studied (Christiansen, 2007, p. 41).

GT research is abstract of time, people and place, giving it a timeless application. GT reveals latent

social patterns in our lives as opposed to being particularistic, or based on an individual incident. GT method is *not* description, because "Description is stale data from the moment it was produced." (B. Glaser, GT Seminar, Mill Valley, May, 2008) Through using GT procedures, powerful concepts that occur daily all around us are revealed.

As suggested above, GT is an inductive method based on emergence of concepts rather than testing hypotheses or fitting preconceptions of what the researcher expects to find. For example, Glaser states, "Forget what interests you and go with what the data says. You don't have to know where it's going to go; let it emerge" (GT Seminar, New York, 2007). GT has been subjected to various criticisms in this regard. There is some debate whether it is possible for researchers to suspend their initial awareness and sensitivity to relevant theories, thus allowing the main concern of participants to emerge (Bulmer, 1979). Other qualitative methodologists have expressed concern that GT does not capture context adequately (Coffey & Atkinson, 1996). However, according to GT, the social context will emerge if it "patterns out" (is relevant) in the data, otherwise it is considered to be preconceived. GT is "a general inductive method possessed by no discipline, or theoretical perspective, or data type" (Glaser, 2005, p. 141) which makes it useful and appropriate to analyse any type of data, including visual data such as photographs. "Researchers like it because it gives them an ontology [what is data] and an epistemology [philosophy of research]" (Glaser, 2005, p. 141).

**Classic grounded theory methods.** Classic GT is a well documented rigorous methodology made up of several specific procedures including: 1) data collection and open coding, 2) selective coding and theoretical sampling, 3) memoing and memo sorting, and 4) theoretical coding and writing up. The procedures are generally sequential, however, the process is

recognized as iterative with much cycling back and forth, as the researcher interacts with the data, and concepts emerge. A brief overview of these procedures is described next.

**Data collection.** Data are typically collected through interviews and observations in the field. However, GT data can also include quantitative and other forms of data such as casual conversations, documents, and other secondary data. This is a broad approach which can be summarized as "All is data" (Glaser, 1978). Conceptual fieldnotes are preferred over recording and using transcripts since this decreases the chance of data overload. It is also preferable to "forget description but remember concepts" (Glaser, 1998, p. 32). Recording also generates "properline data" (comments which the participant thinks the researcher wants) and generates superficiality rather than rich depth (Glaser, 1998).

The mandate is to remain open to what is actually happening and not to start filtering data through pre-conceived hypotheses and biases to listen and observe and thereby discover the main concern of the participants in the field and how they resolve this concern (Glaser & Holton, 2004).

**Open coding.** The purpose of open coding is to discover the *core variable* or "What is this data a study of?" (Christiansen, 2007, p. 49). Open coding occurs by examining the data and assigning a substantive code to an incident or piece of information. During the open coding process, codes are assigned to incidents which indicate conceptually (not descriptively) what is happening in the data (Glaser, 1978; 2001). Concepts in grounded theory might sometimes be *in vivo* concepts (those arising from the participants themselves) which can direct the researcher to theoretically sample (Glaser, 1998).

The researcher continues to open code which generates concepts and their properties/ dimensions (e.g., the degree of the concept). Conceptual codes are based upon five main

questions the research asks to increase theoretical sensitivity during the coding process: What is the data a study of?, What category does this incident indicate?, What is happening in the data?, What is the participant's main concern?, and What accounts for the continual resolving of this concern? (Glaser, 1998). The open coding process forces verification, saturation of categories, maximizes relevance through emergent fit of the data, and directs future theoretical sampling (Holton, 2007). Once the core variable emerges it becomes the focus of the analysis. Selective coding replaces open coding and the core guides further data collection and theoretical sampling for the remainder of the study.

***Selective coding, constant comparative method, and theoretical sampling.*** Ultimately, as concepts emerge and the theory develops, the original number of substantive codes is reduced and elevated to fewer higher level concepts, a process known as delimiting (Glaser, 1998). Selective coding occurs when the researcher delimits the coding to concepts and data that are related to the core variable. The constant comparative method (Glaser & Strauss, 1967; Glaser, 1978; Glaser, 1998) is a method used during selective coding which allows concepts to emerge from the coded fieldnotes and yields rich concepts which begin to indicate patterns in the data. This method consists of comparing new incidents to incidents within categories, integrating categories and their properties, memoing, delimiting the theory and categories, and writing the theory. Earlier coded data is revisited and codes within and across interviews are compared and examined for fit to the emerging theory. At this stage, coding is continued until saturation is achieved. The data in a GT study is considered saturated once nothing new is found and "all data fit" (Glaser, 1978, p. 60). When saturation occurs, all of the data reflect an indicator of some category in the analysis. The same concepts and patterns keep recurring in the data. Neither representativeness nor sample

size is a salient issue in GT since data collection is based on theoretical saturation and completeness (Glaser, 1998; Glaser & Strauss, 1967).

Theoretical sampling involves collecting data for furthering the generation of the theory. In GT research, sample sizes are not determined a priori, but rather are selected as the study proceeds based on the emerging theory. Theoretical sampling supports which data might be relevant to the core category and which categories related to the emerging theory. Interview questions at this point become more directed and focused. Theoretical sampling decisions are made in the field and are informed analysis of the researcher's memo bank.

**Memoing.** Memoing in GT is a "moment capture" where the researcher writes freely on a conceptual level freely about the generated codes and interrelationships in the data (Glaser, 1978; 1998). Memoing serves many important functions.

It [memoing] tracks substantive code emergence, theoretical codes and their integrations, conceptual levels as they become more abstract, saturations, delimiting, density, perspective level and the bias of life experiences and training (Glaser, 1998, p. 181).

Memos also track the validity, fit, and relevance of the emerging theory. Although based on descriptive data, the memoing process elevates the analysis to a theoretical level. Memos contribute to a memo bank which supports theoretical coding, sorting, and writing up the conceptual theory.

**Theoretical coding, sorting, and writing up.** Theoretical coding involves electing a conceptual framework around which to build the theory, and is one of the final steps in generating a GT. Theoretical codes emerge through memo bank sorting. They organize the basic elements of the data and draw connections among them (Glaser, 1978). This step in GT is challenging and is

frequently omitted from qualitative research studies (including GT studies) (Glaser, 2005). It is, however, a key component in the method since it gives the data and theory a rich structure from which to see the interrelatedness of the categories. "While substantive codes refer to the patterns in the data, theoretical codes refer to models arising from the data. Theoretical codes clarify how the properties of categories fit together and provide the imagery for how the core variable resolves the participants' main concern" (Glaser, p. 32, 2005).

Various theoretical coding families exist and can be used alone or in conjunction with one other to organize the data and model the grounded theory. A common theoretical code is a Basic Social Process (BSP) model (Glaser, 1978, 1996, 2005). A BSP processes a social problem and should include at least two distinct emergent stages that "differentiate and account for variations in the problematic pattern of behaviour" (Glaser, 1978, p. 97).

Much of qualitative data analysis (QDA) consists of describing concepts to capture various themes. However, without connecting the substantive concepts or relating their patterns, the analysis lacks the power to account for variations of the concepts at a theoretical level. Theoretical codes not only enhance the substantive story within the theory; they provide a higher explanatory power or more robust grounded theory because theoretical codes increase the strengthening of the relationship between the substantive categories.

Of particular interest is the common tendency and freedom afforded to grounded theorists to label substantive nouns into gerunds (by adding "ing"). This is a common practice in GT, particularly with a BSP (Glaser, 2005) since this helps indicate movement or change over time within the basic social processes. GT stresses the social process as the focus of analysis as opposed to the unit of analysis. The current research focused on theory building around a BSP rather than on describing a particular unit such as mothers or incest survivors.

As the name suggests, sorting involves sorting memos and their concepts into piles to help reveal theoretical codes. Sorting is a critical process that connects the fractured data back together into a conceptual story (Glaser, 1998; Glaser & Holton, 2007). The sorted memos serve as an outline and “first draft” of the grounded theory.

Judging credibility in grounded theory. Glaser and Strauss deal with the issue of credibility extensively (Glaser & Strauss, 1967; Glaser, 1998; 2001; 2003). Credibility in GT is measured by how well the core variable or theory is integrated, is easy to understand, and explains variations in the process study.

A well constructed grounded theory will meet its four most central criteria: fit, work, relevance and modifiability. If a grounded theory is carefully induced from the substantive area its categories and their properties will fit the realities under study in the eyes of the subjects, practitioners and researchers in the area. If a grounded theory works it will explain the major variations in behaviour in the area with respect to the processing of the main concerns of the subjects. If it fits and works the grounded theory has achieved relevance. The theory itself should not be written in stone or as a ‘pet’, it should be readily modifiable when new data present variation in emergent properties and categories. The theory is neither verified nor thrown out, it is modified to accommodate by integration the new concepts. When these four criteria are met, then of course, the theory provides a conceptual approach to action and changes and accesses into the substantive area researched. (Glaser, 1992, p. 15)

The GT method deals with bias and preconceptions through the constant comparison method along with self-interviews. GT recognizes that “the researcher is a part of what he [sic] is producing” (Glaser, 1996, p. xii). Thus, the researcher is encouraged to interview oneself and later

code what he or she wrote. Using the constant comparative process, if a code doesn't pattern out, it doesn't earn presence in the theory. The assumption underlying self-interviews is that it is just more data that may help conceptually elaborate on the concepts. Self-interviewing acknowledges the researcher's perspective as present in the analysis and reduces bias.

Rationale for GT methods in the current study. GT was chosen as an appropriate method to use in the current study for several reasons. First, it is well suited to exploration in less known areas of inquiry. There is a lack of research about self-care in mothers with a history of CSA. This method allows perceptions, practices, and meanings of self-care for survivor mothers to emerge. A GT methodology is designed to allow substantive concepts that explain mothers' main concerns as survivors and parents in a deeper and richer manner than other methodologies allow. Second, GT was selected because it has consistently been documented as a systematic and rigorous methodology. Third, this particular form of GT (Glaserian tradition) was selected because it is a good fit with a feminist paradigm and participatory action research (Keddy, Sims & Noerager Stern, 1996). It has the potential of contributing to meaningful complex knowledge concerning survivor mothers in context that might otherwise be difficult to obtain.

Thus far, a discussion of GT methodology has focused on interviews as the source of data for analysis. However, recent work has suggested that visual data can augment and complement the richness and depth of interview data to an impressive degree. Therefore, a visual source of data was also selected as part of this mixed methods exploration.

**Photovoice methods.** Visual image research has great potential, yet is underused (Harper, 2005). Visual methods have been used effectively with vulnerable participants such as battered women as an empowering tool for capturing their experiences and increasing self-awareness (Frohmann, 2005). Photovoice is also a culturally relevant research model for

Indigenous populations who typically hold less power. Castleden and Garvin (2008) found that photovoice methods balance power, creates a sense of ownership in the research, fosters trust, builds capacity, and is a culturally appropriate project among Aboriginal communities.

Photovoice is a participant action strategy which places a camera in the hands of participants and allows them to create images for personal and community change. "Cameras are not entrusted to researchers or professional photographers but rather given to children, the elderly, or other marginalized groups in order to discuss life as they see it" (Hurworth, 2003, p. 2). The main strength of photovoice is the active engaged collaboration and reciprocity that participants and the researcher assume in data collection and analysis. Participants engaged in photo-based research jointly produce new knowledge where participants are not merely seen "as containers of information that is extracted by the research investigator and then analysed and assembled elsewhere" (Banks, 2001, p. 95). The researcher chose photovoice as a method for the present study because it fosters a sense of community among participants through sharing and giving advice to one another, and serves as an empowerment strategy which fosters group cohesiveness and sharing common experiences (Hergenrather, Rhodes, & Clark, 2006; Wang & Pies, 2004; M. Albl Personal Communication, October 17, 2006). While photovoice is an innovative method for capturing women's experiences, to date, photovoice methods have not been used for documenting experiences of self-care.

The researcher combined visual methods and interview methods to allow for richer data and for a more complete and in-depth GT analysis. It also allows vulnerable populations a creative avenue for self-expression. Photographs are data which can be analysed and included in the development of concepts (B. Glaser, Personal Communication, October 2007). For the present study, the researcher chose photovoice because it had the potential to be empowering for the

survivor mothers in that it provided an opportunity for them to amplify their voices. According to Mason (2002), good research designs require one to address one's ontological and epistemological position since different perspectives can lead to different stories. The current research takes an ontological position that the meaning survivor mothers make about their self-care knowledge, experiences, and practice is important. The present study encompasses an epistemology which highlights the subjective experience of listening to women's voices as primary knowledge in understanding the main concerns of mothers with a history of CSA, empowering these women to generate new knowledge about their experiences by being more active in the creation of data.

### **Participant Recruitment and Selection**

Women survivors of violence are a marginalized group whose diverse experiences are often excluded from the production of knowledge (Lawrence, 1996). Therefore, efforts were made to recruit a culturally inclusive and diverse group of women for the current study through (a) sampling broadly in the community, (b) tailoring the recruitment poster to diverse groups, (c) holding consultative meetings with clinicians at three agencies, (d) hand delivering several recruitment posters to agencies, and (e) attending a local community event held at an agency.

Before data collection took place, the researcher initiated consultations with two community health care agency professionals (e.g., Clinic Community Health Centre, The Laurel Centre) and other local researchers who have used visual methods with vulnerable populations. These consultations strongly contributed to: (a) building choice and flexibility into the participants' research experience, (b) helping verify that the protocol was appropriate for the clinical population of survivor mothers, and (c) establishing "presence" in the community and building relationships, recognizing that recruiting this population (especially a diverse one) might prove difficult. Following

this, 14 survivor mothers of CSA were recruited through posters (Appendix 1) and a letter to various agencies (Appendix 2) at 31 locations throughout the city (e.g., health care facilities, hospitals, counselling agencies, grocery stores, and women's resource centres). An electronic version of the poster was also posted on the university website.

The women were not easily accessible initially, however, entry into one long-term treatment residence led to the participation of seven other women who lived there as well. Women recommended others they felt met the criteria for the study. The researcher approached the women requesting an interview. This process of "chaining of people" and "trust by proxy" strongly affected access to this hidden population. A total of seventeen hours of interviews with mothers were recorded. Only the joint interview and three interviews (3 hours) were not recorded because of technical problems. Mothers were recruited to the study from a therapist/counsellor (n=6), through word of mouth from a friend (n=5), or a poster (n=3).

### **Data Collection Procedures and Protocol**

After receiving ethical approval from the Joint-Faculty Research Ethics Board at the University of Manitoba (Appendix 3), the protocol (Appendix 4) was piloted with a survivor mother in order to identify potential difficulties and make any necessary adjustments. Both interviews and visual methods were used. After signing the consent form to participate in the study (Appendix 5) the researcher met twice with each woman (usually 2-4 weeks apart).

**Interviews.** Interviews lasted between 45 minutes to two-and-a-half hours. A focus group with a post-treatment women's group was pre-arranged following a clinician's request on behalf of a woman's treatment group. However, only three out of the four women who were supposed to attend the focus group did so. The one woman who was absent was interviewed individually later.

The interview locations varied, but most took place in the survivor's place of residence.

Eight women were living in a long-term residential facility for Aboriginal women and their children. One woman lived in a residence which provided services to persons affected by addictions and mental health concerns.

Some of the women had difficulty reading and understanding the consent form and demographics questionnaire, thus, in four cases it was read by the researcher. At the first meeting each woman was provided with a 27-exposure disposable camera to take photographs of what helped them feel good and what was meaningful in their lives. Once the mother's photographs were processed, a second interview was scheduled. Participants were also given a notebook diary to write notes and reflections, although only a few mothers used this tool for the research.

The purpose of the first meeting between the researcher and the mother was to build trust and rapport, gain consent, gather demographic information, and train her on camera use. While this was the initial intent, several of the women spoke extensively and emotionally about their current and past life during the first meeting.

Data collection for the first three interviews began with asking how self-care fit into the mothers' lives. However, following GT methods, the practice of asking about self-care specifically was softened, as it might preconceive the responses. While it was necessary to follow the interview guide, the remaining 11 interviews were conducted with more fluid conversation, avoiding the specific term self-care, and asking more generally about what was important in helping the mothers feel good. This method, according to GT, allowed the survivors' main concerns to emerge. The researcher also completed a self-interview to address her substantive knowledge in the area. As demonstrated later, self-care as defined in the literature was not the main concern of the women in the present study. Rather, their main concern emerged more broadly as a core category: feeling better in the context of violence and trauma.

**Visual Methods.** Only minimal training in camera use was required for the women to feel comfortable. While given the option of having the pictures developed themselves (with reimbursement), all of the women except two allowed the researcher to develop the film and bring the photographs to the second meeting. This demonstrated trust in the researcher and process to preserve their privacy. Two copies of the photographs were made so that participants could retain a complete set of any photographs they gave to the researcher.

After the processing of the photographs, the second meeting took place at a private location. Following the interview guide, participants were asked to talk about their photographs, and provide brief captions for each. Included were questions about pictures they would have taken but did not, and their perception of their involvement in the study. The majority of the women shared all of their photographs, even though they were invited to select 4 to 6 of those “most meaningful” to them.

Of the 14 women, a total of 294 photographs were processed (out of a 378 possible exposures). Each mother took an average of 21 pictures. For the interview, the mothers as a group selected to discuss 128 (44%) of all photos taken, and kept the remainder (56%) to themselves. Reasons given for not showing particular photos were that they were blurry, duplicates, they were of a person who hadn't completed a consent form, or they were not taken for the purpose of the study.

At the end of the second interview, mothers were invited to partake in a brief visualization exercise which aimed to compare the mother's day-to-day lived experience to her ideal lived experience. The exercise was a self-reflective and creative way of yielding further rich data to interpret their discussion and photographs. At the end of the second meeting participants were provided with a complete set of their photographs, a small photo album, and reading material on

self-care. They were also provided with a \$50 honorarium in the form of a gift card. All of these contents were an expression of appreciation for their valuable contribution to the research. Participants also signed consent for specific photographs to be used in presentations and publications, with or without their name attached. Appendix 6 offers a vignette from the fourth interview.

### **Ethical Considerations**

The methods used in this study of survivor mothers present some unique ethical concerns. It is, therefore, necessary to examine ethical considerations in conducting the current study.

**Informed consent.** Informed consent was a primary issue of concern in the current study. It was necessary to design four consent forms for the study: (a) agreement to participate in the research, (b) permission for photographs to be used to promote the goals of the research, (c) to protect confidentiality of secondary subjects (third persons photographed), and (d) focus group consent.

**Confidentiality.** All participants were required to sign a consent form (read by the researcher) prior to participating in the research. All materials were treated as confidential in the present study. No identifiable information was attached to the fieldnotes, photographs or questionnaires. Pseudonyms were used in writing and speaking about the research. Women's confidentiality was thus protected.

The women were instructed to take photographs of people, places, or things that represented their experiences, and were not encouraged to capture others in their photographs, unless it was critical for conveying their meaning of self-care. Every woman consented to use some of her photographs. In many cases, either the woman or (more commonly) her children were revealed. These women wanted their pictures shown to others and some even consented to have

their name attached (a sub-section of the data release consent form). Many were clearly proud of their pictures and their efforts in the research. The researcher reviewed the consent forms with each mother to ensure she understood what she was signing, and also pointed out that she could change her mind later. The decision was made to allow identifying photographs (with a signed consent form). This honoured the women's experience and their ability as consenting adults to have their and their children's faces shown in the photo. A signed consent form was required when photographing others including the mothers' children, otherwise the photograph was destroyed.

**Potential risks and benefits to participants.** One potential risk to mothers in the present study pertained to their vulnerability as survivors of violence where a CSA history could result in survivors experiencing negative emotions and reminders of their abuse. To reduce this potential risk, women were screened (Appendix 7) concerning their experience in counselling for their abuse. Women were told that they did not have to answer anxiety provoking questions, they could take breaks, or stop the interview at their discretion. All interviews were held in a safe, non-threatening and private location chosen by participants. Additional safeguards included: (a) periodic checking with the mothers to minimize negative effects of her participation, (b) providing information on self-care upon the study's completion, and (c) providing a resource list for CSA survivors in Winnipeg. All data collection techniques were piloted for appropriate wording and sensitivity prior to data collection.

### **The Survivor Mothers**

In the present study women ranged from 26 to 57 years of age ( $M=37.29$ ,  $SD=10.93$ ). Eight of the women were separated or divorced; four were single mothers not currently in a relationship; one was widowed; and one was in a long-term non-cohabiting relationship. Most of the women had low incomes. Education levels varied considerably. Of the 14 participants, 10

described themselves as Aboriginal women. Most of the women had more than one child. Five reported having some form of disability (mental or physical). Eight women had two or more offenders. All except one woman reported multiple occurrences of sexual abuse. (See Table 1 for further demographic characteristics.)

Interviews were held in the mother's home (n=3), a treatment facility (n= 8), the mother's workplace (n=1), community agency (n=1), and at the university (n=1). Eight of the mothers were living in a safe home for Aboriginal women and children. Most of these were single mothers whose children were in care with Child and Family Services. Abuse, addictions and a lack of positive parenting skills were the central issues that brought them there.

## Chapter 4: Results

### Data Analysis Overview

Following GT methodology, data analysis began with open coding of visual and interview data including fieldnotes from the discussion about each picture, the captions, and comments about the photographs as a whole. Analysis of both sources of data has also been undertaken by others where text, interpretations, and conversation surrounding photographs are equally important to interviews and should be integrated into the visual rather than treating the visual component as an add-on (Harper, 2005; Pink, 2004; Radley & Taylor, 2003).

**Open coding process.** The process of GT analysis began after the first interview through writing fieldnotes and the open coding process. Fieldnotes were made both during, and following the interviews rather than literal transcriptions of the recorded interviews. However, much time was spent listening to the recordings later in the analysis. Re-listening to the recordings helped retrieve quotes, triggered valuable fieldnotes, and facilitated memo writing and emergence.

In the open coding process the data were coded for categories and their properties. Specifically, incidents (also referred to as indicators) were noted and given a conceptual code. For example, Appendix 8 contains a list of 92 codes which were generated through fieldnote analysis from one of the interviews.

Constant comparison of incidents to each other led to the development of a concept (or category). New categories emerged which fit the data and new concepts fit into existing categories. For example, 72 codes reflected the concept and properties of safe connecting and safe spaces and their importance (e.g., safe connecting, safe refuge, becoming okayed, calming environments, safe intimacy relations). Careful comparison of properties and returning to fieldnotes, however, revealed three substantively different categories: *safe others*, *insulative detaching*, and *safe*

*havens*. These concepts will be further discussed below. Appendix 9 illustrates a sample of the various codes and memos from which the category *safe others and safe havens* emerged.

It was challenging at first to constantly conceptualize the data beyond detailed descriptions of the women's lives. However, with practice and guidance, a multitude of conceptual codes was generated through open coding. Appendix 10 provides an example of fieldnotes and open coding two months into data collection presented at the GT training seminar, New York, October, 2007.

With the researcher's increased experience, the coding became more abstract and less descriptive. Codes were culled, collapsed, modified, and sometimes abandoned for others resulting in fewer and more refined concepts reflecting the data on a higher abstract level. For example, codes of expelling, creating, and self-harming were reformulated into the higher-level concept of *releasing*.

**Selective coding and theoretical sampling process.** After completing interviews with three mothers, the researcher attended a training seminar (offered through the Grounded Theory Institute, October 2007) to present and discuss her initial data. Shortly thereafter, substantive coding led to the emergence of a possible core category of reconstituting a damaged self. A core category is an overriding pattern and main area of concern within the data which relates to all other categories (Glaser, 1978). The main concern of the women in the present study was about feeling better in the context of past sexual abuse which was identified as the primary motivator for the women's behaviour, and which fit the identified categories. Open coding ceased at this point in the study and was replaced with selective coding and theoretical sampling.

As previously discussed, selective coding is the process of delimiting the data to investigate how the concepts relate to the core. Through constant comparison, incidents were compared to each other and the researcher repeatedly returned to earlier coded data to compare

codes within and across interviews examining whether the conceptual codes fit and supported the emerging theory.

Selective coding included creating gerunds given that the substantive theory was based on a basic social process theoretical code model (Glaser, 1996). For example, the concept of “worthifying the self” emerged as ways in which women reclaimed their self-worth. The concept worthifying was selected over terms such as self-worth, or increased self-esteem because it better reflected a higher conceptual level and represented actions and behaviours in keeping with GT analysis protocol.

Theoretical sampling is a process where the researcher collects, codes, and analyses further data in order to develop the emerging theory. Unfortunately, limitations within the current study restricted the degree of theoretical sampling for comparison groups that could be used. That is, following the Research Ethics Board requirements, the potential sample, locations for recruitment, and the interview guide were identified *a priori* data collection began. Due to this limitation, participants were all mothers with a history of CSA by a father figure and who had received counselling for their abuse. Other specific groups or subgroup populations were not accessible for further sampling. In the case where it was deemed necessary for the evolving theory to sample other populations, the researcher would have requested a revised protocol.

Theoretical sampling is “just one source of grounding during the constant comparative method” (Glaser & Holton, 2004). Even though other population groups and characteristics were not theoretically sampled, more focused data collection on emerging patterns was pursued which generated more properties and grounded the theory. Based on the emerging concepts in the data, decisions were made to “pursue” and prompt discussion about different areas within the semi-

structured interview guide. For example, participants were not always asked specifically about their health status and specific health problems, unless the topic was raised by the women themselves.

Discussion of the women's photographs provided many opportunities to pursue more direct questions which were grounded in the concepts of the data. One example of attempting to saturate the category of *cleansing* was to ask the following questions about a picture of a bathtub with candles surrounding it: What was the main purpose of taking a bath? To clean yourself? To relax? To get away and be alone? What did it mean to the mother? Similarly, attempting to saturate the concept of *lightening* the researcher asked about a photograph a woman had taken of her children.

Mother: "I took pictures of my kids. They were just goofing around."

Researcher: (Prompting for further properties and dimensions) Tell me more about fooling around and having fun? What was it about the situation that made you take the picture?

In fact, good visual research addresses analysis of both internal narratives (i.e., what the object is) as well as external narratives (what it means and why it exists) (Banks, 2001). This process was repeated until the categories and their properties reached theoretical saturation and no new information was found. Saturation of concepts was an indicator of theory completeness.

Finally, "During theoretical sampling all is just data to be constantly compared for its meaning in the theory." (Glaser, 1998; p. 159). This means that sources other than the formal interviews themselves become relevant in informing the emerging theory. As the study progressed, other data sources such as casual comments and conversations with agency personnel, telephone conversations and emails with participants, and as a participant observer in the various locations while waiting for the women to arrive at the interview were included and treated as further data to be analysed.

The sample of women in the current study was not representative of the population of women in the province or the city, but rather a sample in an area of interest. Data collection was stopped when it was ascertained that theoretical saturation of the categories were achieved. In other words, when similar incidents were coded for the same category multiple times (e.g., using the constant comparative method *excessing* yielded no new properties, therefore, coding for this incident ceased).

**Theoretical memoing process.** Memoing in the current study was continuous; beginning at the first interview through the writing up stage. By the end of the analysis the researcher's memo bank contained 470 memos. Memos ranged in length from one sentence to a page of text. Questions which arose for the researcher included: *Were the photographs health-promoting? What strengths were exhibited by the mothers? What factors allowed some women to care for themselves more than others? Were there common social contexts across depictions?* Linking these (and other) questions to emerging concepts comprised research memos which were integrated into the analysis. Dictating impressions and conceptual ideas into an Ipod was a useful way of capitalizing on the emotional energy left following an interview. These additional data resulted in later analytic typed memos. Appendix 11 shows examples of early and later memos about the concepts *insulating, reconnecting* and *burying*.

**Theoretical coding.** Following attendance at the second GT seminar (Mill Valley, CA, May 2008), advice offered by Dr. Barney Glaser was to "resort your memos and read about theoretical codes." During the next 9 months and with much sorting, four theoretical codes emerged to explain the theory. Appendix 12 includes visual examples of the theoretical memo sorting process as well as the beginning emergence of the theory.

Several re-sorting efforts revealed four theoretical codes: two basic social

processes (BSP): a basic social psychological process (BSPP) and a basic social structural process (BSSP); cutting point; and cycling theoretical codes. These are explained below.

Glaser and Holton (2005) state that a basic social process (BSP), “processes a social or social psychological problem...Irrespective of whether it solves the problem, to some degree it processes it” (p. 6). There are two types of BSPs – a basic social psychological process (BSPP) which refers to social psychological processes occurring within individuals, and a basic social structural process (BSSP) which is a social structure in the BSP and occurs interpersonally. A BSP includes at least two distinct emergent stages that “differentiate and account for variations in the problematic pattern of behaviour” (Glaser, 1978, p. 97). Stages function as an integrating scheme with which to tie together various sets of conditions or properties. They have the time factor with a beginning and an end, and the transition from one stage to another is typically dependent upon something happening or a “breaking point”. This may be a critical event or a critical juncture that marks transition between stages. Stages may also be marked by a general set of indicators (Glaser, 1978). The theoretical code cutting point deals with significant breaks, critical junctures, turning points, or breaking points. “They indicate where the difference occurs which has differential effects” (Glaser, 1978, p. 76). The theoretical code cycling “refers to going over the same path over and over. It also refers to going over and over the different paths in succession whatever the unit action...Actions or interaction that spiral downward or upward are cycling” (Glaser, 2005, p.24). Various points in the process exist where the survivor is vulnerable to cycling back and forth. For example, cycling between safetying and emotional de-paining may occur once the survivor begins receiving treatment which resurfaces painful feelings and memories.

### **Mothers’ Perceived Experiences in the Research Process**

As noted earlier, at the end of the interviews, the women were asked to comment on their

experiences as participants in the research, and in the photovoice method itself. Their comments in Appendix 13, were insightful and strongly suggest that both the photovoice method, and participation in the study in general was strengthening, fun, and transforming. Also evident was increased self-knowledge and self-evaluation of their self-care efforts. This raised the question for some as to the importance and necessity of self-care for women in their daily lives.

All of the women expressed enjoying the method. Only one mother confided feeling uncomfortable with photographs in general, "Part of the things about pictures is right now I think I have shame when I look at myself, still sometimes. I don't like the way I look sometimes. There are days when it's not good." In many cases the shared photographs were a tool for illustrating their struggles towards wholeness and healing. Being invited to participate in the study and photograph what was meaningful in their lives, gave the women the opportunity for deep reflection on their current (and past) experiences. The photovoice method itself facilitated creative self-caring efforts, trust and rapport building, opportunities for deep reflection, equalized power, and bridged mothers with their children. The mothers' participation inspired self-reflection and self-insight about personal power. The process also facilitated emotional de-paining, lightening and emotional linking to their children (GT concepts introduced in the next section). Aside from two suggestions for a longer time period in which to take pictures, there were no recommended changes to the methods and all of the participants supported the use of photovoice methods in research with survivors of CSA.

### **Findings Overview**

A unifying pattern across all of the women was that they were on a journey towards feeling healthier and stronger, in which their children played an important role. The experience of trauma forced a gap in their healthy growth and resulted in a fracturing of selves. Their continued efforts to reconstitute their damaged selves were evidenced through the components that emerged from

analysis of the photographs and interview narratives. Using GT, complex interactive patterns of behaviours in survivors' lives towards recreating a whole self out of damaged fragments emerged. It consisted of a series of small movements (which include self-care behaviours and attitudes) towards positive change.

Theoretical concepts that emerged from the analysis of visual and narrative data concerned a basic social process of attempting to feel better following past CSA trauma. It involved reconstituting a damaged fragmented self and moving towards a whole stronger self. Through gathering grounded data, the conceptual framework sought to explain three stages referring to survivors' attempts at healing and feeling better over time through: emotional de-paining, safetying, and authenticating and returning to the self. Survivors engaged in various behaviours (i.e., self-abusive, restorative, or coping) which were successful or unsuccessful strategies in response to managing pain from past CSA. The strategies moved them across the various stages of healing. Within this process, various social structures (e.g., poverty, time in one's parenting career, counselling) affected their self-preservation and capacity to mend. Expressed in a conceptual way, the basic social psychological theory of reconstituting a damaged self processed survivor mothers' main concern of feeling better and healing.

The substantive theory and its various properties are described in detail to help to explain the concepts. Constructs were developed after the researcher entered the field and were not preconceived. The stages in the theory were conceptualized by the researcher using indicators in the data and the GT process based on survivors who spoke about (and photographed) ways they cared for themselves and what made them feel good on a daily basis. A model of reconstituting a damaged self is illustrated in Figure 1.



Figure 1. Reconstituting a Damaged Self

The process of reconstituting a damaged self had three stages: *emotional de-paining*, *safetying*, and *authenticating and returning to self*. The stage of emotional de-paining had properties of (a) *lightening*, (b) *cleansing*, and (c) *excessing*. Emotional de-paining involved processes of releasing and managing negative feelings and memories associated with past trauma. The second stage of safetying had properties of (a) *escaping entrapment*, (b) *re-sensing*, and (c) *insulative detaching*. The safetying stage involved efforts towards increased protection and freedom from further harm. The stage of authenticating and returning to self had properties of (a) *worthifying the self*, (b) *focused being*, and (c) *reemerging*. It involved strengthening and restorative behaviours leading to self-worth, self-caring and returning to self.

Reconstituting a damaged self was a transformative and developmental theory which brought relief and healing to survivors. Through managing and releasing pain associated with early trauma, survivors embarked on a healing trajectory through safetying which provided the optimal climate for restorative behaviours and returning to a stronger whole self. Early healing efforts of survivors are generally associated with the first stage of emotional de-paining and later reconstituting efforts were demonstrated in the third stage. However, strategies and behaviours were not mutually exclusive. For example, de-paining and safetying behaviours may still be evident in the last stage [albeit less prominent]. Instead of a steady progression through the three stages, survivors demonstrated upward and downward cycling in the process towards feeling better. Each stage and its properties are explained more fully in the remaining sections.

### **Stage 1: Emotional De-paining**

Reconstituting began with attempts to manage and delimit the painful lasting effects of past CSA trauma. Survivors carried the pain from their past and reported feelings of being entrapped by the difficult feelings. The emotional de-paining stage functioned as a pain reducer and mood elevator that released emotional pain. It involved managing, controlling, soothing, removing, and protecting against troublesome emotions and memories (such as fears, mistrust, and anger) that were constituent of past (and current) violence and trauma. During emotional de-paining the survivor engaged in behaviours which denied and minimized her pain.

Violence, trauma, and emotional loss prompted attempts to release the associated strong emotions. Strong indicators of de-paining emerged in connection to the loss or separation from one's children through death or, more commonly, apprehension by CFS. Efforts towards de-paining were not necessarily conscious strategies. One survivor felt she had little control over her behaviours and said, "The behaviour was given to me." Survivors did their best to feel better, based

on their capacity to process their abuse experiences and the social structural conditions of their lives. The emotional de-paining stage involved three properties which served to manage emotional pain: (a) lightening, (b) cleansing, and (c) excessing.

**Lightening.** *Lightening* was a property of emotional de-paining that can be described as letting go of painful and depressed feelings and opening oneself up to playful moments and unconstrained activities of laughter and joy. It released positive uplifting emotions and involved becoming child-like. *Lightening* frequently occurred in the presence of others. In fact, children were often facilitators of *lightening*. Many of the mothers mentioned how playing, horsing around, and becoming silly with their children helped them connect to their own “inner child” thus expelling deep painful emotions and strengthening emotional connections with their children.

Photographs revealed how witnessing *lightening* in their children was a reminder of hope and optimism during times of unhappiness and stress. One mother’s photograph of her daughter and her playing a game together was entitled: Laughter brings joy and joy brings hope. She said, “I love her laughter, it is so unconstrained. Her laughter teaches me to laugh.” Another mother who had photographed her son with a huge smile on his face said, “My son is always smiling no matter what. Even when he talks he’s smiling and I have to remember to smile.” *Lightening* allowed survivors to let go of self-control and give themselves permission to feel and experience playful pleasure.

*Lightening* took place within other safe relationships which allowed room and safety for humour and laughter. For example, many of the women who were living in a residential treatment facility took pictures of each other and later laughed about their photos in the interview. One woman photographed herself “Fooling around” at her boyfriend’s house (holding \$800) saying, “Sometimes I get so depressed. I laugh when I’m there.” The same woman had her boyfriend

photograph her children for the study since she was not allowed access to them at that time. She later said, "I would have taken pictures of me and my kids fooling around. Funny pictures."

*Lightening* brought happiness and lightness into the survivor's life in times or moments of unhappiness. It distracted from the seriousness of the situation by changing the serious tone of the moment and altering the course of the conversation and social interaction. One woman spoke about how *lightening* (in this case, laughter) distracted her from falling so deeply into the pain and current problems from which she was unable to emerge.

*Lightening* helped to replace angry and depressed feelings the survivor may have had with her life circumstances or her children. Some survivors expressed that *lightening* felt like "a mask." However, one mother saw the inherent value in wearing the mask in order to remain patient with her children and protect them from her negative feelings (i.e., her depression). Deliberately taking time for creating moments of *lightening*, was very important for emotional de-paining. As one mother said,

Moments don't just happen, you have to create a place in your life where joy is acceptable...Nurturing yourself is about finding that. If you don't nurture yourself there's no way to create joy in your life or in the lives of the people you love.

Lightening was a key trajectory for releasing deep entrenched pain which sets the stage for later strengthening. Interestingly, the freeing or "loosening" nature of *lightening* was frequently juxtaposed against former unsafe or abusive relationships where participants felt controlled, trapped, and constrained. *Lightening* facilitated releasing the tight grip of self-control survivors often need. Survivors sometimes experienced difficulty expressing the quality of *lightening* in the experience they shared, either orally or visually. For example, one survivor had provided a photograph of herself attending an uplifting seminar. Later, when asked if there was anything she

would have liked to have taken a picture of but couldn't, she replied, "In the seminars, the dialogue, the laughing, it's not in the picture. The tone, laughter and light heartedness." For visual images of lightening see Appendix 14.

**Cleansing.** The second property of emotional de-paining was *cleansing* which involved attempts to manage and release difficult emotions such as anger, anxiety, or negative self-perceptions. This concept was primarily concerned with releasing and expelling traumatic memories and emotions through cleaning oneself or one's surroundings, telling one's story, and *anger exiting*.

*Cleansing* helped to physically remove reminders of past dire situations which were in contrast to the current situation. For example, one participant who used to be a sex-trade worker photographed Sage House (an outreach and health resource centre for sex trade workers) as a place she used to "clean herself up." She further described spiritual cleansing through partaking in traditional sweatlodge ceremonies in Thunderbird House which "cleanses my body, mind, spirit and soul." Another survivor explained physical cleansing in her photograph where she just finished showering,

I used to have so many baths all the time. I was doing a lot of drugs and stuff and I always felt dirty. So that was three times a day...cause I still felt real bad and dirty. ...Working the streets, you don't feel good and it takes a long time before you actually [pause] feel better.

Cleansing activities allowed survivors to "hand over" or "deposit" their painful emotions into another outlet and release it from within. Expelling through journaling, or crying into a favourite stuffed animal was common. One survivor who had been journaling for seven years said, "It holds a lot of my pain. I don't carry it around all of the time. That's where I let everything go".

*Cleansing* through telling one's story released the pain surrounding one's perception of the bad self. For example, several women in the study expressed that participating in the research was something they had to do, as a form of healing, and that their story "needed to get out." Survivors often told their stories with a sense of urgency which achieved a cathartic effect for them. One mother said, "It helps me each time I do it."

*Cleansing* was also achieved through *anger exiting* which was another property of cleansing and involved an acute release of intense anger and anxiety. *Anger exiting* took the form of physical self-harm (without a deliberate attempt to kill oneself) or uncontrolled bursts of anger and/or violence towards others. An important dimension of *anger exiting* was that strong feelings were released quickly, with little advance planning or consideration. One mother stated, "I would get really mad for nothing. Once I almost stabbed [her partner] because he slapped me, but the kids were watching." *Anger exiting* tended to be over reactive and occurred primarily during a build up of stress when the survivor needed to regain feelings of control. For example, one survivor reported that cutting her wrist released "mental crazy" feelings (e.g., anger, mistrust, jealousy). Her comments illustrated the powerful emotions and dynamics involved in cleansing through *anger exiting*.

The other day I took a blade and went *tkkkkk* [shows by example and sound effects] without even thinking and ripped my pants. Imagine if it went deep? It was an Exacto blade. I'm starting to think crazy...Eighteen months ago I had to get nine stitches. I was angry and just grabbed it, and when he walked out of the room I went *tkkkkk* and blood went... Girls were phoning her house for him. He wouldn't tell them not to phone.

Similarly, another survivor was consuming alcohol and drugs at the time and said, "I cut myself to feel the pain. I was so angry I wanted to cut myself." One of the most interesting dimensions of the stage of emotional de-paining was the intense need for *excessing*. This is where we turn next.

**Excessing.** The third property of emotional de-paining was *excessing* which involved attempting to manage and gain control over painful feelings through engaging in activities in higher than normal frequency. *Excessing* was used to numb, escape and cover up overwhelming pain. One survivor said, "We suffered third degree burns of emotions."

*Excessing* behaviours commonly took place, and were exacerbated during times of stress when the survivor was seeking comfort. The process was described as "a pulling towards a fix", "a kick", "like a drug", or an "escape", and carried a degree of shame for the survivor which often contributed to hiding the process. In effect, *excessing* was sometimes referred to by survivors as a problem or addictive behaviour. In this regard, *excessing* appeared to have had a destructive and harmful dimension; however, it was also important to recognize that the process did function as a temporary comforter and mood elevator by filling a hole or need for the survivor. One participant stated, "When you're an addict, *using* is self-care. But it really is not because you're eating yourself up inside...you feel better when you're using." Another participant described *excessing* as "wrongful nurturing." *Excessing* was achieved through (a) ingesting, (b) amassing and (c) *busy*ing.

Ingesting included taking in large amounts of substances into the body for the purpose of stress and anxiety relief and comfort. Survivors spoke about ingesting through smoking, heavy drinking, drug addictions, sexual activity, and intravenous drug use. *Excessing* also involved more normative and socially acceptable forms such as ingesting large amounts of food through bingeing and stuffing oneself, heavy consumption of beverages such as coffee, and watching movies seven days a week. Ingesting replaced and soothed feelings of anxiety and depression. One participant

described reaching for and “sucking back” a 2 litre bottle of Pepsi whenever she felt down. “I was fixed on that sugar crap...it was a huge soother.”



Caption: The ultimate soother

Another participant stated that smoking was just a state of mind for her, and that it was less relaxing than it was putting something into her mouth. Amassing was the second property of *excessing* and involved collecting items in excess of what was needed. One participant described buying “fix things” rather than items out of necessity that she placed in the closet and then didn’t want a week later.



Caption: The fix and the crash land

Efforts were not always made to hide the accumulation of items from family members. Other forms of amassing included large collections of craft items. One mother took a picture of her living room which was half filled with beading projects. (See Appendix 15 for more images of *excessing*.)

Amassing served the purpose of distraction from difficult emotions. For some survivors, it was similar to an addiction. One mother said it made her feel “higher than a kite” and yet, “It was a moment that’s all it was.” Survivors described how *excessing* decreased when they received therapy. One woman recalled how as she peeled away the layers through individual therapy, “I learned how to not need so much through counselling.”

*Busying* was another dimension of *excessing* which was characterized by intense activity to manage troublesome emotions. Participants describe busying as “racing,” taking on too much, always rushing, and never stopping.

I felt rushed always. If I got everything done then I could do this...the window seemed to get smaller and smaller as the work encroached upon that - like a race almost...Self-care came somewhere in the night when you were too tired.

Hobbies, and creative activities also were components of busying. *Busying* caused survivors to place their needs behind others while focusing on external events, activities or other people. Consequently, meeting the needs of others lessened opportunities for self-focussing and self-caring. One mother said that she rarely wore make-up because she was too busy. After further prompting she said, “I guess it was my partner. I never had time for myself.”

*Excessing* represented a constant struggle for achieving moderation and control. It frequently resulted in damage (e.g., debt, guilt, damage to one’s body, lost relationships) and took away the person’s control. For some survivors, one form of *excessing* often replaced another:

If you're not spending, you're going to go bury yourself in your exercise or something else...I want to love exercising and not have to use that to control myself from going shopping.

In some cases where *excessing* was extreme, other priorities were demoted (e.g., personal grooming, care for children) which was connected to later reparation efforts in the final stage of reconstituting a damaged self. While *excessing* primarily took place when survivors were not yet in a healing place or strengthening stage, less destructive forms of *excessing* sometimes remained present and emerged later in the survivor's healing. One survivor stated, "I have to listen to music. It is not a want, it's a need." Constraining or stopping *excessing* marked a significant transition to the safetying stage in reconstituting a damaged self.

In summary, during the stage of emotional de-paining, survivors attempted to remove the past damage caused by the abuse. The de-paining stage served to mitigate the lasting emotional pain. De-paining served the primary function of coping with and releasing inner emotional pain. Unfortunately, it was less successful for some mothers, "I'm carrying around a lot of secrets I haven't told. I'm not ready. I'm carrying around a lot of pain."

Trying to manage the depth of pain caused from CSA trauma can occur over the course of months or even years. One mother spent 18 years as a sex-trade worker engaging in the process of de-paining. Thus, the process can last a lifetime. The stage of de-paining represented how survivors coped with the conditions of their lives and continued as long as a survivor was "successfully" coping with the painful feelings, and the behaviours were "working." Cycling occurred when there were repeated failures to protect oneself. Therefore, the emotional de-paining process achieved varying degrees of success in reducing or managing emotional pain. Minimal attention was paid by the survivor to safetying and strengthening until a crisis point was reached.

## The Crisis

At a certain point, survivors reached a crossroad in the form of a crisis which interrupted the stage of de-paining. A downward spiral of several stressful events in the survivor's life presented a decision to remain in the de-paining stage or move out of it towards the next stage of safetying. These points of crisis (i.e., theoretical code "cutting point" in GT), were unique for each survivor and were indicated by survivors talking about "hitting rock bottom," "unravelling," and "losing it." Crises forced cognitive recognition that something needed to change in the survivor's life.

My stomach was rumbling. I was hungry all the time. I was tired of making drug dealers rich. I was living in a slum lord rooming house. There was no heat. I was hungry, I was cold. I couldn't do it anymore. Enough was enough. I wanted help, so I was ready.

Releasing guilt from the CSA preempted crises. For one survivor, forgiving her father who abused her and letting go of her guilt and pain freed her to move towards healing. Crises also came with the realization and acceptance that unhealthy relationships offered little but pain. Crises varied in intensity and included: leaving constraining relationships, loss of a job due to heavy substance use, extreme domestic violence resulting in a near death experience, or a failed suicide attempt. Terrifying fear and threats to the survivor's safety often surrounded the crisis:

I got beat up by my partner then days later I was found and was admitted to hospital for 3 days. I almost died from repeated trauma to the head. "I don't want to be hit anymore...I don't want to live like that...the thought of seeing him scared the living crap out of me.

A second survivor's story illustrates moving from the de-paining stage to safetying,

It was just a desperate time. I knew that something had to change, and I really didn't know if I could really do it myself. But it was then that I started attending a Christian prayer group and they just encouraged me and helped me to get through a really difficult time with drugs and really, no self esteem at all. ... That was the big turnaround, starting to look after myself and wanting to better myself, and not wanting to stay where he was. Because that would have been easy to do. But it was also frightening. I knew at that moment, like when I had taken that cocaine, that I had a choice, and the next day I was heading back home.

For others, the turning point signifying the need for a major life decision, was more subtle: "When I turned 50, a light went on. I need to take charge." Entry into the safetying stage was also sometimes expedited due to pragmatic reasons (e.g., losing child custody or where the mother entered a residential treatment program voluntarily.) However, in other cases it involved a conscious decision. One survivor said, "It is about making a choice, making decisions of the heart to love or hate." These junctures represented a critical point where survivors decided to stand up and push back. They also signified the survivor's deliberate intention to look ahead and move forward towards safetying self and healing.

The women in this study chose safetying when they were ready to deal with their problems. Their motivation was high to heal from past trauma and violence. The treatment process was demanding, and sometimes entailed living in a treatment centre for up to six months, without seeing their children. One survivor entered a treatment centre on her own (without her five children) to start working on her abuse issues. She only saw her children once a month:

I came to get some healing done for my abuse so I could be a better parent to them. It is time to get better for them. They've watched me struggle enough and

don't need to watch me struggle anymore... It's just easier for me to focus on what I need to get done without them being here. Because when they are around I'll shut down because so that I don't experience any pain because I won't be good to these guys. I won't discuss my abuse. I'll just put it on the shelf because they need my protection.

Although the events surrounding a crisis were usually negative, the cutting point presented opportunities in survivors' lives to allow them to open up space for self-preservation and healing. The crisis in the survivor's life started a new upward spiral towards a healing trajectory. Arriving at this decision was essential for the recovery process to move forward. Letting go of a past life of abuse and entering treatment was a form of opening self up to change and healing. One survivor said, "I finally gave in."

### **Stage 2: Safetying**

The second stage in reconstituting a damaged self was safetying. Precipitated by a crisis, in this stage survivors focused on safety and protection. The primary concern was to stay safely away from their previous unhealthy patterns of behaviour, and to begin healing.

Unlike survivors' early experiences of violence and trauma which compromised their feelings of safety, the safetying stage created safe spaces for themselves. Safetying facilitated the capacity to heal themselves and to feel good in the presence of others. Survivors in the present study were constantly struggling for safety: emotional safety (trusting relationships), physical safety (violent johns and abusive partners), and safety for their children. Safetying was achieved through the properties of: (a) *escaping entrapment*, which through *safe others*, *safe havens*, and *spiritual connecting* involved self-protective efforts to keep oneself from returning to previous unhealthy behaviours, (b) *re-sensing*, in which the survivor began to see the world differently, gained new

insight on her own and her children's lives, and included *compensatory atoning, and emotional linking*, which maintained emotional ties to one's children and (c) *insulative detaching*, where the survivor, still not fully trusting others, refrained from fully engaging with others.

**Escaping entrapment.** *Escaping entrapment* was one property of the stage of safetying. The survivor mothers lacked the tools to escape the long-term effects of their CSA and the structural conditions in which they found themselves. The process of *escaping entrapment* involved self-protective efforts to free oneself from persons, situations, and habits which could be a channel towards unhealthy behaviours and relationships. *Escaping entrapment* mitigated against returning to previous negative patterns of behavior such as *excessing*. Securing safe intimacy through *safe others* and securing *safe havens* were two dimensions of escaping entrapment. These are discussed next.

**Safe others.** *Safe others* reflected relationships which offered a degree of safety in which the survivor could share her thoughts and feelings. Healing and replenishing were properties of the relationship. *Safe others* included faith-based or treatment groups, children, loved ones, favourite pets, friends, and counsellors. Securing safe intimacy through *safe others* was characterized by feelings of security, trust, calmness, feeling whole, having the ability to move on, and people to whom survivors can talk about anything.

Unhealthy relationships frequently constrained survivors' efforts towards doing things for themselves and moving forward in their lives. *Escaping entrapment* was evident through survivors speaking about emotionally abusive and controlling relationships which held them back in various ways. One survivor recalled, "He was my ball and chain." Others were involved in relationships which threatened their or their children's lives. Thus, securing *safe others* was self-preserving. I

imparted a greater sense of freedom, and provided opportunities to build positive self images which replaced negative self images fostered within their dysfunctional family of origin.

Securing safe intimacy also met the survivor's need for giving and receiving love in a safe environment, even if the intimacy relation was not necessarily another person. One participant remarked, "In my nurturing and caring for [her dog], she cares for me." Sometimes just by being in close proximity to a safe other was enough. One participant stated, "In an evening we may never say anything, but just knowing that one another is there brings comfort."

The ability to successfully secure *safe others* varied a great deal among survivors. Interpersonal communication difficulties and trust impairments were tragically common, and sometimes impeded their movement towards the final stage of strengthening the self. Securing *safe others* was critical for building and reinforcing a sense of trust which was a critical dimension of reconstituting a damaged self. One mother said, "I'm not a real big person who trusts people...It is hard to trust others. I trust people too much then I just get burned." Another survivor stated she had still not found the "right" counsellor after 30 years. Further,

I am closer to material things than I am to human beings. They brought me more fun...than dealing with people. Relationships with others were over there.

The basic social structural process of receiving treatment (i.e., therapy) was critical in the safetying stage by reversing the downward cycle to emotional de-paining. One survivor said, "I'm in the midst of things, yet not in the midst of life. I know I need this. My healing was in a way, a vacation to concentrate on myself and I think that's okay." The process of therapy, however, also may cause a downward spiral into de-paining as well, since it can facilitate the emergence of painful feelings, and thus a need for emotional de-paining. One survivor spoke about having "bad days," typically after she had been in a counselling session for her abuse, when she withdrew from

others. Through the process of receiving treatment, survivors gained hope and optimism, sometimes for the first time in their lives. One survivor's photo of her counsellor as a *safe other* illustrated this.



Caption: Reverend Margaret - An incredible person

**Safe havens.** *Safe havens* was a second dimension of escaping entrapment. This was the process of locating oneself in a secure nurturing environment. Like *safe others*, *safe havens* were not always structured, formal arrangements. Whether the environment was a physical formal structure or an event or activity, the critical element was that it facilitated healing and safe healthy relationships (e.g., *safe others*). In fact, survivors photographed faith-based centres, structured treatment-based environments or informal gatherings with friends. The process of securing *safe havens* (a) increased the opportunity for building nurturing safe relationships, (b) allowed survivors to escape being entrapped by old habits and abusive relationships, and (c) facilitated mental and physical healing.

First, *safe havens* increased opportunities for building nurturing safe relationships by providing a context of encouragement and fellowship which helped the survivor feel whole. One

survivor photographed a restaurant where she gathered with other women to share a meal and said, “It builds me up.”



Caption: Dinners out

Such safe gathering spaces also established opportunities for continued engagement and connection as well as increased levels of intimacy. Second, *safe havens* insulated survivors from risky people. For example, a struggling addict photographed a safe meeting place (i.e., Robin’s Donuts) to socialize with her friends who were still addicts because “they are too tweaked out on crack to bring to my apartment.” Another survivor sought refuge with her children at a women’s shelter to get away from her abusive partner. Another stated, “I like being in my bed wrapped up in my blanket. Makes me feel I have a home, not just a house. It feels like that at Wahbung (treatment agency) as well.” Third, *safe havens* facilitated mental and physical healing. One survivor took a picture of her veranda and described it as a peaceful place that is “soothing to the soul.”



Caption: My veranda

A third survivor commented on the photograph below: "This is where I go for sweatlodges. It cleanses my body, mind, and my spirit and soul knowing that I cleanse myself. Because you pray really hard in there. They pray for you."



Caption: Thunderbird House-A place of healing.

It cleanses my body, mind, spirit and my soul.

The photograph of Thunderbird House (above) was represented by a mother as both a source of spiritual cleansing and as a *safe haven*. It was common for photographs to depict more than one concept. For example, two of the mothers spoke about specific photographs which facilitated their sense of safety as well as spiritual cleansing. As such, *safe havens* often facilitated cleansing. The ability to create safe nurturing spaces and peaceful places enabled survivors to re-sense and appreciate their surroundings and place in the world (See Appendix 16 for images of *safe havens* and *safe others*.) Connecting with *safe others* and *safe havens* allowed survivors to create new structural conditions for themselves and their children which supported their self-preservation. The process of safetying and escaping entrapment frequently came in the form of traditional counselling relationships, however, safetying for many women in the study took the form of *spiritual connecting*.

***Spiritual connecting.*** *Spiritual connecting* was a third dimension of *escaping entrapment* which referred to a process in which survivors hand over their pain (from their current or past abuse) to a form of higher power. Whether *spiritual connecting* came from outside oneself, or from within, it involved survivors asking for, and accepting help. One survivor reflected on her photograph below by describing it as:

The ultimate nurturing soother. The one that got me through all the junk. Dad built the cross which represents church. Leaning on God a lot. Placing it in his hands. I grew up around faith. I learned to lean on that a lot and dump it there because who else can you dump it in and say you take care of it because I can't?



Caption: Conversation with Jesus

*Spiritual connecting* often followed a crisis or desperate state in one's life and continued into the third stage of reconstituting a damaged self as an important ongoing strengthening and supportive process. *Spiritual connecting* provided inspiration, increased self-worth, encouragement, and a more positive sense of being. It also ameliorated feelings of depression. One survivor in the study recently began collecting angel figurines since it made her feel protected.

It makes me feel like I'm being watched. Good. That I am important to somebody.

I'm not here for addictions. I am here to deal with 27 years of abuse... I'm

spending my time trying to heal my spiritual side too.

Spiritual connecting represented efforts at replenishing and putting a fractured self back together.

Connecting to a higher power fortified survivors' spiritual connections leaving them feeling encouraged, anchored, strong, whole, and able to move on. Spiritual connecting assumed many forms. While it was not always appropriate in the study to take a picture of spiritual traditions or healing places, many women spoke about them and how they provided hope and optimism.

Several survivors experienced great comfort in returning to their traditional native spiritual ways of healing. One Aboriginal survivor who was raised in a non-aboriginal home reconnected to her culture during her healing and felt replenished through “losing herself” while drumming and dancing. Another who was not introduced to traditional ways stated, “I don’t follow nothing, cause I was never shown a different path to go down, anything to believe in.” Instead, she found relief in frequently reading A.A. (i.e., alcoholics anonymous) books which allowed her to stay grounded and decreased her risk of falling off the wagon, “Otherwise I get too confident in my sobriety.”

Other examples of traditional *spiritual connecting* included: smudging, seeking advice and guidance from elders, attending sacred ceremonies such as sweatlodges and pipe ceremonies and pow wow dancing. Others found safety and strength and *escaping entrapment* through attending peaceful, quiet masses, prayer meetings, or from celtic roots and spiritual symbols.



Caption: My shields: To believe in what is possible

(See Appendix 17 for images of *spiritual connecting*.) Through *spiritual connecting* survivors relinquished the belief that they must cope with their pain on their own.

**Re-Sensing.** The second property of the stage of safetying was *re-sensing* which involved changing self-perceptions (including priorities and values) as well as perceptions of one’s

surroundings. *Re-sensing* arose when survivors moved into the safetying stage and received some form of therapy or treatment. The process of *escaping entrapment* provided a new context for assessing one's situation and changing perceptions - an awakening. For example, one young mother stated, "I used to think it was hard being a parent with 3 kids as a single parent, but I took things for granted."

*Re-sensing* involved re-orienting in the world in general as perceiving both the self and the environment as somehow different. Survivors mentioned having previously not seen the world around them as clearly, and reported a heightened sense as if their eyes "were opened". *Re-sensing* involved rich visual and sensory descriptions coupled with renewed appreciation as well as embracing new beginnings, and returning to hope and optimism. One mother photographed a sunrise outside of her veranda and explained, "Sunrise for me is about hope, new beginning, you can start again...It's spiritual... It helps put everything into perspective." The same survivor also felt that she had "emerged from being buried."



Caption: The dawn

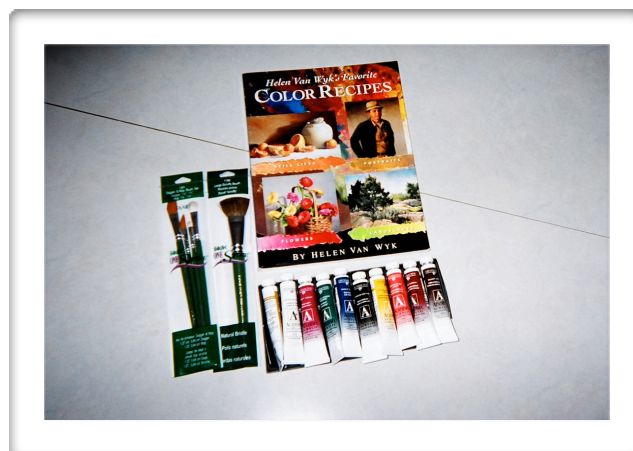
One woman photographed some local art painted on the side of a building and said,

I appreciate art more now and the efforts it took people to make it... I just used to walk by them but today my eyes are opened. I see a lot clearer now. I even go and hug a tree [laugh] because they look so beautiful.



Caption: Art and seeing other people with gifts.

Many survivors connected *re-sensing* to light, or re-emerging from previous darkness into light. The world becomes a different more beautiful place. One participant photographed her paints and recalled, "Everything I did was black and white, now I want to paint in bright colour."



Caption: Feeling in technicolour.

While *re-sensing* may be partly due to no longer being addicted to sensory altering substances (many women described being in a drug induced haze during emotional de-pairing), *re-sensing* also arose for women with no addiction history.

*Re-sensing* also took the form of becoming more aware of one's vulnerability and need for self-love and nurturance. An ex-street worker recalled feeling afraid and vulnerable walking around the neighbourhood at night where she previously used to work. Another survivor who described herself as someone who never would have spoken to a researcher about her life, was also surprised at how her musical preferences had changed from hard rock songs to love songs, or, in her words: "mushy stuff." Finally, *re-sensing* also involved recognizing the beauty in relationship to others in the world, and that some relationships had suffered. This pointed to the importance of self-forgiveness, and *compensatory atoning*.

***Compensatory atoning.*** *Compensatory atoning* involved attempts to repair damage caused in relationships for which the survivor felt responsible. Through therapy and *re-sensing*, survivors recognized certain events or situations in the past which fractured the mother-child bond. Children were the primary focus for *compensatory atoning*; survivors attempted to transform an abdicated parenting role into a safekeeping-guardianship role. This was done through completing a treatment program and regaining custody. One survivor had given custody to her husband saying, "I never was a mom." She was looking forward to regaining custody and "winning" her children back. A photograph she took of her son represented "My prize I get when I finish."

Examples where *compensatory atoning* was required to relieve strong guilt, loss, and grief included: a mother's unavailability to her children due to excessive behaviours, a mother's disbelief at her child's abuse disclosure, and adult children's behaviour (addictions, low self esteem). One survivor expressed that she needed to "repair the collateral damage." Another regretted not being

there emotionally to raise her children. One survivor tearfully recalled: "I put my kids through watching their mom be beat up lots of times because I didn't feel good about me."

For survivors who had lost custody, regaining parental guardianship and having the chance to have things "return to normal" with their children was a paramount concern. One mother's visualization of "the perfect day" was: "Waking up in my own bed at home with my kids. Going through a regular routine. Having breakfast with the kids and sending them to school. Bringing them home for lunch...a regular day."

*Compensatory atoning* had the potential to break intergenerational patterns of violence. One mother who was raised by non-Aboriginal adoptive parents felt guilty for damages done to her children due to the effects of colonization on herself. Consequently, she expended tremendous energy towards teaching her children about Aboriginal values and traditions at a very young age (e.g., all were pow wow dancers as toddlers).

*Compensatory atoning* was critical for mending parent-child relationships, rebuilding trust, strengthening ties, regaining custody arrangements, and relieving survivors' deep guilt.

*Compensatory atoning* was important as well, in moving survivors towards becoming whole. One mother felt she needed to reassure her daughter of her presence and rebuild connections among her children.

I made a lot of promises I couldn't keep. It crashed us all down...Okay, it's time to get on with life again and start over. Start over. I had to rebuild trust and friendship with my children.

She felt good by "doing right" by her children by entering treatment and giving them hope. She reflected on her photograph (below) and said, "No matter what, the children will be okay with the mother there, the peace pipe and hope."



Caption: Mom is here. I am okay. You don't have to worry.

Successful *compensatory atoning* was critical in order to permit self-forgiveness and move towards strengthening and healing. When successful, *compensatory atoning* relieved strong emotions such as guilt, regret, anger, loss, and grief because of past events which fractured the mother-child bond. When unsuccessful, the pain remained and survivors were left with a choice to “move on” or cycle down to de-paining strategies. Sometimes *compensatory atoning* did not repair the damage caused to relationships, or relieve the guilt of survivors. One mother felt guilty when recalling how her “ups and downs” affected her adult children. She apologized to them and moved on, but confessed that it was still painful. *Compensatory atoning* allowed survivors to rebuild trust with their children and to re-establish strong emotional linking. Related to *compensatory atoning*, *emotional linking* was a process through which survivors in treatment strengthened and maintained emotional connections to their children.

***Emotional linking.*** As a dimension of *re-sensing*, *emotional linking* consisted of survivors’ attempts to remain in close emotional proximity to emotionally significant relationships (i.e., in this case their children). *Emotional linking* served a critical function of supporting survivors’ efforts towards strengthening and returning to self. Children were a central part and motivator for reconstituting a damaged self for survivor mothers. They were strengthening, reassuring, and

represented love. Nearly all of the mothers embraced the experience of becoming a parent. Many expressed that it was all they had known. Therefore, when their children were removed from their custody and they entered a treatment program, they felt alone and many became depressed.

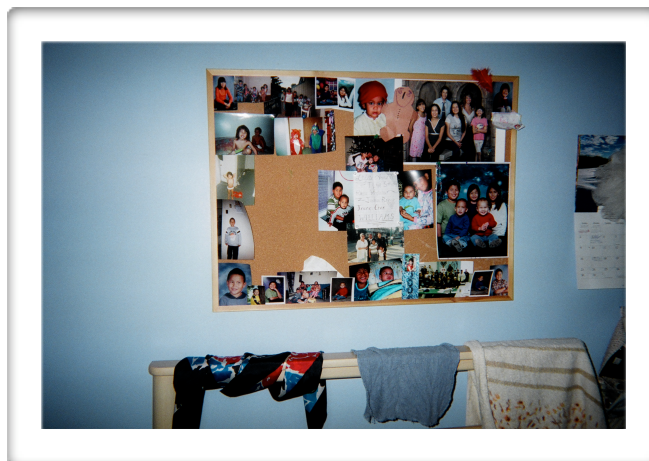
“I am really missing my kids and don’t feel whole without them. I had first child just after turning 17. That’s all I’ve known, being a mom. I put myself in many classes as soon as I became a parent to know how to do it.”

“It helps by getting the love. When they come, you get all the hugs and kisses... I guess it’s about bonding. I had a mom who was afraid to hug and kiss us and I don’t want that for my kids. I want them to be able to come to me when they have a problem.”

“My daughter’s strength brings me strength to be stronger. [We] are drawing strength from each other.”

“Everything I do revolves around my kids. I came to heal from my abuse so I am a better parent to them.”

Patterns of *emotional linking* were seen in representations of honouring and remembering children by keeping gifts given by their children on display. *Emotional linking* was represented by one mother who photographed her bulletin board and said, “My bulletin board represents me as a whole. Everyone that’s important to me is on there... and sometimes I just sit on my bed and look at it even though I see them every day.”



Caption: My bulletin board

Similarly, a second mother said, “When I’m having a bad day I look at all the stuff they’ve given me and it always helps me get through the day.”

Patterns of *emotional linking* were also seen through branding (i.e., body markings, tattoos). For example, numerous tattoos (some elaborate and some simple) were frequently evident on survivors. Another survivor revealed a tattoo for her baby who had died. It helped her stay connected with her infant and to cope with the loss. One survivor who had six children had their names placed on her ankle.



Caption: My Pooh bear tattoo. My kids are me.

Tattooing served as a documentation of where the survivor had been, including both joyous strengthening as well as painful struggles. *Emotional linking* was a reminder of being loved, served as a connector to one's children, and was critical in strengthening and returning to self. (See Appendix 18 for additional images of *emotional linking*.) For some survivors, *emotional linking* brought a sense of closeness and belonging. However, others felt safer in this stage by remaining emotionally distant from others through *insulative detaching*.

**Insulative detaching.** The last property of the safetying stage was *insulative detaching* which was a process of maximizing one's safety in relation to others through limited sharing of oneself. Through physical or mental means, survivors kept others away, thus maintaining low intimacy levels and protection from perceived harm. Insulative detaching offered a source of comfort, security and relief from anxiety concerning perceived danger, perceived threat, or when the survivor felt stressed or vulnerable.

*Insulative detaching* contained both mental and physical dimensions. First, it was achieved through hiding oneself from others (including one's partner and children). One participant said,

I hid myself for years. No one knew very much about me. Everything I did I kept to myself...I never got to nurture my family the way I wanted because I was missing...I'm not able to give 1000%. There's a part of me I need to keep myself safe.

*Insulative detaching* also contained a physical dimension. For example, one survivor recalled, "I didn't want to do anything that was going to make me more attractive to somebody. That way I always felt like I had a shield." Thus, *shielding* served to keep the woman's body hidden or less visible for self-preservation and protection. Survivors spoke about covering themselves with extra clothing or a blanket to protect their body from physical or psychic injury. Shielding oneself

protected survivors from emotional damage in a climate of perceived fear and anxiety. For example, one woman slept with a large body pillow or stuffed animal between her body and her partner which helped her feel safe and protected within the context of an intimate relationship.

Reduced insulating could result in fear, anxiety, and vulnerability that the body's protective barrier was removed, which forces the survivor to become visible and vulnerable. Reduced *excessing* (e.g. bingeing and overeating) brought the self to the forefront which produced feelings of vulnerability and fear of unwanted attention and affection.

Even using my weight. Like I lost over 100 pounds since I've been here and it scares me because I'm losing weight so I'm going to become possibly more attractive to other people and then I can't keep people at an arm's length from me.

Physically hiding and covering one's body (whether it be through extra layers of body fat or clothing) acted as a protective barrier to the outside world, and increased the perception of safety by reducing the intensity of emotions and fear. One survivor recalled visits to a psychiatrist over several years in which she rarely removed her long black coat and instead, sat with it wrapped around her during the sessions, with only her head, hands, and feet visible. In another example, a survivor stated during the first meeting, "I could have never looked at you in the eyeball."

In summary, in the safetying stage survivors improved their physical and emotional health as well as acquired a new lens on the world. Survivors experienced renewed appreciation and gratitude for their own lives and their children's lives. *Re-sensing* occurred as survivors left previous distortions behind. Through securing safe intimacy relations and *safe havens*, their self-respect and self-esteem increased. With the beginnings of increased personal worth, survivors began to choose a course towards strengthening because they believed they were worthy and deserving. Survivors chose to surround themselves with people who made them feel good and

loved.

The amount of time survivors spent in the safetying stage varied since it involved altering perceptions and belief systems. For example, one survivor said:

I thought it was okay for these people to hit me because I was not worth anything. It makes me so angry that I actually thought that way. I couldn't believe that people were saying it was wrong... I needed four years to believe it.

The safetying stage provided survivors with opportunities for safe intimacy, safe spaces, and reparative efforts. One survivor commented, "I'm just trying to get through the day." One survivor who had lived in numerous institutional environments and was currently in a residential facility expressed, "Sometimes I get tired being in here. I want a home environment, not a centre environment... Sometimes you need your own space."

Cultivating security through safetying created a fertile environment where emotional, physical, and spiritual healing is possible. In looking at and reflecting on her photographs together as a whole, one survivor said, "I'm still not there". Once safetying was attended to, survivors turned their attention to the third stage of authenticating and returning to self. It was in this stage that priorities shifted to focus on nurturing oneself.

### **Stage 3: Authenticating and Returning to Self**

Authenticating and returning to self was the last stage in the process of reconstituting a damaged self. This third stage was concerned with finding, accepting, restoring, and thus protecting one's true self. It was during this process that the survivor accepted the damage that was done to her and began to protect her inner authentic self. This process included the continued development of the survivor's capacity to heal. Authenticating and returning to self transcended the previous stage of safetying by conscious action towards transforming the fragmented self into a

stronger whole. For example, prior to this stage, survivors spoke about losing themselves in the negative effects of the trauma or in the experience of parenting. In this stage, however, survivors spoke about finding themselves again. Similar to a re-birth, survivors began to grow into themselves, reconnecting to previous stronger versions of themselves with increasing self-acceptance towards a unified whole. This stage consisted of more conscious behaviours that demonstrated efforts towards valuing oneself.

The increased self-value and self-acceptance demonstrated in this stage increased the sense of control and power that the survivors had in their lives, while at the same time provided a sense of authenticity. Integral to this last stage of authenticating self were the properties of: (a) *worthifying the self*, where survivors embraced and nurtured their self-worth through *beautifying*, and *elevating a displaced self*, (b) *focused being*, which allowed slowing the pace of their lives through *silencing*, and *moment grabbing* and (c) *re-emerging*, where survivors took back power and control through *safe visibility*, and *knowledge sponging*.

**Worthifying the self.** *Worthifying the self* encompassed behaviours which increased a sense of self value and built self-esteem. *Worthifying the self* made it easier for survivors to nurture themselves. This concept was achieved through the behaviours of *beautifying*, and *elevating a displaced self*. One survivor recalled changing her self-perceptions in this way:

I'm starting to get [okay] with my weight. Before I was not happy with my weight (thought I was big and huge) and portrayed myself like that, and now I'm changing my thinking, trying to watch what I eat and feel better...I'm believing in me.

Some Aboriginal women expressed how identifying with their cultural roots in the healing process facilitated self-esteem and the returning to self. One woman stated,

I'm Métis, not full blood. I've always grown up with people always saying, 'Native people are just bums, they're just this, just that.' That's the way I was thinking. So when I see Native people doing something for themselves it makes me proud because we're not just bums.

Loving and accepting their true inner selves allowed joy and hope into survivor's lives. One survivor reassured her "inner child" that things were going to be okay. Self-nurturing and beautifying gave her inner child a message that she's getting back into control and she doesn't need to be afraid. "I am here to protect you because I am an adult now."

**Beautifying.** *Beautifying* referred to a process in which the survivor nurtured a positive view of herself through enhancing her appearance. *Beautifying* behaviours included spending money on beauty products (e.g., make-up, bath soaps) or through pampering treatments to enhance one's appearance (e.g., manicures, pedicures).



Caption: Getting my nails done for the first time. Very excited!

*Beautifying* underscored the survivors' increasing self-acceptance and perception of becoming more desirable. One survivor said that putting on make-up made her feel "girly." Nearly every woman in the study spoke about or photographed **beautifying** behaviours. *Beautifying* occurred in

the environment as survivors began to see themselves as worthy of having beauty surround them. Surrounding oneself with sensory experiences and beautiful objects was a common form of self-nurturance and strengthening for many survivors during the process of *worthifying the self*. One survivor who photographed roses in a vase, which she frequently purchased, stated:

Roses are more than a flower. They are stately and beautiful and strong. They have a strong presence. I enjoy them so friends bring them to me. I feel very special. I gain such delight to look at and enjoy them.

Another example of creating comforting experiences was numerous photos of bubble baths. *Beautifying* included surrounding oneself with beautiful objects that delight the senses such as candles, bubbles, soaps and bath products. Increased personal pride over having nice things and pleasant surroundings became a necessary part of healing. One survivor living in poverty had recently begun to purchase beauty products, even though she perceived them as luxury items. She began doing this as she began feeling worthy of feeling clean and having beauty surrounding her. She stated: "I had to learn to love myself again."

*Beautifying* increased the survivor's positive self-regard, self-esteem, and perceived self-worth. While it was confidence building, many survivors did not engage in *beautifying* until they reached the strengthening stage; before this point *beautifying* was neglected and not seen as important or as a priority. As one survivor said,

That's how it is when you're on drugs- you don't really care about yourself. All you want to do is get high. It's hard to explain... you don't think about yourself. It was just an escape and I think going back even further I think a lot of it was with my father. You don't want to remember those things. You want to think about those things and you don't care about yourself.

***Elevating a displaced self.*** *Elevating a displaced self* was another dimension of *worthifying the self* and involved “inward focussing” through putting one’s own needs first (as opposed to previous outward focussing). Survivors frequently “sidestepped” caring for themselves in lieu of caring for others. They displaced themselves in relationships with abusive partners or even with their children. One mother of teenagers and young adults said, “I gave my life to my kids.” A second mother said, “I’ve never really cared for myself. I’ve put other people’s needs before my own until now. I’m just starting to do things on my own.” Reflecting on her photographs as a whole one survivor said,

All of these things you see today...I would have never allowed myself these kinds of things in my earlier life. I’ve evolved to granting myself permission and caring for myself in this way...I’ve never done just me before. I’ve evolved to granting myself permission to care for myself. It was always family first... I have grown more comfortable with these practices over the last 6 years in allowing myself these things.

Survivors frequently spoke about how they had lost themselves. A mother stated, “It is like I buried myself for awhile and didn’t see that I’d let everything go.” She later stated that it was only after beginning counselling that, “For the first time I felt like I got some sense of myself.”

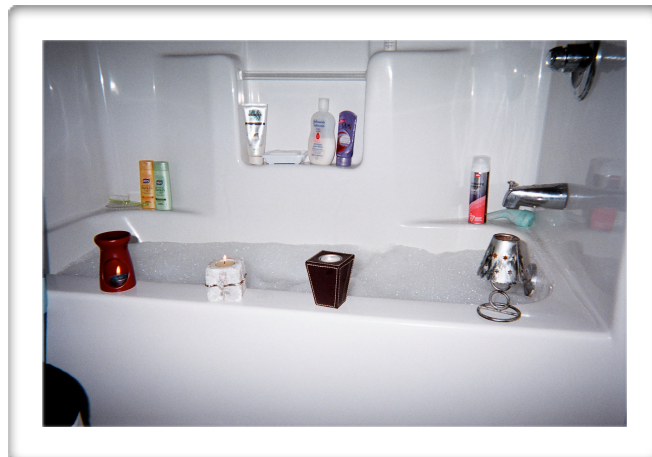
Survivors in the stage of authenticating self began moving from sacrificing their needs, to attending to, or elevating their needs. One mother commented,

Without sounding selfish, I put myself first and I think that is important. If I didn't enjoy myself, I wouldn't do things for others. And I don't think that's being selfish. I think I enjoy myself. I enjoy what I choose to do...and it makes me feel good about myself.

Greater self-value was acquired as survivors, often for the first time, began to put themselves first. They engaged in self-comforting behaviours and allowed themselves to be cared for by others.

**Focused being.** *Focused being* was the second property in the stage of authenticating and returning to self. In contrast to *excessing* and *busying*, it involved creating experiences and environments which allowed slowing down, looking inward, and experiencing silence alone. Through *focused being*, survivors valued time alone by themselves. Silence was empowering and imparted a sense of control over the survivor's life and freedom to take control. It also served to enhance creative thought processes, concentration, and intellectual alertness which were often blocked by *busying*.

Needing and desiring to be alone was important since it contained therapeutic aspects such as reinforcing connectedness to one's own body. Mother survivors spoke about having relaxing massages and taking long hot baths instead of five-minute showers.



Caption: My time out - relaxation

Others mentioned sweatlodges, meditation, and bathing rituals which bring in the presence of

one's body. Several survivors spoke about or brought pictures of themselves sleeping to relax and rejuvenate themselves. One single mother mentioned how she wasn't able to get enough sleep before coming into treatment because her children were with her all of the time.

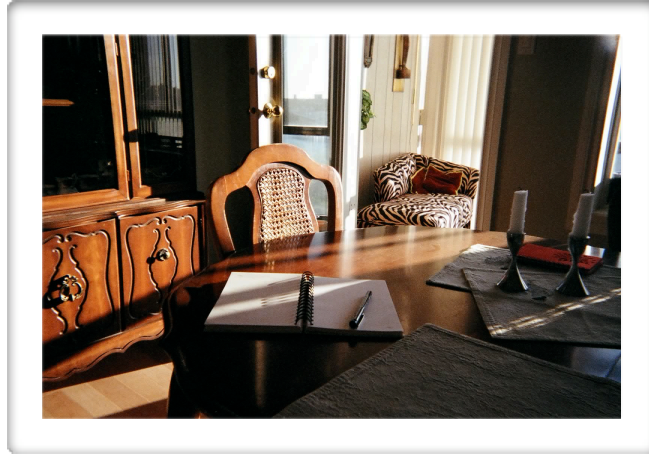


Caption: Sleeping beauty

Thus, treatment and therapy were a basic social structural process through which reconstituting a damaged self occurred. Treatment allowed connecting with *safe others* and provided permission and opportunities for rejuvenating and *beautifying* oneself.

*Focused being* was a process of mental restoration which also assisted in achieving self-insight and enabled survivors to focus on their needs and desires. One survivor photographed her journal and said,

That's a picture of my journal and my pen, and both are very important to me. It is a ritual that I write every day [sometime twice a day]. I have beautiful journals and beautiful pens...I've used scribblers but now I've moved to beautiful colours and beautiful paper. Journalling is more than just writing for me - it's a total experience... Journalling helps me process my thoughts. The journal has become my friend in a lot of ways. It is my *self-talk*. It's how I start to problem solve.



Caption: My story

Moments of self-reflection helped to slow the pace and intensity of daily life. Restoring oneself through creating calming experiences and environments was mentioned frequently by survivors who appeared to be in or moving towards the third stage of authenticating and returning to self. In fact, there was little evidence of these calming experiences and rituals during emotional de-paining or safetying. While reflecting on one of her photos, one survivor explained how a bath is not just “a bath.”

It is not just my bath. It is about the music, candles, the bath water and the smell of what I put in the bath water. It's about senses. I immerse myself in it and it is total [sic] self indulgent. It is peaceful and I'm calm... Like a spiritual experience.

Many survivors spoke about wanting to escape or lose themselves to allow some time away from a controlling partner or even one's children. Similar to the effect of *safe havens*, calming environments also affected survivors' relationships with their children indirectly. One participant acknowledged: “My overall state affects my interactions with my children. If I'm calmer then I'm better with them...I would be of more value to them in my calmed state than in my stressful state.” Another mother said, “It makes me appear stronger to my daughter and reassures her that I am strong enough to support her.”

*Moment grabbing* involved deliberately slowing down the often-hectic pace of life, and savoring solitary moments. Whereas busying was described by survivors as a race, *moment grabbing* involved consciously stopping and “taking in the moment.” One survivor’s description reflected how she moved from *busying* to *moment grabbing*,

I’m like at Disneyworld, I’m on every ride at once. That morning I [said to myself], ‘You’re gonna sit where the [laundry] basket is and the laundry, and the mess, and you’re just gonna frickin make a cup of tea and sit there [laughs] and I did that to myself today. You should see what my house looks like!

Creating safe nurturing spaces and peaceful places also facilitated *focused being* and *moment grabbing*. One survivor, for example, photographed her veranda where she ritually watched the sunrise. She stated,

Of the things I see out this window are about me being here. I feel such gratitude and appreciation for being able to be here... Being in the moment. I just enjoy the morning. I’m peaceful and calm and alone. It has become my morning ritual.

When asked to visualize and describe an ideal day in their lives, the majority of women in the study described *focused being* and *beautifying* experiences which included: spending time alone, pampering oneself at a day spa, sitting on a beach, or going on a vacation to concentrate on oneself. One mother used the term “catching the moment.” It is worth noting that being alone was a luxury for mothers with several children or a controlling partner. One survivor described her experience being alone in the bath,

[I was] relaxed, no phone calls, nothing, just sitting there... I guess my alone time is most of my self-care because I never really got that ... I had my kids, I was busy all the time, and I was with my partner 24/7 you can say. I actually went out and put myself in

things just to get out of the house...[Now] I can be alone and not have to worry about what I'm going to get accused of next.

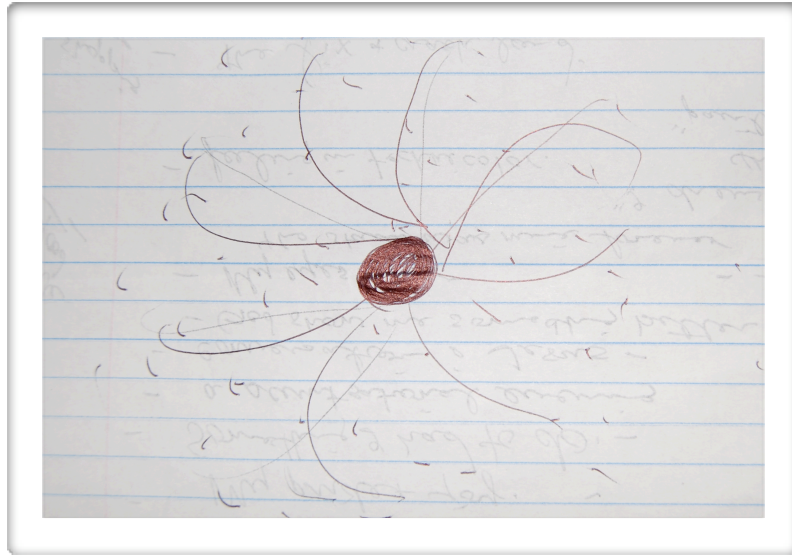
One woman came to a treatment centre for housing purposes.

It is a good program here now that I'm here I was just going to come for a place to stay and bring my kids, but the girls you get really close to and the programs you learn a lot and the counsellors are very helpful... there's so much here. And no matter how crappy you're feeling there's always girls in the smoke room who joke around and laugh. And I took a bunch of pictures of all the girls here because that's kind of my self-care because no matter how shitty I was when I was at home I would come back and I would start talking and...

Needing and desiring to be by themselves did not remove the need to be with their children; rather, it provided an opportunity for authenticating and returning to self through relaxing and replenishing. Being in a live-in treatment program afforded some of the women time to heal and strengthen themselves. However, one single mother who expressed needing time away from her five children had little choice about bringing her three youngest children to the interview. In fact, for many survivor mothers, *focused being* and *moment grabbing* may have only been possible when their children were no longer living with them, had left home as adults, or after they left an unhealthy relationship. One woman was able to focus on self-nurturing because, "It was now that my kids didn't need me in the way that they had."

**Re-emerging.** *Re-emerging* was the third property in the stage of authenticating and returning to self and referred to a transformative process which involved survivors returning to and reclaiming their authentic selves. Several survivors in the study spoke about wanting to return to themselves. For example, one survivor felt that a part of her self-identity had been taken, and that

through her healing she felt she was re-emerging, opening up, and moving towards a unified whole. While drawing multiple dots on a piece of paper, she described herself like scattered seeds. She felt fragmented, pulled by others, and recognized the need to reintegrate a coherent sense of identity.



Caption: I was five different people to five different people...I couldn't stand it...Now I'm pulling this solid thing in. Pulling it in [as she connected the dots and pulling them into the centre].

*Re-emerging* also encompassed being able to acknowledge and return to previously held interests (or develop new interests) which in turn facilitated a sense of power and presence. For example, experiencing more respect for herself, a survivor started doing things for herself and on her own. She didn't need others as much and was proud to say how she went to three movies by herself. She began demanding more respect from her children and learned basic construction and how to paint her house to take it up a notch. Reflecting on her photo she said, "Because I'm up a notch. I don't feel so shitty about myself."

Many of the survivors opened themselves up to creating in this stage. Creating included using many different media, such as sewing, knitting, painting and making jewelry. Returning to crafting reawakened feelings of familiarity, joy, a renewed sense of self-value, and growth. One participant stated,

Within you there's a song. A song of hope, nurturance and joy. And what the war [abuse] did was I just turned the song off. And what sewing does for me is that it turns my song back on.

Getting to know oneself again through reconnecting to dropped interests or activities they did earlier was important in this phase of the healing process. One mother was surprised at how she had stopped painting and said, "How could I have forgotten that?"

**Safe visibility.** A dimension of *re-emerging* in the third stage was demonstrated through *safe visibility*. *Safe visibility* was the means through which survivors achieved greater comfort and confidence in being noticed by others. In the process of reconstituting their damaged selves, survivors began to transcend insulating, covering, and fearing attention to acquiring greater self-confidence, self-respect, and self-acceptance. *Safetying* and *worthifying the self* facilitated a move towards uncovering oneself and feeling more comfortable in the presence of others as a person of value and worth. *Safe visibility* for one survivor was apparent when she spoke of her perfect day as pampering herself in a day-spa and then "driving in a limo all over the city to be noticed." Another survivor recalled wanting to feel invisible at many points in her life, yet only during treatment did she partake in self-care activities to make herself feel important and noticed. Finally, a third survivor modified her personal style from "dressing to impress" men, to dressing for comfort. She began to care less about what other people thought and began to alter her appearance by sewing her own clothing.

At about 47 I changed from wanting to dress up and be attractive to men to not caring as much. I used to have to be blonde and dress up for men. Later I darkened my hair and dressed in moderation. I want to be stylish with some self-respect...I liked myself that way, still do.

It is worth noting that while some women spoke about feeling more comfortable in their own skin and being noticed in a positive way, others did not feel comfortable about their bodies. One survivor who was in the third stage said that body intimacy was still a very difficult area for her as she still felt a lack of emotional safety when sexuality or body intimacy was involved. "If I was just an *it* I would be happy that way."

Overall, during this third stage of reconstituting a damaged self, increasing positive regard about one's physical self was apparent, as was an overall self-acceptance. Negative feelings were replaced by statements of worth and value such as, "I'm believing in me" and survivors' perceptions about being a person of value and worth increased.

I've got things to do other than drinking or being with an abusive guy to make me feel good. I thought that being with a man was the only way I could be happy. I'm not going to die without being with a man.

This stage brought forward a sense of starting again, and freedom to be a child. One survivor stated, "Even at 46 I felt like a kid with permission to go for it."

***Knowledge sponging.*** *Knowledge sponging* referred to a process in which survivors actively acquired information through formal or informal information gathering, education, or training. The process of gaining new knowledge and learning, increased feelings of self-awareness, self-confidence, and control in the mothers' lives. *Knowledge sponging* occurred frequently during certain periods such as becoming a parent or during periods of illness.

*Knowledge sponging* helped survivors feel more confident and in control over their life circumstances and allowed them to become authorities on themselves, especially when it came to dealing with an illness. One survivor with cancer photographed her local library stated: "Knowledge nurtures me because it makes me feel secure and warm." A second woman who suffered from numerous health problems researched her illness online.

I did a bunch of research on fibromyalgia because I didn't know what it was so that way I know what it is and what will help. Because I knew how to deal with it I'm able to function better than sitting near worrying about what it is and what it is going to do. This way I know what will help and possibly make it easier for me. [I found out] there's a link between the fibromyalgia and abuse. I didn't know that.

*Knowledge sponging* was a self-empowerment tool which provided personal fulfillment and helped the development of positive self perceptions. Efforts towards *knowledge sponging* included attending seminars, going to the library, using a computer for research, counselling and therapy, and upgrading one's formal education. One survivor returned to school to complete a Master's degree following her divorce from a controlling partner.

My quest was to find my voice. I couldn't hear it. Finishing my Master's degree was the most important thing in the world to me. I was juggling ten balls in order to be able to do it, making sure home was looked after, busy looking after everyone and everything and this was one little piece for me. I was not going to give it up for anything and I made that choice.

Several other survivors struggled to complete their high school diplomas while simultaneously attending treatment for their abuse and managing the complexities of parenthood. These struggles and the strengths of these women cannot be understated.

In summary, the final stage of authenticating and returning to self reflected pampering activities and doing things for oneself in an effort towards transforming the previously fragmented parts of the self into feeling whole. This quest may not be easy to attain. One survivor reflected: “Allowing self the time and place are factors, and removing guilt, having money, setting the stage for enhancing the senses, having the luxury of privacy for the experience.”

### **Results Summary**

Through a grounded theory analysis, a basic social process of reconstituting a damaged self was developed. The survivors in this study demonstrated three stages and their various sub-processes in an effort to achieve feeling better in the context of past CSA. Survivors engaged in *emotional de-paining* in an effort to rid themselves or minimize emotional distress related to the past trauma, and or current circumstances. They secured safe places and relations with others through *safetying*. Some reported being at a point in their life where they felt stronger, had attained more inner strength and confidence, were content, and had reached a point of *authenticating and returning to the self*. Moving within these healing stages allowed participants to reflect on their past abuse and current relationships, and to arrive at a more complete and comfortable place of strength.

The stages presented in this theory are not intended to be linear. As discussed, they may overlap and cycling back and forth between stages was common. Certain dimensions of survivor mothers determine which stage they are in, how long they remain in a stage, and if they cycle back and forth between stages. The dimensions include self-value and self-worth, perceived safety and trust in others, being a parent, and the mothers' capacity to mend and heal. For example, survivors in the authenticating stage may still engage in safetying behaviours, however, the primary emphasis in their lives remains on strengthening and nurturing efforts. Also survivors in the

safetying stage may cycle back to the de-paining stage temporarily to cope with newly recognized pain or anxiety emerging from counselling, only to return back later to safetying.

The survivors in the current study were all at different places in their healing journey: from those who had recently been released from a detoxification centre and off the streets for 30 days, to those who had their own businesses and just purchased a high-end condominium following a divorce. The journey of recovery from past abuse also varied across participants. Some survivors primarily spoke about strengthening and healing, while others primarily reflected safetying. Clearly, reconstituting a damaged self can be a long process involving taking small safe steps, for the most part, on one's own. One survivor who was in the strengthening stage stated, "Where I am today is a whole different place... and I didn't just get here in one big step. It took a lot of little steps to get here."

## **Chapter 5: Discussion and Conclusion**

Taking a grounded theory approach, the role of self-care in the daily lives of survivor mothers was explored in the present study. An in-depth understanding of the meaning and practice of self-care for women within the context of the long-term effects of CSA was attained. For women attempting to balance the deleterious effects of childhood trauma with the challenges of parenting, self-care was one small but important component of the larger process of healing and “reconstituting a damaged self.” Present analyses culminated in a basic social process that incorporated three different but inter-related stages of growth and healing. Many elements of this process are consistent with previous work on characteristics and dynamics of recovery from past abuse. The present findings complement differing theoretical frameworks and empirical findings concerning how survivor mothers’ self-concept, self-efficacy, powerlessness and depression impact their self-care and self-protective efforts.

### **Traumagenic Dynamics Perspective**

Finkelhor’s psychosocial framework (Finkelhor & Browne, 1986) provides one explanation concerning how a survivor mother’s self-care behaviour might be influenced by her past abuse. For example, stigmatization explains how sexually abused children incorporate notions of badness, shame and guilt into their self-image. Early formed self-concepts and patterns of self-esteem influence our motivations and attitudes towards later self-care behaviours. CSA has been shown to have a negative impact on survivors’ sense of self in adulthood if a negative evaluation of self-worth has persisted (Harter, 1999). Finkelhor and Brown’s (1985) traumagenic dynamics suggests that abuse creates an altered world view, poor self-concept, and low self-worth and self-esteem in relation to self-care. Coupled with a tendency in the CSA literature to blame mothers for their own and their children’s abuse, it is not surprising to find evidence of poor self-concept, low self-worth

and self-esteem in the present sample. Franken (1994) stated, "There is a great deal of research which shows that the self-concept is, perhaps, the basis for all motivated behavior. It is the self-concept that gives rise to possible selves, and it is possible selves that create the motivation for behavior" (p. 443). The present study demonstrated that survivor mothers' self-concepts and self-efficacy towards self-care were damaged, often through a lifetime of physically, sexually, and emotionally abusive interactions with others. These interactions affected their perceptions and actions relating to the practice of self-care or lack thereof. Mothers spoke about intense feelings of loss, guilt and shame with regard to not feeling entitled to self-care, as well as the negative consequences their children experienced prior to and during their healing process. The impact of these overpowering feelings contributed to feeling unworthy of self-care, and a lack of self-efficacy concerning their self-care abilities.

Social service agencies and counselling programs were an integral component of the basic social process that helped survivors develop and re-claim their own capabilities and self-worth. These supports enabled survivor mothers to change poor self-concepts, and re-examine their beliefs and feelings about themselves. In some cases, counselling helped survivors develop more accurate, healthier perceptions about themselves and their environment which made them stronger and more resilient. Thus, as survivors moved through the "reconstituting a damaged self" basic social process into the strengthening stage, they discovered (or re-discovered) themselves as worthy of feeling better and protected from violence. Survivors' stronger self-concepts became more congruent with who they wanted to become and/or who they were at a previous time in their lives. Their increased sense of worth and value directed them to be strongly motivated towards their own needs and self-care efforts, and reflected an openness to consider practising self-care. These findings are consistent with other work examining self-worthiness and the practice of self-

care (Furlong & Wuest, 2008). This study found that “self-care worthiness” was a salient condition that was necessary in order for caregivers of persons with dementia to perceive themselves as needing or deserving self-care.

The traumagenic dynamic of betrayal describes how trust is impaired and manifests into later grief and depression. One of the most common effects of CSA is depression (Putnam, 2003; Browne & Finkelhor, 1986) and depressive disorders among mothers have been consistently linked to poorer parenting skills, including a potential for using more punitive and aggressive discipline (Cohen, Hien & Bathelder, 2008). In the present study, survivor mothers sought to escape depressive symptoms by *excessing*, which involved ingesting large amounts of food, drink, and other substances.

*Lightening* also mitigated against depression by substituting feelings of sadness and anger with patience and emotional control (at least temporarily). It is important to note that while some survivors described attempts at *lightening* as “wearing a mask,” they still perceived its benefit. Cognitive therapists have argued that learning this strategy for lessening depressive symptoms may become less conscious and more effective over time (Beck, Rush, Shaw & Emery, 1979).

The traumagenic dynamic of betrayal was also evident in trust issues identified by survivor mothers in their inability to judge the trustworthiness of others. Only one woman reported being in a long-term stable intimate relationship at the time of the interview. Impaired trust perceptions help to explain vulnerability to unhealthy relationships, and a need for *escaping entrapment* and rebuilding trusting safe relationships. A lack of trust in partners also complemented their perceived inability to fully protect their children from witnessing or experiencing intimate partner violence, or sexual victimization. In addition, the traumagenic dynamic of powerlessness was also evident in survivor mothers’ lowered sense of self-efficacy and perception of oneself as a victim. Most experienced

great loss of control in their lives due to drugs and addictions. Their sense of powerlessness left little room for self-agency and self-care, and accounted for multiple attempts of leaving unhealthy relationships. Survivor mothers spoke of feeling caught in the pain of their abuse, and feeling desperate and out of control.

In summary, the traumagenic dynamics of powerlessness, betrayal, and stigmatization (Finkelhor & Browne, 1985) were evident in survivor mothers' descriptions of self-concept and self-esteem. While feelings of lessened capacity and worthlessness clearly limited some women's ability to practise self-care, others overcame these feelings and made enough progress on their healing journey to not only engage in, but enjoy, self-care efforts. The basic social process of "reconstituting a damaged self" described this journey in rich detail.

### **Social Learning Theory**

Social learning theory is also a useful explanatory framework for the findings in the present study by applying the concepts of modelling and positive reinforcement. The more frequent and enduring survivor mothers' past negative experiences were, the higher the likelihood that they adopted and internalized negative self perceptions. Women spoke about feeling ugly, dirty, controlled, hurt, and not whole; these feelings were often accentuated through the actions and reactions of others. Other researchers have also noted the enduring negative self-view of abuse victims (Barnes et al., 2009). Recent social cognitive theory suggests that these negative self-assessments will negatively affect survivor mothers' health promotion efforts (in this case self-care) and health status (Bandura, 2004).

Mothers spoke about their partners discouraging them from pursuing self-interests, and it was not until they were outside of these relationships that they began to change their behaviour, alter their perceptions, and engage in more self-care. When survivor mothers entered counselling,

the therapeutic relationship challenged their beliefs about themselves and others (e.g., *re-sensing*). For example, one woman took four years to believe she did not deserve to be beat up by her partner.

Social learning theory also explains lack of self-care due to the absence of having observed self-care practices by their own mothers and caregivers. Survivor mothers commented about a lack of positive role models concerning self-care in their family of origin and some recalled witnessing domestic violence. It is therefore not surprising to see an absence of self-care in survivor mothers who were in the early stages of healing. While social learning theory accounts for the lingering consequences of past experience, it does not adequately capture the importance of social context for survivor mothers in the present study.

### **Feminist Theory**

Using a gender lens, violence can be seen as a normative experience for women and is analogous to the multiple traumas survivor mothers experienced (in addition to their past experiences of CSA). Radical feminist theory draws linkages between the social structural conditions of women's lives and violence. Acknowledging these social structures provides an important frame of reference for better understanding survivor mothers' self-care efforts. It is pointless to try to understand incest survivor mothers' self-care efforts without examining the power structure and social context which influence their behaviour.

**Conditions of survivors' lives.** The women in this study experienced various struggles in their lives. Not only were they attempting to remove their past emotional pain from CSA; but many were also coping with current social conditions of poverty, racism, violence and others traumas. The material condition of poverty emerged as relevant in the present study and related to one's ability to access resources and to heal. The conditions under which the women in the study lived

were highly variable, yet, in many cases restricted their self-care opportunities. For example, many survivors resided in a transition centre without easy access to their children, which afforded little privacy and personal freedoms, and often contained as many as 30 women in shared rooms. Several women did not own their own vehicle and had to rely on others or public transit. Lack of personal resources coupled with ongoing underfunding to social service organizations (Chartrand, 2000) provided women in the present study with few choices about engaging in self-care behaviours. Various conditions gave rise to the women's ability to engage fully and completely in the safetying and authenticating processes. Poverty and lack of adequate childcare were voiced as barriers to having the time for self-healing. Survivors in the study were frequently surrounded by emotionally abusive partners, and were in situations in which it was difficult to remove themselves from and required de-paining efforts. Lack of healthy relationships and access to social resources hindered attempts to escaping entrapment.

Finally, many of the survivor mothers reported having poor health. Health Canada estimated the mental illness for men and women is 20%. Five (36%) of the women in the study reported suffering from a physical or mental disability. This finding has been supported by others (Tonmyr, Jamieson, Mery, & MacMillian, 2005) who found that while women with a history of child abuse were more likely to report having a disability due to mental health problems, childhood sexual abuse showed the strongest association. This finding suggests that more research is needed on the association between CSA and later disability and its effect of one's self-care. The effect of comorbidity of conditions such as mental illness and CSA also has implications for services for mothers with a history of CSA.

The patriarchal context of the family has traditionally been neglected in violence research, and feminism has been at the forefront for critiquing the traditional social structure of the family.

Under patriarchy, children have few rights to control what happens to their bodies (Butler, 1994) and some have even argued that the family is a breeding ground for violence (Yllö & Bograd, 1988). Survivor mothers revealed how their self-care efforts and their lives in general were often constrained by patriarchal family structures and relationships (e.g., having no time for oneself due to attending to partner's and children's needs, restricted freedom, and feeling like one's "wings had been clipped"). One mother stated, "He kept getting me pregnant (5 kids) to keep me. I was happy with my first two, but when you're pregnant every year you can't go out and get a job."

Being alone with oneself emerged as an important component of "reconstituting a damaged self" as it provided an opportunity for releasing, reintegrating and restoring self. Being in a treatment program afforded women this opportunity, as did having their children old enough to move out of the home. Time for healing outside of a structured treatment centre where one can achieve time alone with oneself was nearly impossible for survivors without access to social supports and financial resources.

The majority of women in the present study were lone parents with low income and little education. Activities aimed at strengthening their healing (e.g., focused being, beautifying) were also constrained and limited by marital status and financial resources. Survivors with limited financial resources were less likely to focus on strengthening and self-nurturing efforts. While only a few of the women in the present study were in the last stage of "reconstituting a damaged self", it cannot be understated that their strength and resilience depended upon their access to resources and ability to use various strategies. Mothers who were in the strengthening stage often had more education and/or greater access to information and services. They also were able to successfully remove themselves from abusive relationships. This finding was consistent with Hyman and Williams (2001) who found that resilient women were more likely to have higher economic status

and more education. Due in part to the conditions of their lives, some survivors were more vulnerable to reverting back to the stage of de-paining, and less able to access the resources required for moving into and remaining in the third stage of strengthening.

**Cultural factors and healing.** In addition to the social contexts described above, it is also important to consider cultural factors that influenced survivor mothers, since ethno-cultural influences contain important messages and values systems that may influence self-care and healing. The majority of women in the present study self-identified as being of Aboriginal origin. Thus, acknowledging and respecting indigenous culture and the historical context of colonization is imperative to understanding how Aboriginal survivors navigated the basic social process of “reconstituting a damaged self”.

It has been well documented how historically, native families were subject to having their dominant cultural beliefs replaced by European values and beliefs. Many lasting effects of assimilation and colonization included: (a) patriarchal notions of property, (b) discipline measures used by men towards women and children, (c) lack of Native spirituality, (d) residential schools and related abuse, (e) removal of children and placement in non-native families, (f) diminished parenting skills, (g) little nurturing and subsequent low self-esteem, and (h) self-concept problems and a sense that native culture was inferior (Martens, 1988; Miller, 1997; Morrisette, 1994; Weaver, 2009). Many of the Aboriginal women in the present study lost their children to child welfare authorities. Some were raised in non-Native homes. Some felt confusion about their culture, heritage and traditions and faced racist societal attitudes. Others struggled to regain a sense of their culture for themselves and their children in their path towards healing. Historic trauma and cultural disruption during centuries of colonization have resulted in devastating long-term effects on families and communities.

The trauma to which Aboriginal peoples were exposed in the past continues to be manifested intergenerationally into the present. Unresolved and cumulative stress and grief experienced by Aboriginal communities is translated into a collective experience of cultural disruption and a collective memory of powerlessness and loss (Reimer, Bombay, Ellsworth, Fryer, & Logan, 2010, Definitions p. x). Acknowledging these forces is important in understanding the healing journey of these women as described in the present study. Reimer et al. (2010) found that healing for residential school survivors involved re-learning cultural practices, reconnecting to cultural activities, and redeveloping self-esteem through self-pride and strong cultural identification.

Research by Mangelson Stander (2000) on patterns of healing and recovery of Native American trauma survivors in Utah also supports key findings in the current study. Using ethnographic methods of participant observation and in-depth interviews with Native American urban women, Mangelson Stander identified a four-stage model of recovery. Similarities with the present study included: a stage-model of recovery, survivors' children as a significant factor for women's healing, and a personal healing decision representing the healing process moving forward. Strategies supporting the commitment to recovery were similar to the current theory: spirituality and religion, education, formal recovery programs or counselling, significant others or social networks, relocation, and culture/roots. Finally, both studies revealed the importance of respite for mothers through childcare as a necessary support for women's recovery.

### **Incest and Recovery**

The current findings align strongly with feminist therapeutic process and recovery. In her book about incest recovery, Dinsmore (1991) wrote that incest survivors are scarred for life but not damaged beyond repair. Dinsmore (1991) documented how women tended to put their own needs behind others (e.g., partners, boyfriends, children). Her concept "taking back" describes women

beginning to put their needs first. This powerful concept reflects the process of *elevating a displaced self* described in the present study. The main goals of feminist therapy are empowerment and personal control (Herman, 1992b; Dinsmore, 1991).

Survivors must be allowed to heal in their own ways. Feminist therapy is a process about change and helping women recognize themselves as an oppressed group, and grounded in the belief that the personal and political are connected. The goal is to help women make changes for themselves and their environment as opposed to teaching specific skills or interventions. (Dinsmore, 1991, p. 6)

Self-cutting, which was mentioned by several mothers in the present research, has been pathologized within medical discourse. In contrast, feminist therapy has recognized anger as important in the healing process (Dinsmore, 1991); thus, the concept of “anger exiting” gains relevance in this context as an important process within *emotional de-paining*. An alternative view informed by feminist therapy would be to interpret cutting as a releasing mechanism, and to understand the underlying causes.

The finding that healing from CSA takes place on a continuum with various stages of recovery and re-experiencing earlier stages has been suggested by others (Duncan, 2004; Dinsmore, 1991). “There are times when one makes it through a stage only to return to it later, but the second time around the stage is experienced in a different way, generally with more insight and clarity” (p. 33). Mastering the various stages of recovery results in the survivor experiencing life more fully. Dinsmore’s work also showed how one heals and grows within communities. This illustrates survivors *escaping entrapment* through securing *safe others* and *safe havens* within the social structure of treatment and therapy. Finally, feminist therapists also have written about trigger points (Dinsmore, 1991) or the emergency state (Bass & Davis, 2002) which closely reflect the

*cutting point* described in the current study.

Findings from the present study also correspond to a recent qualitative meta-synthesis of the healing process from sexual violence (Draucker et al. 2009). The present study's stage of safetying appears synonymous with Draucker et al's phenomenological term *lifeworld*, whereby survivors attempt to seek safety and create a secure environment to keep safe. Similarly, Draucker et al.'s *restoring a sense of self*, whereby survivors repair damaged parts of themselves through healing activities to make them stronger, shares aspects of the third stage of authenticating and returning to self in the present research.

### **Harm Reduction**

Recent research considers culturally sanctioned behaviours such as tattooing, body piercing, and branding as self-harm behaviours, and stresses that the phenomenon of self-harm is complex and not clearly understood by researchers or health care professionals (Mangnall & Yurkovich, 2008; Harris, 2000). From the standpoint of survivor mothers, the main goal of the tattooing and cutting behaviour they described was to decrease feelings of emotional pain through the process of "anger exiting". This finding is consistent with others who have found that episodic self-injury behaviours are occasional occurrences resulting in stress release and better mood (Yates, 2004; Simeon & Favazza, 2001).

Health care professionals often do not understand people who self-harm (Harris, 2000) and may perceive them as manipulative, impeding medical admissions, and less deserving of care (Hopkins, 2002). Yet, research shows that taking time to talk and build relationships with self-harmers decreases the problem (Mangnall & Yurkovich, 2008). The basic social process described in the present study raises the issue of understanding self-harm behaviours of survivor mothers in

the larger context of “emotional de-paining”. This finding is consistent with Harris (2000) who states,

Self-harm can only be understood by referring to the cultural framework within which it is produced and by examining the cultural processes and practices within which it is contextualized. This is why the quantitative approach to self-harm, which inevitably aims to provide breadth at the expense of depth, fails to provide an explanation for self-harm. This is also the reason why a qualitative approach is implied. (p. 169)

### **Emotional De-Paining: The Imperative to Release Pain**

As noted earlier, depressive symptoms were common among survivor mothers in the present study, and they often used *emotional de-paining* as one means of coping with negative emotions. Depression is one common consequence of suppressing past hurt and negative emotions. In her book Berger (2005) wrote,

The foundation layer of our repressed feelings is hurt....If as children we were not allowed to take the time to discharge our hurt completely, we will not know how to allow ourselves the time we need to grieve completely at all (p.182).

Berger’s description of the various ways that people defend against hurt (e.g., feeling depressed or acting out) parallels the *emotional de-paining* behaviours described by survivor mothers. Her reference to discharging hurt also indicates a need for giving the self time to heal, which was reflected in the substages of “safetying” and “being alone with oneself”. Further, shutting down hurt prematurely may contribute to repeated cycling in the *emotional de-paining* stage, “If we shut down on our hurt before we have allowed ourselves to grieve enough, we get stuck in our hurt. It reverberates in our system and we keep feeling it for years” (p. 182).

### **Safelying: Therapeutic Landscapes as a Place for Healing**

Recent research on therapeutic landscapes has been receiving increasing attention within disciplines of health geography, nursing, and urban planning. This research suggests a strong connection between emotions and place regarding healing. Research on healing among breast cancer survivors (English, Wilson, & Keller-Olaman, 2008) shows how homes can be shaped into healing or therapeutic landscapes, and nurtured through the creation of individual spaces of comfort. This research illustrates the survivor's body as the site of illness within a landscape of healing. Gesler (1992) termed therapeutic landscapes as locations associated with treatment or healing. Specifically, they are places in which "physical and built environments, social conditions and human perceptions combine to produce an atmosphere which is conducive to healing" (Gesler, 1996, p. 96).

This important work supports "reconstituting a damaged self" in that it recognizes that certain places can enhance health and contribute to healing. It is worth noting that the majority of the survivors' visualizations in this study focused on what Gesler terms "extraordinary landscapes" (e.g., treatment centres, nature, spas). Nearly every woman who was living in a treatment centre spoke about the importance of her environment as a place where she could heal. Two survivors outside of a structured treatment setting spoke about (and photographed) their extensive efforts to create a safe, nurturing, healing environment for themselves. The visual methods in the current study were particularly useful in this regard for allowing the women to capture the nature of healing spaces which may have been difficult to put into words.

### **Post-Abuse Adaptation and Resilience**

Several researchers who have examined women's resilience as adults following CSA have also noted their resilience and positive adaptation (Banyard & Williams, 2007; Bogar & Hulse-

Killacky, 2006). Crisis points identified in the current study were similar to those found in qualitative interviews by Banyard and Williams (2007). Turning points, which were shifts or changes in how the women led their lives, were related to risk and protective factors in positive adaptation. Also consistent with the basic social process identified in the present study, spirituality emerged as an important component of resiliency determinants (Bogar & Hulse-Killacky, 2006; Banyard & Williams, 2007) and precipitated the turning points (Banyard and Williams, 2007).

Self-care may be critical to both the healing process and the development of resilience in survivor mothers; however, current findings suggested that survivors need to have reached a point in their healing where they have decided to escape entrapment, accept being worthy of self-care and possess the courage to take back power to restore and return to the self. This is consistent with Glaister and Abel (2001), who showed that incest survivors who felt they had successfully healed from their abuse had also made the decision to heal, were taking care of themselves, and were learning new skills and ways of thinking.

### **Advancing Method, Methodology, and Substantive Theory**

Little in the way of academic research has addressed the self-care experiences of survivor mothers. The findings of the present study make a valuable contribution to the literature in several ways. Several methodologies and methods exist for researching family violence, yet feminist theory reveals that some are more appropriate than others. One of the primary concerns of survivors of CSA is feeling safe in the presence of others (Schacter et al. 2004). Consequently, building a sensitivity to trust into research methodology with vulnerable populations requires particular attention and specific methods that address these complex dynamics. For example, visual methods facilitated trust-building with the researcher in the present study (Kreklewetz, 2008). Using classic grounded theory (GT) with visual methods was innovative and effective for empowering survivor

mothers with increased self-awareness. It allowed a richer understanding of these women's lived experience, and provided a means for their voices to be heard. As one survivor reflected, "I can't believe the stuff that's come out of my mouth. I never voiced out my anger that I listened to my ex-husband and let him take (my son)."

The use of photographs extended classic GT methods and added substantially to the research process by providing a visual tool for expression. "Like words, images are part of who we are, who we think we are, and who we become - they are integral to questions of identity and purpose" (Weber, 2004, Concerning Images section, para.1). Photographs also provided an avenue for new insights and understanding of oneself, a process Taylor (2002) referred to as reflexive learning. Findings of the present research demonstrate the richness and value of the photovoice method in understanding sensitive topics in vulnerable populations through constructing a less threatening, more equal, and often enjoyable environment for women to speak about personally meaningful topics in their lives. In effect, the use of photographs (a) helped elicit discussion about self-care and healing, (b) created an inventory of meaningful images of trauma survivors, and (c) offered a self-reflective educative tool for empowering survivor mothers to become more aware of the steps and actions they take towards self-nurturing and healing.

The current classic GT methodology lent itself to feminist research (Keddy et al., 1996) and did not support androcentric standards of science which is evidenced by theory driven research and themes of power and control in interviewing and collecting information from participants. Adhering to the tenet of classic GT methods ensured that the study did not follow a pre-existing theory about self-care which "defines and draws boundaries around the phenomenon" (Smith & Glass, 1987, p. 8). This approach ensured that the women's voices were at the forefront. The GT method also did not support the positivist paradigm of science in resisting standard pre-defined

operational definitions of self-care. Instead, mothers were asked to speak about their main concern. Feminist researchers have argued that too many constraints are placed on participants in asking them to fit their experience of violence into narrowly defined operational definitions (Kelly, 1988b). Linden's method of using oral histories with holocaust survivors (1993) raised issues with positivist field research and supported an inductive method of data collection and analysis with survivors of trauma and violence. Grounded theory in the present study reflects a commitment to "antipositivist field research" (Linden, p. 103) and as some have argued, "GT has always been implicitly feminist in its pragmatist epistemology/ontology" (Clarke, 2007, p. 346).

Finally, the choice of research methods supported a strengths-based versus deficit-based approach to research. Given the majority of the women in the study were Aboriginal, this approach was important and consistent with guidelines proposed in the ethics of research involving indigenous peoples (Ermine, Sinclair & Jeffrey, 2004). By encouraging survivor mothers to speak about their lives and experiences of violence and self-care, the present research imparted a message that their stories are important and that they are not alone in a larger culture of violence against women. Bearing witness and encouraging survivors to speak out about their experiences not only supports their healing efforts (Brison, 2002), but raises awareness of incest and CSA. "The very prevalence of sexual violence can, paradoxically, render it invisible" (Brison, 2008, p. 192). The present research contributes to seeing CSA as a gender-based trauma and sex crime against women (Brison, 2008, p. 196).

The present research also makes a substantive contribution to the literature on trauma and CSA in that it provides a better understanding of both the barriers and supports for self-care, healing and self-nurturing behaviours for survivor mothers. The present findings provided insight into the wide range of strategies used by 14 survivor mothers in their self-care efforts, and suggest

that self-care is sometimes in the eye of the beholder and does not always consist of health-promoting behaviours. Further, given the diversity of self-care practices in the present study, it becomes clear that one particular form or strategy may not apply equally well to all.

Although the present research was limited to a small sample consisting of women who were predominantly of Aboriginal origin, there was some variability in sampling evident by the inclusion of women from various income levels, ability, education levels and with differing numbers of children. Their healing and self-care efforts were complex and influenced by various social conditions and personal backgrounds, and different healthcare concerns were identified. The present findings filled a gap in the existing literature about the unique mental health needs of this population, and also identify important information for better understanding their physical health care needs as well.

The three main stages of the basic social process of “reconstituting a damaged self” advanced current theory concerning the long term effects of childhood sexual abuse, as well as theory pertaining to self-care of parents. This process provided a strengths-based perspective on the healing and self-care practices of survivor mothers, and advanced a harm-reduction approach by viewing their self-care efforts along a continuum of care. Finally, it bridged connections between CSA, health promotion, parenting, and self-care.

Substantive and emancipatory knowledge was created through the present research by revealing the struggles of survivor mothers’ efforts caring for themselves in the context of past CSA and the current social conditions of their lives. It has also been frequently claimed that victims of trauma need to tell their stories to help them heal (Brison, 2002; Ford & Crabtree, 2002). Telling one’s trauma narrative plays a significant role in moving the survivor from the undoing of the self (caused by the trauma) to recovering or remaking of a self (Brison, 2002).

The communicative act of bearing witness to traumatic events not only transforms traumatic memories into narratives that can then be integrated into the survivor's sense of self and view of the world, but it also reintegrates the survivor into a community, reestablishing bonds of trust and faith in others" (Brisson, 2002, p. xi).

Thus, the current research not only created awareness of self-care for survivor mothers, but it also advanced knowledge that self-care strategies assist in the healing process of child sexual abuse. One can also speculate that the GT method of inviting participants to talk about what was meaningful to them facilitated empowerment and emancipatory knowledge.

### **Limitations of the Research**

There were several methodological limitations to the present study. The survivors who participated were self-selected; because the sample was not random, it was not representative of the larger population of mother survivors and their circumstances. Most of the women in the present study were of First Nations background with low socioeconomic status, residing in a care facility such as an addictions treatment centre, and often had children in care by Child and Family Services or other persons. Given these characteristics, it was possible that the process of healing from past CSA for these women may have differed from the healing process of other survivor mothers who were not facing these challenges. This limitation can be addressed by more theoretical sampling in future research, such as including women who do not have their children in Child and Family Services care, or those survivor mothers not living in poverty. Broader sampling may reveal different pertinent issues for this population, thereby enhancing both transferability and validity of the present findings. Another related sampling limitation concerns bounded data collection (Glaser, 1998, p. 85), meaning that there was a lack of comparative groups which limited theoretical sampling and the constant comparative method. Sampling from other population groups

(e.g., other survivor groups such as cancer survivors or survivors of personal crime) may have provided additional, unique data for comparison. Given the characteristics of the present sample of women and the lack of a comparison group, caution must be applied when drawing conclusions about the relevance of the healing process to other groups of women.

The study was also limited by its small sample size, and by the fact that all the women who wanted to tell their story had prior counseling experience. The knowledge and insight of these women into the effects of their incest and self-care has undoubtedly been influenced by their counselling experiences. It would be useful in future studies to examine incest survivor mothers with no formal counselling experience and/or use a comparison group of non-CSA survivor mothers. In addition, the perspective of male CSA survivor fathers was not addressed. While it was beyond the scope of the present research to include father survivors, their perspective would be a valuable addition to the grounded theory process and also enhance the transferability and validity of the present findings.

Research participants were paid an honorarium for their time. This raised the possibility of properlined data (Glaser, 1998), where participants tell the researcher what they want to hear. Other potential biases, such as the influence of conditions co-existing with the long term effects of CSA including physical health concerns or disabilities, may have also exerted effects on mothers' self-care practices and their ability to heal. Finally, women were screened based on their self-reported history of CSA in the family, however, other characteristics of their early family environments were not measured. Research has increasingly shown that adverse family environments (e.g., substance abuse, intimate partner violence, sibling abuse) may also help explain variation in survivor's healing (Martsof & Burke Draucker, 2008). Despite these limitations, rigorous adherence to classic GT method in the present study produced a conceptual framework

anchored in data which tapped into a coherent pattern of behaviour present in the lives of childhood sexual abuse survivors. The current study made a significant contribution to the literature by highlighting relevant areas for future research as well as important implications for practitioners of treatment and prevention programs.

### **Research Implications**

The findings of the present research suggest that the basic social process of “reconstituting a damaged self” may have broader application than for CSA survivors alone. In fact, this process may also apply to other forms of abuse, trauma or chronic conditions. The literature concerning “remaking selves” raises provocative questions about the usefulness and applicability of the current findings to these other contexts.

Brison’s (2002) discussion of her loss of identity and journey towards remaking a new self following a sexual assault and near death experience revealed similar characteristics to the stages of the basic social process uncovered in the present study. Seventeen years following her trauma Brison (2008) wrote “I have regained my lost self” (p. 195). Her words resonated with the final stage of authenticating and returning to self. Similar to “reconstituting a damaged self” in the present study, Brison (2002) discussed her healing as “piecing together a shattered self” (p. x). The present study’s stage of emotional de-paining along with the concepts *cleansing*, and telling one’s story strongly corresponds to Brison’s (2008) following comment,

Now, because I have worked through the trauma, whatever narrative repetition I engage in is consciously chosen. It is far removed from the early compulsion I felt to say at least something about the assault to everyone I knew - and even to people I'd just met - before I could carry on a conversation about anything else. (Brison, 2008, p. 196)

Similarly, Oke's research (2008) on survival, recovery and remaking of self illustrated how survivors

attempt to remake themselves following intimate partner violence. Her concept of *breaking down and breaking through*, experienced by most women in her study, was similar to the present study's stages of safetying and authenticating and returning to self where women find new meanings in their lives and begin recovery. In Oke's study, loss of self was influenced by conditions of anxiety, depression, self-blame, and turning points. Similar to the crisis point in the present study, these involved imminent danger, desperate states and contemplating suicide.

Interesting research by Seymour (1998) revealed how people build and reconstitute their lives following a major personal disaster. Focussing specifically on persons with paralyzed bodies she discussed processes involved in remaking the body. Her work revealed how societal pressures and rigid social categories influence and limit a person's ability to reconstitute themselves. For example, Seymour discussed how women who have experienced sexual victimization may struggle with trying to reconstitute oneself given the social constructions of sexuality female.

This body of illuminating research prompts the question of the application of the current findings to others who have survived traumas or who are faced with tragedy or loss. Research needs to investigate whether "reconstituting a damaged self" is a basic social process that could be applied to victims of personal crimes (e.g., robberies, house burglaries, sexual assault) - those surviving a car crash, struggling with cancer, those who are residential school survivors, and war veterans. Future research needs to explore how self-care and this process may apply to these survivors' lives.

To some degree, every person has had experiences which leave lasting pain, and require a process of healing, rebuilding, or resolution to bring the person back to a sense of wellness, wholeness, and health. In addition to childhood sexual abuse, "reconstituting a damaged self" may be applicable to persons ending long-term relationships, experiencing single parenthood, or the

death of a spouse. Research exploring the third stage of the process (i.e., authenticating and returning to the self) may be particularly relevant in explaining the process of how they attempt to reconstruct their lives and their self-identity without a life partner.

Future research should extend the scope of the basic social process revealed by the present research to generate a more complete, formal ground theory (Glaser, 1996; 2007). The goal of formal grounded theory is to "extend conceptually the general implications of the core category" (2007, p. 115) which fills in gaps of the theory and raises its explanatory power. Knowledge is cumulative and developing a formal GT builds on and extends existing knowledge about this important substantive area.

"Reconstituting a damaged self" may serve as a buffer between one's abuse and one's parenting. Mothers expressed how their self-care efforts and therapy increased their self-efficacy in parenting. All of the mothers expressed that engaging in emotional de-paining, safetying, and strengthening efforts made them better able to function as women, and as caregivers to their children. Future research is necessary to assess whether parenting continues to be manageable over time, with experience, and with healing. Given the large variation in the long-term functioning of CSA survivors, and the fact that not all survivors experience negative long-term effects (Finkelhor, 1990), further research is needed to examine resilience among survivor mothers. Specifically, the identification of intervening factors (e.g., the support of family or extended relationships) that facilitate and support movement to the strengthening stage would be of clinical benefit. In addition, future studies should investigate how effectively survivors are able to cope with their abuse-related distress through emotional-de-paining, given that some remain cycling in this stage for many years. It is also important to consider other processes which enable survivors of childhood sexual abuse, and survivor mothers specifically, to strengthen themselves and build

resilience. Research in this area would be useful for clinical intervention or prevention programs.

Men with histories of CSA have been neglected in research, yet some studies have reported prevalence rates as high as 4.8% (Canada), 7.5% (United States) and 60.9% (South Africa) (Pereda et al., 2009). We know even less about the experience of incest survivor fathers. Questions about how incest fathers' experiences have affected their self-care and their parenting, as well as if they, too, experience "reconstituting a damaged self" remains to be asked. With the growing awareness of male children as victims of sexual abuse, the future exploration of this topic is vital.

Finally, future research must acknowledge the complexity of the healing process of trauma survivors by examining more than a single time point. Future longitudinal qualitative research designs would be better suited to capture change in women's health and self-care as it occurs over time, rather than retrospectively as in the present study. Repeated measurement of self-care behaviours using creative methods such as photovoice may also provide clinical benefit, as awareness of healthier lifestyles may be enhanced.

### **Practice Implications**

The findings from this interdisciplinary research are relevant to health care professions. The results of the current research provide community health care providers, and researchers with valuable information for understanding both the strengths and areas of need for survivor mothers. Health professionals and clinicians may also be interested in "reconstituting a damaged self" as a more general process with implications for other trauma survivors, and for those in different types of recovery from common chronic conditions. This basic social process holds important implications for treatment of trauma survivors as it provides broad guidelines for addressing the various symptoms that may present in therapy. For example, identification of the three stages (emotional

de-paining, safetying, and authenticating and returning to self) and their related properties can guide therapy plans for therapists. Greater attention needs to be paid to the self-care of survivor mothers, not only for their own mental and physical well-being, but because their sense of wellness may contribute to their children's well-being, or risk and vulnerabilities.

It is important to note that while many women in the present study found counselling helpful, healing efforts were not restricted to formal therapy. Healing was demonstrated to have a rich and broader meaning through spiritual and emotional activities, empowerment, and cultural activity. The womens' photographs in the present study and the concept of spiritual connecting depicted themes of spiritual healing similar to Knapik, Martsolf and Draucker (2008) who interviewed male and female survivors of sexual violence. Survivors need to have access to multiple forms of informal and formal-based treatment models.

Attaining and continuing healthy supportive relationships are often not easy for CSA survivors. Hooper and Koprowska (2004) found that mother's friendship networks were limited by frequent moves from abusive partners, fear of leaving their home, lack of opportunity in childhood to develop social skills, or other effects from their abuse (lack of confidence, trust, and self-esteem). Not all of the women at the time of the interview were connected to a formal counselling system which included safe others. In some cases safe others were limited to favourite pets or one's children. Active healing is an important component of resiliency for survivors, yet, two survivors in the present study had difficulty finding persons they could trust during their healing. This finding was similar to others who found that not all survivors of trauma perceive the formal counselling relationship to be helpful (Bogar & Hulse-Killacky, 2006).

In the absence of survivors' ability to locate *safe others*, research needs to focus on spirituality and other forms of strengthening which lend themselves to self-care. Clinicians should

identify ways to facilitate connections between survivors and safe others. Broadening the clients' safety networks to those who can assist them and their children (e.g., instrumentally, financially, emotionally, and socially) may increase their strengthening efforts.

The present research also found that two women felt that their incest experience rendered some positive effects in their adult lives. This finding is consistent with others who found that survivors may indeed perceive some positive outcomes following their victimization experience (Draucker, 1992b). Draucker revealed that when incest survivors were asked how they adapted to the incest experience nearly 50 percent reported at least one positive outcome relating to four themes: (1) increased ability to relate to other victims, (2) increased understanding in the causes of abusive behavior, (3) an increased sense of personal strength, and (4) an increased self-awareness. These findings are important for clinicians working with incest survivor mothers in order to validate their experiences.

Mothers in treatment centres for substance addictions often have to separate themselves from their children temporarily during treatment or permanently, after losing custody. Mothering, however, remains critical in their healing. Findings from the current study show how mothers had powerful bonds with their children and that, even though they were often not present, their children played a facilitative role on their mother's healing and ongoing strength through emotional linking and lightening and through the research methodology itself (e.g., use of photovoice).

While several mothers felt that being in the therapeutic environment away from their children was similar to a vacation away from their chaotic lives, the parent-child bond remained strong and was a vital facilitator in their strengthening efforts, motivation to get healthier, and resilience. Increased awareness of this issue is necessary for professionals advocating for and working with this population. Survivor mothers identified key strategies for maintaining the parent-

child bond. The strategies (as exemplified by *emotional linking*) may be useful in education in the context of parent-child separation, and in parent-child reunification efforts. The surprising finding that the use of cameras and visual methods bridged mothers separated from their young children, points to cameras as potentially powerful therapeutic tools.

Finally, we need to keep the political context of incest in the foreground. “Reconstituting a damaged self” helps to highlight the fact that incest is part of a larger problem of gendered violence against women. Without confronting the constraining social structures and barriers to women’s rights to safety, research alone will be insufficient. Family violence is a social problem, not an individual one. Stable funding is necessary for women’s shelters and transition homes to support their (and their children’s) healing efforts. Research exploring systemic and contextual factors that hinder opportunities for self-care and healing is needed. While women weren’t directly asked if their children had been abused, some of the women revealed that they had. Others felt tremendous guilt over their children witnessing violence towards the mother. Research needs to examine factors such as the mother’s lack of power to protect her children in and out of her home, and the father’s control over the family including physical and/or sexual violence towards the mother that may account for the occurrence of violence towards the children. Longitudinal research tracking these women before counselling, and perhaps during their initial pregnancy, bearing in mind contextual factors, could help reveal what their early parenting experience was like and the possible risk factors associated with their children being abused. Children should be made a priority and funding should support reuniting mothers with their children and providing the infrastructure needed to support single survivor mothers in their self-care and healing journey.

## **Conclusion**

The present research identified a basic social process for systematically understanding the

self-care perceptions and practices of survivor mothers. A substantive grounded theory of “reconstituting a damaged self” was identified using both classic grounded theory and visual methods. This innovative methodology provided a creative and empowering complement to traditional language-based data collection methods, and reflected the collaborative and empowerment goals of the present study. It also allowed an empathetic understanding of the complexity of self-care in the healing process of CSA survivors to emerge. “Reconstituting a damaged self” was a non-linear process strongly influenced by social context as well as individual history.

While it was not a goal of the present study to investigate the entire recovery process, present findings do contribute to the literature on CSA survivors by emphasizing how the long-term effects of CSA impact parenting and self-care efforts in adulthood. The three stage basic social process advances both theoretical perspectives and empirical findings concerning the long-term effects of CSA and the healing process, particularly for mothers. “Reconstituting a damaged self” may be applicable to other forms of trauma and recovery, and future research should address these other pertinent areas. In conclusion, the present findings confirmed that listening to survivor mothers’ voices and acknowledging their resilience provided a unique perspective on the role of self-care in their recovery from childhood sexual abuse.

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## Tables

**Table 1 Mother and Family Demographic Characteristics**

Characteristic	Frequency
<b>Marital status</b>	
Single	4
Married	0
Living with significant other	0
Separated/Divorced	8
Widowed	1
Long-term relationship	1
<b>Education level completed</b>	
Up to 8 <sup>th</sup> grade	2
Some high school	4
High school graduate	3
Some College or technical diploma	2
College Graduate	1
Some University	0
University graduate	0
Masters degree or doctorate	2
<b>Employment status</b>	
Full-time	4
Receiving welfare assistance	7
Part-time student	1
Stay-at-home parent	1
Other	1
<b>Socioeconomic status</b>	
<\$10,000	6
\$10,000-20,000	2
\$21,000-30,000	2
\$31,000-40,000	0
\$41,000-50,000	2
\$51,000-75,000	0
>\$76,000	1

Table 1 cont' *Mother and Family Demographic Characteristics*

Characteristic	Frequency
Number of children	
1 to 2	4
3 to 4	6
5 to 6	4
Time spent in counselling	
Less than 1 month	1
1 to 6 months	3
6 to 12 months	1
12 to 24 months	1
>24 months	6
Occasional (e.g., informal, pastoral or religious-based)	2
Relationship to offender	
Biological Father	4
Stepfather	3
Brother	2
Grandfather	1
Stepsister	1
Uncle	3
Male cousin	2
Female Cousin	2
Other	7
Number of offenders	
One	6
Two	6
Three	1
Four	1

## **Appendices**

## Appendix 1 Recruitment Poster




# MOTHERS

## DO YOU TAKE TIME FOR YOURSELF?

Mothers are so busy caring for others  
What do they do to take care of themselves?

A female doctoral student at the University of Manitoba is doing a research project on how mothers nurture and care for themselves. The project uses interviews and photographs (which you take yourself) over a 2-3 week period.

Please call if you are:

-  A mother or stepmother of at least one child, and
-  Have a history of sexual abuse as a child or teen, and
-  Have had past or current abuse counselling

You will receive a gift card, your photographs, and a small photo album at the end of the study for your help. No experience taking pictures is necessary.

This research has been approved by the University of Manitoba. Please contact Christine at 474-XXXX or (email address) for more details

## Appendix 2 Agency Letter

Letterhead

Date

Dear Clinician:

I am a Ph.D. Student at the University of Manitoba and am conducting research for my dissertation. The purpose of my research is to examine ways survivor mothers of childhood sexual abuse take care of and nurture themselves. I am writing to ask for your agency's assistance in recruiting participants for my study.

As you are probably aware, there is an alarming prevalence of child sexual abuse in society and the extent of a survivor's long range suffering has been well studied. The effects of child sexual abuse on the self-care efforts of women survivors has not been studied. I am particularly interested in sexual abuse survivors who are now mothers themselves. The focus of this research is on how mothers who have experienced child sexual abuse take care of themselves. I am inviting mothers (of any age) who have been sexually abused as a child by male family member (not necessarily blood related) to participate in this study.

Women will be asked to use a disposable camera to take pictures of self-care in their lives. Two confidential meetings will take place between the mother and myself in private to answer questionnaires and discuss their photographs. A \$50 honorarium in the form of a gift card will be provided for their time, and childcare and bus fare costs will be reimbursed.

The protection and comfort of the women who agree to participate in this study is of utmost concern. Therefore, I am seeking only survivors with past or current counselling for their sexual abuse who you feel would be appropriate. I have enclosed a copy of approval from the Joint Faculty Research Ethics Board at the University of Manitoba.

**I would very much appreciate your assistance in recruiting women for this study by:**

1) Posting the enclosed recruitment poster on your bulletin board(s) which invites women to contact me directly, and/or 2) Passing this information on to your staff or directly to clients who you feel fit the study criteria.

I would also be pleased to provide an executive summary of the results of this study to you and your staff upon completion of the study. You can contact me or my thesis supervisor with any questions you have.

Thank you for your time.

Sincerely,

Christine Kreklewetz

Principal Investigator

Christine Kreklewetz M.Sc.

Ph.D Candidate, IIP

Department of Family Social Sciences

University of Manitoba

Supervising Professor

Caroline Piotrowski Ph.D.

Associate Professor

Department of Family Social Sciences

University of Manitoba

**Appendix 3 Ethics Approval Certificate**

11 May 2007

**TO:** C. M. Kreklewetz (Advisor C. Piotrowski)  
Principal Investigator

**FROM:** Wayne Taylor, Chair  
Joint-Faculty Research Ethics Board (JFREB)

**Re:** Protocol #J2007:039  
“The Experience and Meaning of Self-care in the Lives of Mother  
Survivors of Childhood Sexual Abuse”

Please be advised that your above-referenced protocol has received human ethics approval by the **Joint-Faculty Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

**Please note:**

- if you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to Kathryn Bartmanovich, Research Grants & Contract Services (fax 261-0325), including the Sponsor name, before your account can be opened.
- if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

### Appendix 4 Personal Data Questionnaire and Interview Guide

Please tell me about yourself and your family so I can describe the group of women who participated in this study. All of the answers you put down are private and confidential and they will not be shown to anyone else. There are no right or wrong answers.

#### Part 1 Demographic Data

1. How old are you? \_\_\_\_\_ years old

2. What is your relationship status?

- Single (Not in a relationship; not previously married)  
 Married  
 Living With Significant Other/Partner  
 Separated/Divorced  
 Widowed

3. Which of the following categories best describes your work status right now?

- |  |  |
|--|--|
| <input type="checkbox"/> full-time                       | <input type="checkbox"/> full-time student   |
| <input type="checkbox"/> part-time                       | <input type="checkbox"/> part-time student   |
| <input type="checkbox"/> unemployed and looking for work | <input type="checkbox"/> stay-at-home parent |
| <input type="checkbox"/> receiving welfare assistance    | <input type="checkbox"/> retired             |
| <input type="checkbox"/> leave of absence                | <input type="checkbox"/> other:              |

4. If you are married or living common-law, which of the following categories best describes your partner's work status now

- |  |  |
|--|--|
| <input type="checkbox"/> full-time                       | <input type="checkbox"/> full-time student   |
| <input type="checkbox"/> part-time                       | <input type="checkbox"/> part-time student   |
| <input type="checkbox"/> unemployed and looking for work | <input type="checkbox"/> stay-at-home parent |
| <input type="checkbox"/> receiving welfare assistance    | <input type="checkbox"/> retired             |
| <input type="checkbox"/> leave of absence                | <input type="checkbox"/> other:              |

5. What was your combined household income last year before taxes?

- |   |  |
|---|--|
| <input type="checkbox"/> Less than \$10,000   | <input type="checkbox"/> \$41,000 to \$50,000  |
| <input type="checkbox"/> \$10,000 to \$20,000 | <input type="checkbox"/> \$51,000 to \$75,000  |
| <input type="checkbox"/> \$21,000 to \$30,000 | <input type="checkbox"/> \$76,000 to \$100,000 |
| <input type="checkbox"/> \$31,000 to \$40,000 | <input type="checkbox"/> over \$100,000        |

6. How many people live in your home? Adults \_\_\_\_\_ Children \_\_\_\_\_

7. How many children do you have and what are their ages?

- |                            |        |           |                  |                 |                 |                  |
|----------------------------|--------|-----------|------------------|-----------------|-----------------|------------------|
| 1 <sup>st</sup> Child-Male | Female | Age _____ | Living with you? | Full time _____ | Part time _____ | Not at all _____ |
| 2nd Child-Male             | Female | Age _____ | Living with you? | Full time _____ | Part time _____ | Not at all _____ |
| 3rd Child-Male             | Female | Age _____ | Living with you? | Full time _____ | Part time _____ | Not at all _____ |
| 4th Child-Male             | Female | Age _____ | Living with you? | Full time _____ | Part time _____ | Not at all _____ |

8. What is the last grade you completed?

- Up to 8<sup>th</sup> grade  
 Some high school  
 High school graduate  
 Some College or technical diploma  
 College Graduate  
 Some University

- University graduate
- Masters degree or doctorate

11. Other than Canadian, to what cultural group(s) would you say that you belong?  
(e.g.: Chinese, Filipino, Ukrainian, French, Somali, Mexican, Pakistani, etc.)  
\_\_\_\_\_

12. Do you consider yourself a person of Aboriginal, Inuit or Métis descent?  Yes  No

13. Do you consider yourself to be disabled (i.e., limited in what you can do at home, at work or at school, because of a disability or chronic health problem)?  Yes  No

If yes: Briefly describe disability: \_\_\_\_\_

**Part 2 Sexual Abuse History Questions**

*This section may be more difficult for you to answer since it asks a few questions about your past abuse). Feel free to stop and take a break if you need to.*

Many different people can engage in sexual abuse. Please indicate the person(s) who sexually abused you before you were 18 years old.

Instructions: In the first column place a check next to the relationship you had with the person who sexually abused you. Check as many as necessary. In the next columns, please indicate whether the sexual abuse occurred one time or many times.

		Once	Many Times
Biological Father (Blood relative)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biological Mother (Blood relative)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stepfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stepmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stepbrother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stepsister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Male cousin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Female Cousin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please Specify _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(For example, babysitter, priest, family friend etc.)			

2. If you are currently in counselling or have received counselling in the past, approximately how much time did you spend in counselling?

- Less than a month
- 1 to 6 months
- 6 to 12 months
- 12-24 months
- More than 24 months
- Occasional Informal, Pastoral, or Religious-based counselling

## Interview Guide

### Viewing Individual Photographs

1. Please tell me about your photograph
  - What is happening in your picture?
  - How often do you normally do this?
2. Why did you choose to take a picture of this?
  - What does this mean to you?
  - What does it say about caring for or nurturing yourself?
3. How easy or difficult is it for you to do this or make this happen in your life?
  - Are there things that make it harder for you to do this?
  - Are there things that make it easier for you to do this?
4. How do you feel during/after doing this?
5. How do you think doing this (or not doing this) affects you as a mother?
  - Affects your parenting? Why?
  - Affects your children? Why?

### Viewing the Photographs Together

1. Now that we have looked at all your pictures individually, what do you think about the pictures as a whole?
  - a.Prompt: What is your first impression of your pictures in looking at them all together?
  - b.Prompt: Is there anything that surprises you?
  - c.Prompt: If you could put it into just one sentence or phrase, what would you say about how you take care of yourself?
2. How does seeing them all together make you feel?
3. What made you choose these particular photographs to share today in the interview?

### Visualization Exercise (5 mins)

1. Draw or describe how the picture in your head is similar to, or different from your day-to-day lived experience
2. Can you think of anything you could do in your life right now to make that image come to life?

### Context Questions

1. Was there anything that you weren't able to capture - something you may have wanted to take a picture of but couldn't?

2. Was there anything you wondered about photographing but didn't after thinking about it?
3. Do you think that you would have taken different pictures if you were the only one to see the photographs?
4. Would you say that your beliefs about how important it is to take care of yourself have changed or remained the same over your life?
5. Would you say that your self-care practices have changed or remained the same over your life?
6. Do you feel that how you care for yourself has anything to do with/is influenced by your cultural practices or beliefs?
7. Do you see any connection between your past abuse history and how you nurture and take care of yourself as an adult?

### **Health and Well-being**

The next four questions are about your health.

1. How do you feel your overall physical health is?  
 Probe: Do you have any physical health-related problems or concerns?  
 Has it changed much over time? (Become better, remained the same, or become worse)  
 Has it changed much since you became a parent?
2. How do you feel your overall mental or emotional health is?  
 Probe: Do you have any mental health-related problems or concerns?  
 Has it changed much over time? Has it changed much since you became a parent?
3. What are the kinds of things that have contributed to your health and well-being over time?  
 In answering this question, think about types of services you need for your well-being, not just those provided by medical professionals.
4. What are the kinds of things made it difficult to maintain good mental or physical health and well-being over time?

### **How the Methodology Worked**

1. How did you find the research process in general? (Using the camera and taking the pictures) Prompts:  
 How easy was it to use the camera and take pictures?  
 What did you like or dislike the most?  
 What would you change to make it better?  
 How did others react to you taking pictures?

2. Would you recommend taking pictures for other mothers as a way of showing their self-care?

3. Was the time period in which you took pictures (2 weeks) *typical* or *normal* for you?

Prompt: Did anything out of the ordinary happen?

Prompt: Did anything happen that made the time period more pleasurable or more upsetting for you than usual?

### **Ending the Interview**

Sometimes people who are involved in research feel that it has changed the way they think or act in some way.

Has your participation in this research has changed your thinking or behaviour in any way?  
Is there anything that you want to ask or mention that we have not discussed?

Thank you very much for your time, help and cooperation and for sharing so much of yourself. There are **several** ways to access a summary of the research upon its completion: 1) have a summary mailed or emailed, 2) access in online on the family Social Sciences Web Site, 3) if you want more than a summary, to contact me directly. [*Sign honorarium form and provide the gift card*]

## Appendix 5 Participant Consent Form

[Letterhead Here]

Research Project Title: The Experience and Meaning of Self-Care in the Lives of Mother Survivors of Childhood Sexual Abuse (CSA)

Researcher: Christine Kreklewetz 474-XXXX  
Faculty Advisor: Dr. Caroline Piotrowski 474-XXXX

*This consent form, a copy of which will be left for you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what this research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.*

It has been explained to me that Christine Kreklewetz, a doctoral student at the University of Manitoba, is conducting a study exploring how mothers with a history of CSA nurture and take care of themselves. The information obtained in this research will be used for Ms. Kreklewetz's Ph.D. dissertation and to further research in the area stated above. Ms. Kreklewetz or her advisor, Dr. Caroline Piotrowski can be reached at the above telephone numbers if there are any questions or concerns at any time during this study.

I understand that I will be asked to take photographs with a disposable camera provided to me of the ways I care for and nurture myself. I will participate in an initial meeting (private or group depending on my choice) for 1 to 2 hours in a private agreed upon location. At this meeting I will receive some brief camera training and be asked to complete a demographic questionnaire. The questionnaire will take about 10 minutes to complete and the answers will be used to describe the group of mothers who participate in this study. At a second meeting, with the researcher only, I will share only photographs I am comfortable showing and discuss them. The second meeting will last between 1 to 2 hours.

I give my permission for the meetings to be tape recorded with the understanding that the recordings will be used solely to assist in analyzing the data and will later be destroyed. I understand that **all the information I provide will be completely confidential which means that my privacy will be protected.** I understand that recordings, transcripts, and other materials related to the research (e.g., photographs, notebook diaries) will be kept in locked offices of the University of Manitoba and my name will not be written or attached to any materials.

I understand that while the information gathered may be made public through the researcher's Ph.D. dissertation, academic journals or professional conferences, my name or other identifying information will not be revealed unless I give my consent. Further, I understand that only those images and citations connected to the photographs that are approved by me on the data release form will be used by the researcher in the dissertation, publications, and presentations. I understand that current laws require that information about abuse against children or persons in care must be reported to the authorities.

I understand that there will be no costs for me to participate in this study. If I choose to process my photographs myself I will be reimbursed upon presentation of a store receipt. As a token of appreciation for my time I will receive an honorarium of \$50 at the end of the second meeting in the form of a gift card from a choice of four local retailers. Once the research is completed I can request that a copy of the results will be sent to me by calling the contact numbers provided above.

I understand that I am free to withdraw from the study any time and/or refrain from answering any questions I prefer to omit, without prejudice or consequence.

My signature on this form indicates that I have understood to my satisfaction the information regarding participation in the research project and I agree to participate. In no way does this waive my legal rights or release the researcher or the University of Manitoba from her legal and professional responsibilities. My continued participation should be as informed as my initial consent, so I should feel free to ask for clarification or new information throughout my participation.

This research has been approved by the Joint-Faculty Research Ethics Board at the University of Manitoba. If I have any concerns or complaints about this project I can contact any of the above named persons or the Human Ethics Secretariat at 474-XXXX. A copy of this consent form has been given to me to keep for my records and reference.

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Participant's Signature

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Date

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Researcher's Signature

---

Date

## Appendix 6 Nancy's Story

### Nancy's Interview

Nancy (pseudonym) (42) described herself as a struggling, yet recovering addict. None of her four adult children lived with her and she remained single. In contrast to the street and rooming houses in which she had previously lived, she now lived in a safe structured environment where she could attend school and receive counselling. Her residence was monitored by cameras which initially bothered her, but she came to feel reassured about this increased safety measure for the residents.

Her apartment was a pleasantly decorated and neat apartment, which she later told me was in contrast to previously sleeping on the floors of dirty rooming homes where cobwebs replaced the current pictures on her walls. She said, "It is good to have your own things." We chatted about how she decorated from the Dollar store because she lived on a limited budget.

Nancy said that we needed to begin the interview with a traditional smudging ceremony (a ritual that many aboriginal women practice to cleanse themselves), which she began to do when she "got back to (her)self" and began reconnecting to her Aboriginal culture. Spirituality was very important to her, as smudging and sweatlodges cleansed all aspects of her being. Connecting to a higher power also gave her strength and made her to feel welcomed and loved by others.

Nancy lived in poverty. Several times she mentioned barely having enough money, and using second hand clothing stores, pawn shops, and food banks on a regular basis. At one point Nancy contacted me to ask if we could move the interview up. Her welfare cheque had not come in that day and she called me to see if I could give her the gift card to go get some food. She didn't have enough food for the weekend and was hungry.

Agencies were seen as a lifeline for gaining back control in her life. She said, “drugs really took control of my life...Anchorage really turned my life around. If it was not for Anchorage I’d probably be dead by now.” Nancy had entered a 5 month detoxification program which she described as having saved her life. She saw this as the first step in taking control back in her life after being on the street for over 15 years. She described herself as being “a working girl” six months before the interview. With less than a grade 8 education she lived on the street and described herself as a junkie who relied on heavy drug use and the sex trade for daily survival. She spoke of how her drug addiction to crack cocaine and other substances had taken control over her life. She showed me her “cashed out veins” that doctors in Emergency had difficulty accessing. She then showed me her various tattoos which covered the track marks. She felt that crack should be called “more” since it was so addictive. “It was like tentacles reaching out for me”. She recalled neglecting eating and caring for herself because her focus at that time was on earning enough money to support her habit. She felt bad since she had gained weight since she stopped the drugs. She spoke of several places she had lived during the previous years which allowed her to “take a break from the street” and clean herself up.

When I met her, Nancy had been in and out of prison for robbery, theft, assault, and drug related crimes. She spoke about being raped, beaten, and “left for dead at the side of a road.” She experienced a tragic loss of a baby to SIDS. She later had a tattoo placed on her neck in memory of her baby. She came from a history of violence and abuse by others as a child and later as an adult. Her uncle sexually abused her on a daily basis. Nancy was acquitted of attempted homicide to an abusive partner. With several suicide attempts and heavily medicated periods, she was on anti-depressants and struggling to stay clean. She experienced several health problems due to her prior lifestyle. She kept saying that she went through things that no one would even believe what

she had to do to survive. She had been receiving counselling for more than two years. How she took care of herself changed tremendously over time and she felt that all the things she went through only made her stronger.

She described a period of time in her life when she “hit rock bottom.” “My stomach was rumbling. I was hungry all the time. I was tired of making drug dealers rich. I was living in a slum lord rooming house. There was no heat. I was hungry, I was cold. I couldn’t do it anymore. Enough was enough. I wanted help, so I was ready.”

A difficult part of Nancy’s ongoing healing was that “I had to learn to love myself again.” In her healing journey (her words) she conveyed her new appreciation for life. She described how she began to see everything in life differently and more clearly, because her eyes are opened. She spoke about how she began to see so many different colours around her such as the green grass. She recalled feeling more than a little embarrassed when someone was watching her as she hugged a tree “because they look so beautiful”. Her enjoyment and taste in music changed from hard rock to romantic love songs. She felt more connected to the words than she had ever been in the past and found them meaningful. For the first time in her life she began to take frequent baths and buy pretty bath products for herself. Previously, she described herself being always dirty and never spending money on herself for beauty care products. She now liked to have bubble baths with candles and scented soaps. Even her perception of personal safety changed from one where, “I never used to back down” to feeling vulnerable and fearful for her personal safety when going out at night.

At the time of the interview Nancy had supports in her life. She enjoyed volunteering work at the residence and felt an emotional connection to people who came in from the street especially other sex-trade workers who came into the drop in centre. She saw other women like herself

“where I used to be.” She often helped and inspired others to take the journey towards healing. Through helping others she said she felt valued and needed.

She met with others who were still on the street in places such as coffee shops where she would counsel and encourage them to take the journey towards healing. She said that it made her feel good to help others in a similar situation that she had been in. She recognized that most of them were too high on crack (or “tweeked out” in her words) to meet at her home, recognizing her vulnerability. All the while she felt that the pull of the street was strong.

She got satisfaction from crocheting items for others, listening to music, and buying herself plants (several green leafed plants adorned the kitchen table next to her window). She valued the opportunity she had to continue her education and saw this as a big part of her healing and making positive changes in her life. She told of how she would even help wake her neighbor to attend classes and meetings in the mornings since the neighbor was having difficulty coming off of addictive substances. Her classroom was where she first saw the poster about the research study.

Nancy visualized herself receiving various pampering treatments at Giselle’s Skin Care Salon where she was “Having a Nancy Day”. She said, “ I take care of a lot of people. I’m too busy to care for myself.”

### **Nancy’s photographs**

Nancy discussed and gave permission to use 14 out of 19 photographs. They included buildings which she felt were safe places in her life and which she described as her safety net. She accessed these places for a meal, to get clean, obtain hygiene products, needle exchange, health care, and counselling. Others were of her counsellor, her classroom, and the food bank she visited regularly, a crochet project for a friend, her bathtub or “time out,” music discs, Robin’s Donuts, and street graffiti art in her neighborhood. In reflecting on her photos together she stated: “My new life.

My new way of living. It's all clean. It is all positive. There's no negativity. Changing for positive ways. There was never no hope."

## Appendix 7 Telephone Screening

Hello, my name is Christine and I'm returning your call about the "Mothers taking care of themselves" research study. Thank you for calling. Can you tell me how you heard about the study?

I'm a PhD student, this research is being supervised by a professor at the University of Manitoba and has been approved by an ethics committee. We are looking for some very specific women to be in this study so I need to first ask you some questions to find out if you are who we are looking for:

1. Have you ever experienced sexual abuse by a male family member (not necessarily blood related) as a child or as a teen?
2. Are you a mother?
3. Have you received any counselling for your abuse? (Names are not needed, just their position) How long ago was this?

*If not currently in counselling, I need to caution you that your involvement in this study may bring up material that is upsetting to you. Therefore, it might not be in your best interest to participate in the study without currently being in counselling or having several supports in your life.*

*Positive Screening:* Your answers suggest that your background falls within the guidelines for the study. Would you like me to tell you a bit more about the study? It will take about five more minutes. Do you have a few minutes right now?

*Negative Screening:* Unfortunately, your answers suggest that your background does not fall within the selection guidelines for the study. I want to thank you for interest in this study. [Explore the mother's motivation for being a part of the study and refer her accordingly to appropriate resources]

### Description of Study

I am a mother myself, and I know how busy life gets bringing up kids. Often, we barely have time for ourselves. In this study I am interested in finding out all the ways in which mothers with a history of CSA nurture and care for themselves. While there are just a few questions about your past abuse, the focus is not on your abuse history, but rather on how you care for yourself now.

In this study you be asked to fill out one questionnaire telling some basic information about yourself. I will provide you with a disposable camera and ask you to take pictures over two weeks describing self-care in your life. Have you used a camera before? No experience taking pictures is necessary as we will spend some time practicing and getting used to the camera. I will develop the pictures and then we will meet to talk about them. Your involvement in the study will mean that we will need to meet two times. You can choose whether you want to meet in a small group with other women who are survivor mothers at the first meeting for some brief camera training and to complete a questionnaire, or meet with me individually.

The first meeting will take about 1 hour at a place we agree on and where you feel comfortable. We will talk about important things to consider in taking pictures and provide you with some training on using the camera. I will ask you to complete a questionnaire about your background and we will practice with the camera with until you are comfortable using it.

You will be asked to take pictures over the course of two weeks showing ways you nurture and care for yourself. If you like, I will also leave a notebook with you to write some brief notes about your the pictures, questions or thoughts and feelings during the study. I will leave a stamped envelope for you to mail the camera back to me so I can develop the photographs and have them ready for the second time we meet. Alternatively, you can develop the pictures yourself and be reimbursed by providing a receipt.

### **Second Meeting**

The second meeting should last between 1 and 2 hours. At this meeting I will bring your printed photographs and we will discuss them together in private, or in a group if you prefer. I will need to audiotape our discussion with your permission to help me later when writing my thesis.

Your participation is completely confidential. This means that no one else will see your pictures without your permission, and what you say to me will not be shared with anyone else. Anything I write in my thesis either talks about the group of women as whole or protects your identity by changing your name or anything else that can identify you.

- I will be available by telephone or email for any questions or problems.
- You will not be judged for the quality or images of the photographs.
- You can choose not to answer a particular question, stop the interview, or withdraw from the study at any time.
- I will make a second set of copies of your photos for you to keep.
- I will need to tape record our discussions so that I can accurately capture and remember what you say. No one else will listen to the recording and after the study is completed, the recordings will be destroyed.
- No one else will see your pictures without your permission first (aside from the photo development studio).
- Finally, you will receive an honorarium of \$50 in the form of a gift card from a choice of four local retailers as a thank you for all of your time and help.

Do you have any questions?

Does this sound like something you'd be interested in participating in?

- If YES - What would be a good time for us to arrange to meet?
- If NO- Would you like some time to think about it? Thank you for your time and interest. (Provide phone number to supervisor if requested.)

**Appendix 8 Substantive Codes from Fieldnote Analysis Interview M4**

92 Codes

Acting out- incarcerations	From grey to colour	Pulling her
Addiction	Gaining weight	Reawakening
Alone with self	Giving	Reemerging
Appreciating	Grieving	Renewed caution
Attempts at undoing the damage	Growth	Re-sensing
Beautifying	Healing	Returning to self
Caring for self	Healing persons and places	Ritualizing
Changing	Home	Safe connecting
Child loss	Hungry	Safe environments
Cleansing	In control	Safe haven
Connecting	Ingesting	Seeing in color
Connecting to others' pain	Insecurity	Self-accepting
Counselling others	Insulating	Self-defense
Covering	Losing control	Self-harm
Cutting point	Losing weight	Self-respecting
Danger	Lost childhood	Smoking
De-harming	Naturing	Spending money on self
Desperation	Need to feel loved	Spiritual cleansing
Drugs	Neglecting self-care needs	Spirituality
Elevated self above her addiction	Nervous going out-unsafe	Starving
Emerging hope	Numbing	Story-talking as healing
Emotional linking	Nurturing	Stress relief
Enabling	Optimism.	Struggling for safety
Expelling her story	Pampering	Suicide
Facilitator of others healing (other-focussing)	Perceived loss of childhood	Supporting others
Fearing own death	Personal cleansing	Surviving
Feeling dirty	Personal pride	Tattoo branding
Feeling ugly	Polishing a previously tarnished self	Undoing
Fractured family ties	Poverty	Violence by partner
	Private space	Wanting acceptance
	Protecting	Wanting love

### Appendix 9 Codes and Memoing Examples

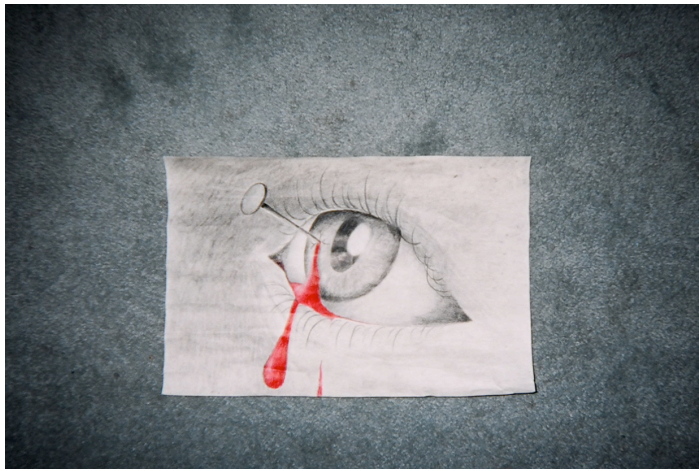
The table below lists eight examples of memos (out of more than fifty) which were used to generate the categories for Safe havens, Safe others, and Insulative detaching in the second stage of the theory


Memo #	
132	Code: Securing safe spaces M4 It was important for her to feel welcomed, loved, and accepted. She described her local food bank as welcoming and loving. "They even pray for you" she said. Perhaps this is a similar need for the women in the transition house with their children (to feel loved).
335	Code: Safe others M11 Having safe others by their side enables survivors to become stronger and thrive. Safe others allow them to see what can be beyond what is. Her boyfriend allowed her to see what she could have: a home away from bad influences, stability for her and her kids, no drinking/drugs
94	Code: Connecting with Healing Persons and Places M4 As part of the stage of safetying and moving towards strengthening. Agencies were seen as a lifeline towards gaining back control in her life (safetying). Many of the women experienced great loss of control of her life due to drugs and addictions. Connecting with agencies (self-focussing) were first attempts to regain control over their lives and in some cases saved their lives. "Anchorage really turned my life around. If it was not for Anchorage I'd probably be dead by now." Drugs really took control of my life, I was really messed up". Self-care comes in the form of the survivor identifying safe places and spaces. Identifying safe people to call upon to help in their healing
73	Codes: Treatment; Catching the moment [in vivo code] M8 She finds herself more relaxed now, not getting overwhelmed, feeling free, "a vacation to concentrate on myself". "Being in treatment is almost like a vacation. I'm in the midst of things, yet not in the midst of life. I know I need this. My healing is in a way, a vacation, and I think that's okay." Being in treatment gives them permission for moment grabbing, silencing and self-care.
415	Code: Safe Connecting with animals M2 Safe relationships developed between survivors and animals once their children were no longer there. Some women spoke about few close intimate relationships with others. Many mentioned one close friend or partner or counsellor. ...For other women, safe nurturing connections were provided by a favorite pet which were considered family and influenced who the women let into their lives. "For me [long pause] she's my family." If her dog didn't like the man she was dating, she thought twice about seeing him again. Animals as a safer source of nurturing than people in her life.

Memo #	
416	<p>Code: Giving and receiving love M2</p> <p>Favorite animals, rather than people sometimes occupy a special place in the lives of survivors. The reciprocal relationship provides safety (safelying) and security (strengthening) "In my nurturing and caring for [dog' name], she cares for me."</p>
151	<p>Code: Limited self-sharing M1</p> <p>Her photo of a restaurant represented going out for dinner with friends. She was in the midst of close friends yet never says much. "I think I'd rather be listening. I'm not really that outspoken. It will come eventually, but for the most part, I just like to listen. I just like to listen. It's just being able to listen to other people. To be able to be quiet and listen to what they want to say." Listening is more comfortable for her. Hearing what others have to say is less risky than sharing. Is this about a particular form of safe connecting when you hold part of yourself back? Is this an attempt to keep others at a safe distance? It is a component of creating safe intimacy with others and safelying self. Safe activities- watching movies with roommate every night distracted from having to share- outward focused. This is about being in the presence of others (connecting) but withdrawing simultaneously through limited sharing of self</p>
179	<p>Code: Safe Relating M3</p> <p>Detaching self from others</p> <p>In the first meeting she spoke for a long time (expelling) about her relationships with others where she would "Pull with one hand and push with another" (to "preserve" herself -her words) "I'm not able to give 1000%. There's a part of me I need to keep to keep myself safe." Protection from others is the overall concern here. She keeps part of herself back. She later spoke about how this kind of safe relating was a barrier for her to develop intimacy with her partner and children.</p>

**Appendix 10 Fieldnotes and Open Coding Excerpts**

Excerpts of fieldnotes and open coding from Interview M3 presented at the first GT seminar (Grounded Theory Institute, New York, October 2007)

Fieldnotes	
<p>She showed a painting she had recently done, then she showed a photograph of a drawing she did at age 19. (See below) She then spoke about how she used to draw whatever she felt. "This one is 'drawing away the pain'. She said, "My eyes have seen something that should have never have been seen. The stain was mine forever." I drew away the pain. That was so damn satisfying to draw because it hit it right on the way I felt ugly". She "got away" from drawing what she wanted and began drawing what others wanted (wedding portraits) She now feels a strong desire to return to painting what she wants, and painting in color. "Everything I did was black and white. Now I want to paint bright colour."</p>	<p>Self-expression of her pain                      Drawing/Creating                      Resisting then following her heart                      Ugly                      Forgotten self                      Returning                      New colored view of the world</p>
	<p>Photo Caption:                      "Drawing away the pain"</p>

Fieldnotes	
<p>Discussing her photograph of a tailored wool casual jacket entitled "Wrapped In A Blanket" (See below)</p> <p>At about 47 she changed from wanting to dress up and be attractive to men to not caring as much. She still wanted to be stylish with some self-respect. This was reflected in her sewing comfortably stylish garments</p> <p>She went back to things she felt comfortable in and said she "really lost sight of that stuff". Couldn't believe she could forget that. "It is like I buried myself for awhile and didn't see that I'd let everything go." Now she wants to sew comfortable fleece blazers wrapped up like a blanket. "I want style, but my way. I want to design my own clothes". Can't wear regular clothes where I work, it is too cold. I liked myself that way, warm and comfortable.</p> <p>"Sewing is something else I want to try because its another side of creativity. At this age, it is starting to come out fierce. I think I filed it for awhile."</p>	<p>Resisting Valuing Self-respect Loss of self Loss of past interests Covering self Taking back control Growth in self-acceptance Needing Comfort Self-acceptance Taking back self-interests Creating Neglected self</p>
 A photograph showing a white sewing machine on a white table. To the right of the table is a red mannequin wearing a red jacket. The scene is set in a room with a white wall and a wooden floor.	<p>Photo Caption: "Wrapped in a Blanket"</p>

## **Appendix 11 Evolving Memoing**

Examples of the emerging concepts of insulating, reconnecting and burying. The later memo on insulating demonstrates a greater conceptual richness about the concept by beginning to identify its indicators and conditions.

### **Early memos presented at GT Seminar, New York, October, 2007**

#### **Insulation Memo M3-14**

Insulation encompasses a sense of self-protection, which may be similar to covering self. It reduces social and emotional connectedness to other people.

#### **Insulation Memo M3-11**

Insulation may reduce the intensity of emotions – this is similar to code of calmness and emotion regulation which came up many times (M1, M2). Insulation, thus seems to help regulate emotions and foster a safe sense of belonging when one is with others but still wishes to remain at a distance emotionally.

#### **Reconnecting Memo M3-17**

Are reconnecting to self and reclaiming self the same?

Similar to reemerging as a butterfly. She reconnects to who she was and begins to like herself more.

#### **Burying Memo M2-3**

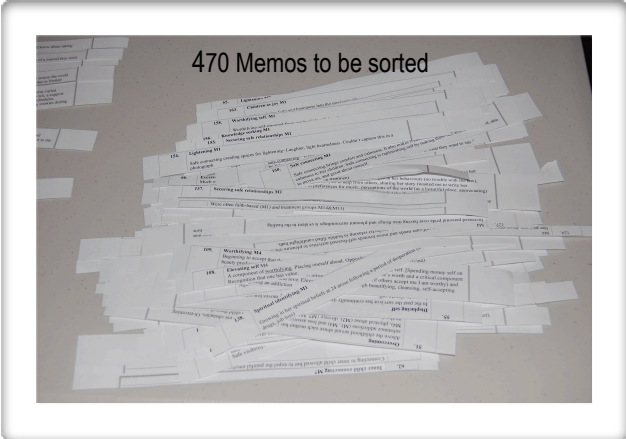
Burying self seems similar to covering and insulating oneself (for protection against something?)

### **Later memo about insulating presented at GT Seminar, Mill Valley, May, 2008**

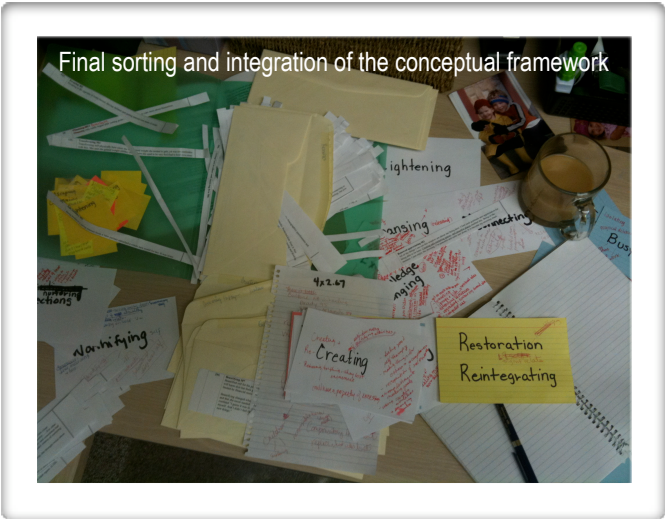
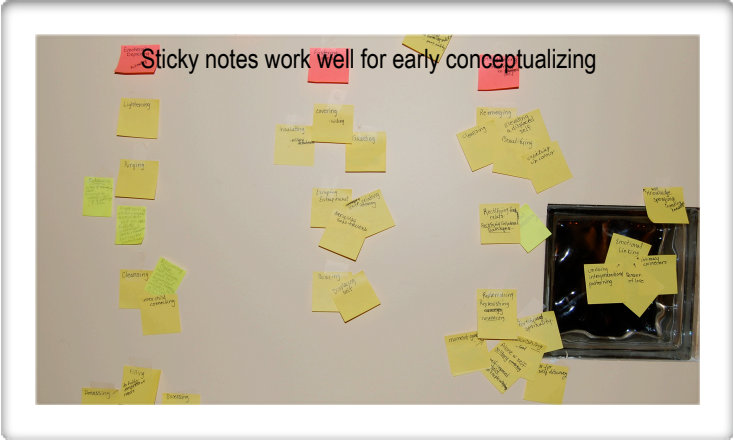
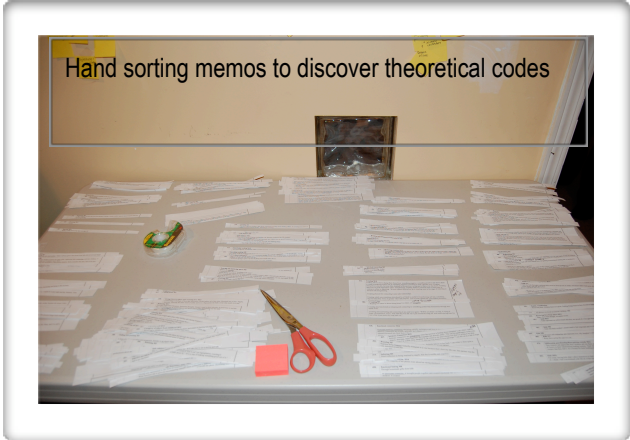
#### **Insulating Memo (05/05/08)**

Women insulated themselves in a variety of ways for the purposes of covering and protecting themselves during times of worry, stress, and threat. Forms of insulating are putting up a psychic wall (to protect the mind) or a form of barrier or shield, such as clothing or a blanket (to protect the body) from physical or psychic injury. Covering oneself (whether it be through layers of body fat) reduces harm to the person with the layers of padding (in this case, unwanted sexual attention). It separates the woman from others and keeps things from penetrating the person.

Appendix 12 Methods and GT Analysis Process



**Appendix 12 cont. Methods and GT Analysis Process**



### Appendix 13 Women's Reactions to the Research Process

"Aside from being a bit nervous about the questions and the unknown I think it has made me more aware that I'm doing alright. The things that happened long ago don't bother me like they did. I've been kinda set free. That's what's been revealed to me- I'm O.K. with it".

"I really began to think about what I did in my life. I thought, what is it that I need to do for myself here in my life? Because so much of my life is other-focused...It was quite shocking because I began to realize that I haven't done anything very self-focused for a long time. It does become like a terminal disease to you."

"It was a remarkable experience...The project really allowed a creative way for me to begin to really look at what had gone amiss in my life...And whatever else happens in this for me, whether I die tomorrow or not, people will come and see those pictures and they will know that I loved them, and that's what its all about in the end".

"I thought that it was a great way to capture those special moments because they are now for me, a part of that journey and I get to keep the pictures and the stories behind them. It was very effective".

[An email sent following the interview]:

"I commend you on the process – photos, captions and reflections followed by discussion – very meaningful and lasting. The little red notebook is not only being used, it is a symbol of my continuous learning journey and this time focussing on an area that I may not have been paying attention to – the relationship between my childhood experiences and my self-care as an adult and with corresponding pictures and captions - revealing."

"It changed my thinking in making me more aware of the things I do for self-care. I wouldn't have named it as self-care, it was just my time. Self-care now means this and when I do these special things I'm naming it self-care and it kind of feels good in a way".

"Absolutely. I liked this visual approach. I think that's important".

"It was good. It actually made me think about what I can do to care for myself. I've never really thought about that, and I was thinking really hard about what I can do. It made me think about what things are important in my life and I never really had the time or anything to just sit down and think about me".

[Combining photovoice methods with an interview] "It's the picture, and then the words fill in the gaps. That's just so much more".

### Appendix 14 Examples of the GT Concept Lightening



Fun and laughter builds moments of nurturing.

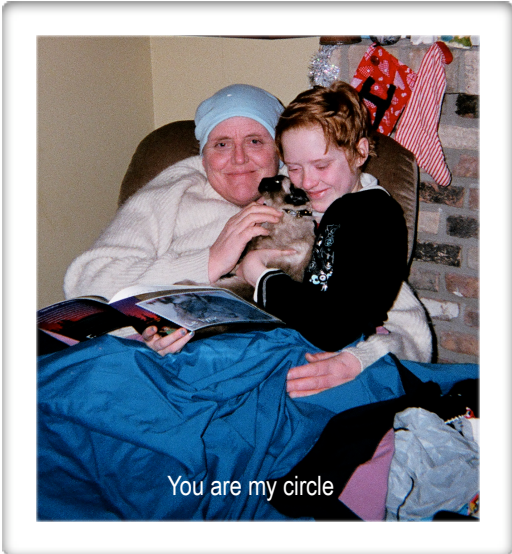
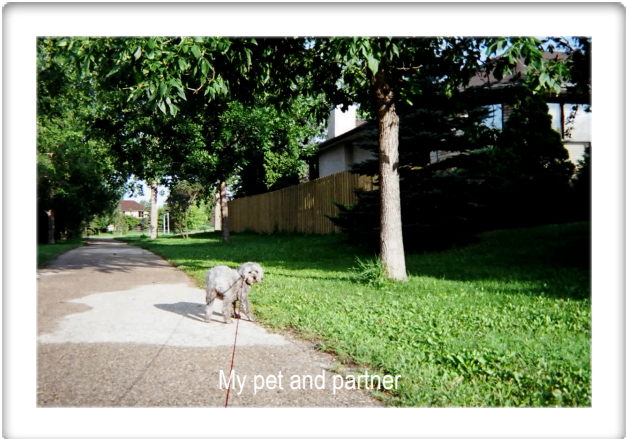


Makeover- just being silly. My daughter did my face and I just let her.

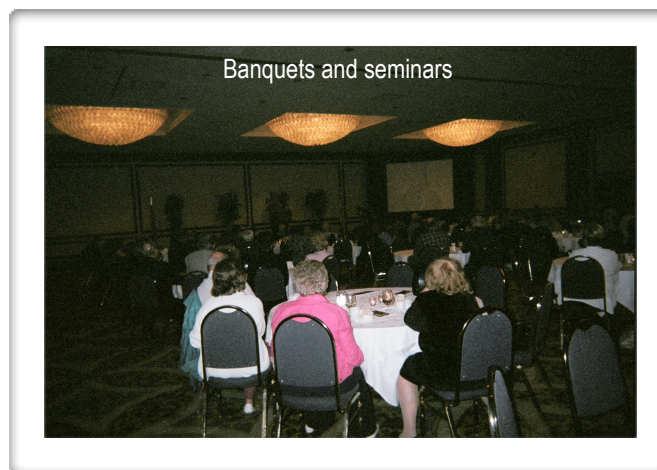
Appendix 15 Examples of the GT Concept Excessing



Appendix 16 Examples of the GT Concepts Safe Havens and Safe Others



**Appendix 17 Example of the GT Concept Spiritual Connecting**



Appendix 18 Examples of the GT Concept Emotional Linking

