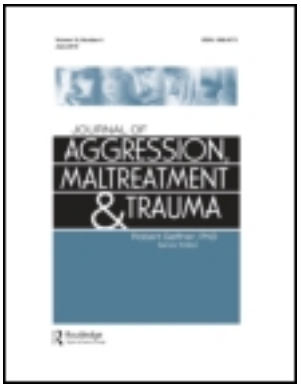

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Childhood Psychological Maltreatment and Perception of Self, Others, and Relationships: A Phenomenological Exploration

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EFFECTS OF CHILDHOOD MALTREATMENT

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

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Interpretative phenomenological analysis was used to investigate perception of self, others, and relationships in adults with a history of psychological maltreatment during childhood. Six participants from a low-cost counseling agency completed a semistructured interview. Four superordinate themes emerged: (a) shame-based perception of self, (b) self-protection from emotional pain, (c) limited awareness of others, and (d) shame-based roles in relationships. Psychological maltreatment has pervasive and deleterious consequences for self-worth, perception of others, and interpersonal functioning.

KEYWORDS interpretative phenomenological analysis, psychological maltreatment, shame

Psychological maltreatment (PM; Crawford & Wright, 2007; DeRobertis, 2004) refers to chronic childhood familial relationship dynamics that has been described as emotional abuse, emotional neglect (Brock, Pearlman, & Varra, 2006; Spertus, Yehuda, Wong, Halligan, & Seremetis, 2003), verbal

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aggression (Vissing, Straus, Gelles, & Harrop, 1991), psychological abuse (Ferguson & Dacey, 1997), and emotional maltreatment (Wright, Crawford, & Del Castillo, 2009). It includes acts of commission (abuse) and omission (neglect; Hart & Brassard, 1987; Hart, Brassard, Binggeli, & Davidson, 2002). The American Professional Society on the Abuse of Children (1995) defined PM as "a repeated pattern of caregiver behavior or extreme incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or of value only in meeting another's needs" (p. 2; see also Glaser, 2002). PM includes spurning, terrorizing, exploiting, corrupting, denying emotional responsiveness, isolating, and mental, health, medical, or educational neglect (Hart, Binggeli, & Brassard, 1998).

Despite gender differences in the prevalence of sexual and physical abuse (Brock et al., 2006; Gibb et al., 2001; Higgins & McCabe, 2003), no gender differences are evident for PM (Grassi-Oliveira & Stein, 2008; Wright et al., 2009). T Hart and Brassard (1987) argued that PM is a stand-alone form of maltreatment and the core of all forms of childhood maltreatment. Wright et al. (2009) suggested that PM might be among the most pervasive forms of childhood maltreatment as well as among the most destructive. Other researchers have argued that PM could be more detrimental to subsequent functioning than physical or sexual abuse (Ney, Moore, McPhee, & Trought, 1986; Vissing et al., 1991). PM has been associated with a wide range of adverse outcomes, including dissociation (Ferguson & Dacey, 1997), anxiety (Higgins & McCabe, 2003; Martsolf, Draucker, & Chapman, 2004; Spertus et al., 2003), depression (Higgins & McCabe, 2003; Martsolf et al., 2004; Spertus et al., 2003), perpetration and victimization in adult interpersonal aggression (Crawford & Wright, 2007), alexthymia (Goldsmith & Freyd, 2005; Hund & Espelage, 2006), emotional distress (Grassi-Oliveira & Stein, 2008), low self-worth (Brock et al., 2006), suicidal ideation and hopelessness (Gibb et al., 2001), increased posttraumatic stress symptomatology (Grassi-Oliveira & Stein, 2006; Spertus et al., 2003), and disordered eating (Hund & Espelage, 2006). Yet, PM is a neglected field of study relative to other forms of childhood maltreatment (Behl, Conyngham, & May, 2003).

PERCEPTION OF SELF

A child's internalization of parental experiences and messages provides the foundation for self-perception (Eisenberg, Cumberland, & Spinrad, 1998; Shipman, Zeman, Nesin, & Fitzgerald, 2003). Internalization of messages of contempt, rejection, and disapproval results in intense self-derogatory ideations (Harter, 1999) and global, stable, internal, negative self-attributions (Crawford & Wright, 2007; Sachs-Ericsson, Verona, Joiner, & Preacher, 2006). These children might perceive themselves as unacceptable, inferior (Harter, 1999), a failure (Lumley & Harkness, 2007), or unworthy of love (Feiring,

2005). PM has also been associated with the belief that the individual is vulnerable to harm but unable to prevent it (Lumley & Harkness, 2007; Wright et al., 2009), possibly underlying a sense of helplessness (Gibb, 2002; Hankin, 2005) and powerlessness (Herman, 1992). Powerlessness becomes a salient part of the individual's self-identity (Wolfe, Jaffe, & Jette, 2003).

Individuals with a history of PM manifest low self-worth (Brock et al., 2006; Mullen, Martin, Anderson, Romans, & Herbison, 1996). This is the most commonly recognized outcome of PM (Mullen et al., 1996; Varia, Abidin, & Dass, 1996). The global sense of low self-worth extends to a sense of "inner badness," that the core self is somehow rotten (Harter, 1999). Negative self-perceptions are commonly associated with shame (Harter, 1999). Individuals with shame-based representations might perceive themselves as chronically helpless, powerless, worthless, and incompetent (Harper, Austin, Cercone, & Arias, 2005). In college students, Wright et al. (2009) found that chronic contempt, put-downs, rejection, criticism, disapproval, and being ignored were related to self-representations of shame and defectiveness. PM might also invalidate the child's thoughts and feelings. Emotions and emotional expressions deemed undesirable by the parent might be criticized (Goldsmith & Freyd, 2007). The blame, condemnation, and criticism of PM could be incorporated into representations of self-blame that contribute to an overall sense of low self-worth and feelings of shame.

PERCEPTION OF OTHERS

Bowlby (1988) theorized that chronic childhood maltreatment by primary caregivers resulted in internalizing of stable global internal negative perceptions of others, significantly impacting subsequent relationships. Pearlman and Courtois (2005) asserted that survivors of complex trauma develop a negative perception of self, develop a negative perception of others, experience a lack of trust, and experience revictimization. Roche, Runtz, and Hunter (1999) proposed that a negative perception of self combined with a negative perception of others leads to significant interpersonal problems in adulthood.

Evidence regarding perception of others is inconsistent. Some studies have associated a negative perception of others with difficulties in interpersonal functioning (Bartholomew & Horowitz, 1991) and posttraumatic symptoms including anxiety, depression, dissociation, and sleep disturbances (McLewin & Muller, 2006). Other studies have found no significant association between a negative perception of others and adult posttraumatic symptomatology (Muller, Sicoli, & Lemieux, 2000). Evidence has suggested that having both a negative perception of self and a negative perception of others is more predictive of adult posttraumatic symptomatology than negative perception of self alone (Muller et al., 2000; Roche et al., 1999).

PM and shame predict emotional inhibition (Crawford & Wright, 2007; Harper et al., 2005; Krause, Mendelson, & Lynch, 2003; Lumley & Harkness, 2007; Wright et al., 2009). A child might inhibit emotional displays to appease a caregiver and avoid further maltreatment (Goldsmith & Freyd, 2005). However, emotional inhibition impedes the ability to express emotion in healthy ways, which could contribute to difficulties establishing and maintaining healthy relationships. For example, the ability to express emotions, desires, and needs is important in avoiding conflict (Crawford & Wright, 2007). A pattern of chronic emotional inhibition might lead to adult depression and anxiety (Crawford & Wright, 2007), and could mediate the relationship between PM and psychological distress (Krause et al., 2003), and between PM and the individual's subsequent victimization or perpetration of adult intimate relationship aggression (Crawford & Wright, 2007).

When children are unable to meet parental standards and gain parental love and support, they might attribute this to innate badness. Herman (1992) suggested that the child creates a false self that will hide self-perceived flaws. This strategy allows the child to avoid contempt and derision, appease others, gain their approval, and reduce incidents of maltreatment. The development of a false self is associated with depressive symptoms, low self-worth (Harter, Marold, Whitesell, & Cobbs, 1996), and relationship conflict (Harter, 1999). Individuals who create a false self feel hopeless about their ability to please others (Harter, 1999). Some psychologically maltreated individuals might withdraw from relationships rather than face the constant expectations of maltreatment (Crawford & Wright, 2007). Drapeau and Perry (2004) found that individuals with a history of childhood verbal abuse were likely to express a desire for distance in relationships.

The literature exploring the nature of PM has largely used quantitative methods. Hypotheses derived for testing have typically been drawn from studies of sexual and physical childhood maltreatment. This approach might leave the unique features of PM hidden. In this study, we sought to use a qualitative approach and focus on PM. The purpose of this study was to address the ways in which PM during childhood influenced perception of self, perception of others, and perception of relationships.

METHOD

Participants

Adults with a history of childhood PM were recruited from a low-cost counseling agency in Christchurch, New Zealand. PM was determined by participants and therapists, based on a definition and list of examples of PM provided by the researchers. Smith and Osborn (2003) recommend five to

TABLE 1 Demographics of Participants

Pseudonyms	Age	Gender	Relationship Status	Employment Status
Kate	68	Female	Married	Retired
Jack	57	Male	Single	Unemployed
Anna	34	Female	Single	Unemployed
Jane	53	Female	Married	Working
Tara	57	Female	Single	Working
Anya	43	Female	Single	Working

six participants as a reasonable sample size. Six individuals agreed to participate in the study, and recruitment was stopped at this point. Table 1 displays the participant age, gender, and pseudonyms. Inclusion criteria were a history of PM, current ongoing psychological therapy, and therapy related to their PM history. Exclusion criteria were a history of sexual abuse, significant physical abuse, or both.

Measure

Interpretive phenomenological analysis (IPA) is a qualitative method for analysis of complex contextual data about perceptions and understandings of a distinct and closely defined group. It was used to analyze complete coherent narratives that represent the lived experiences of participants. The interview questions were developed in accordance with Smith and Osborn's (2003) recommendations. Questions were open-ended, were neutral (rather than value-laden), and avoided jargon or technical terms. Following a set of questions to allow rapport building, overarching questions and prompts were designed to explore the perception of self, others, and relationships, both in the present and in the past. Examples of questions from the interview schedule are "How would you describe yourself as an individual?" and "What are your thoughts on whether or not those experiences of being emotionally hurt as a child had any long-term effects on your view of people in general?"

Procedure

After human ethics committee approval, participants were informed about the study by their counselor or therapist and completed a "permission to contact" form if they wanted further information. All interviews were conducted by the first author. Participants read and signed the consent form and completed a demographic form. They were asked the interview questions from a semistructured interview schedule. Interviews lasted 1 hour and were audio recorded. At the end of the interviews, participants were debriefed, encouraged to ask questions, and thanked for participation. The audio recordings were transcribed for analysis.

Analysis

The aim of IPA is to explore, represent, and interpret the means by which individuals make sense of their personal and social world (Larkin, Watts, & Clifton, 2006). IPA goes beyond generating an account of the insider's perspective of the individual's experience by requiring the researcher to draw out and disclose these meanings through an interpretative process. Smith and Osborn (2003) deemed IPA particularly suitable when the topic under study is complex, contextual, novel, dynamic, relatively understudied, and concerned with processes, especially regarding issues of identity, self, and making sense of the personal and social world. Chapman and Smith (2002) suggested that IPA's flexibility and detailed analysis are useful when the topic being studied is relatively unexplored, and might be sensitive and emotional for the participant. The flexibility of IPA creates the opportunity for interviewers and participants to engage in a dialogue, and allows participants the maximum opportunity to give a full, rich account of their perceptions and sense-making processes (Smith & Osborn, 2003).

The analysis was based on guidelines described by Smith and Osborn (2003) and involved reading each transcript enough times to become immersed in the data. The *double hermeneutic* phenomenology is a two-stage interpretation process where "the participants are trying to makes sense of their world [and] the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2003, p. 51). Analysis is filtered through the researcher's interpretations, perceptions, and biases. Thus, IPA is a dynamic process that involves the participant's personal perception and the researcher's active interpretations. Analyst bias, prejudice, and preexisting perceptions were managed by bracketing during the analysis assumptions drawn from the literature and was only later compared with the data generated from participant narratives. The second author independently assessed a selection of the transcripts. Participants reviewed the emerging themes for consistency with their own narratives.

RESULTS

Table 2 summarizes the 4 superordinate and 13 subordinate themes that emerged.

Shame-Based Perception of Self

Shame

Participants developed a shame-based perception of themselves as inferior. They spoke of low self-confidence and a low sense of self-worth. These issues coalesced around shame. For example, Jack noted, "In my world I

TABLE 2 Emerging Superordinate and Subordinate Themes

Shame-based perception of self
Shame
Self-blame
Self-protection from emotional pain
Desire to please others
Development of a false self
Self-inhibition
Withdrawal or avoidance of interpersonal contexts
Limited awareness of others
Self-referencing
Mistrust
Dichotomizing others
Shame-based role in relationships
Difficulty forming and maintaining relationships
Difficulties with emotional intimacy
Isolation
Internalization of parent's relationships

was at the bottom of the list and all the people that I knew were stacked above . . . better than me." This shame-based perception of self could result from the internalization of negative messages from parents about self-worth that were critical, demeaning, invalidating, or rejecting. Jane reflected on her mother's influence on her self-perception:

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

Shame was associated with fear of exposure as inferior in the eyes of others. Jane indicated:

> [I'm afraid of] making a dick of myself, not being capable enough, not being bright enough, feeling stupid if I said something, going over what I said, bashing myself around [because I believe people will see me as inadequate].

Self-blame

Participants blamed themselves for things beyond their control. For example, Kate blamed herself for her family's physical health problems and returned home to care for family members:

> I had a chance to go to Bible College. I went up there for 6 months to study and I wanted to take on social work, but then my mother and

> grandmother both became ill because I had left home. Nobody could cope with me leaving.

Participants felt responsible for the feelings, thoughts, and behaviors of others, and they felt that they deserved punishment. Anya expressed it best:

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

Self-Protection From Emotional Pain

Primarily in interpersonal contexts, participants used a variety of coping strategies to protect from emotional pain.

Desire to please others

Pleasing and appeasing others (as a means of self-protection) was evident in the accounts of participants. Anna was clearly aware of her need to "be nice to" or please others as a self-protective measure against emotional pain:

> I think I'm always incredibly, incredibly nice to people all the time, and I think it's a defense, like I'm frightened all the time, and I'm really, really, nice. . . . I find it really hard to say how I feel because I'm scared of personal attack.

Stated another way, participants developed a strong aversion to displeasing others. They learned to expect painful feedback from others as a result of the behavior modeled by their parent(s). Kate spoke of severe consequences of displeasing her stepfather:

> I accidentally burnt his saucepan once. . . . He had a go at me the way he used to . . . and this is no exaggeration, for 2 hours he would go on about your faults, almost from the time you were born right up to the age you were when you were living with him.

Development of a false self

To avoid judgment, invalidation, betrayal, and rejection, participants behaved in ways perceived as acceptable to others. By adopting a false self, participants felt that they were able to avoid expected emotional pain from others. For example, Kate explained:

> With my mother I always had to say "yes" and "no" and hope I said it in the right place, but I could never express how I felt, I could never be honest. If I didn't like anything, I couldn't dare say I didn't like it.

Self-inhibition

Exposure of the inner self created a sense of vulnerability to others. Therefore, participants inhibited thoughts, feelings, desires, opinions, or dreams of any emotional significance. Jane spoke about the effect of her history with her mother on her ability to be "open" in relationships: "It made me a bit of a closed book, so I found it really difficult relating to others, or having close relationships . . . cause I'd hold back." This need for personal privacy developed after their parents ridiculed, ignored, invalidated, or rejected attempts at communicating important thoughts and feelings. Anna expressed the experience of having her opinions and feelings invalidated by her mother: "I was never allowed to express an opinion . . . my mum was always second guessing me, and nothing that I felt was really important. It was like it didn't matter how I felt or who I was."

Avoidance or withdrawal from interpersonal contexts

Participants withdrew from jobs, social activities, and relationships to protect themselves. Here is Jane's experience:

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

Withdrawing, avoiding, or distancing oneself in some relationships might be an adaptive coping strategy. Anya found that distancing herself from her friends and family, especially her mother and father, gave her opportunities for self-growth and recovery:

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

Participants distanced themselves from relationships, events, and feelings by switching the grammar of their narrative. For instance phrases such as "my parents," and "our relationship" were replaced by phrases such as "the parents," or "that relationship."

Limited Awareness of Others

Self-referencing

When asked the question, "How would you describe your thoughts and feelings about people outside your family?" participants answered by referencing others in terms of themselves. They responded by saying something about themselves: "I was probably quite judgmental" (Tara), "I wouldn't have been that trusting" (Jane), or "I felt . . . completely alien" (Anya). The focus of shame, self-blame, and self-protection reduced the individual's ability to develop an awareness of the complex internal experience of others. Participants were commonly unaware that the behavior of others was driven by their own internal processes rather than the participants' inadequacies. Tara explained:

> Now I can actually feel okay about other people's response . . . and know it's actually their issue and not mine, which I could never do in the past. . . . I wouldn't have been able to think that before . . . to be able to look at where they [are] coming from.

Mistrust

Mistrust was associated with self-protection from emotional pain based on the belief that others are going to hurt, betray, or reject. Anna noted, "I always felt they [boyfriends] were going to leave me, so I would leave first. I couldn't trust them and I couldn't believe that they actually really loved me."

Dichotomizing others

Participants tended to dichotomize people into opposing groups such as (a) maltreatment (victim vs. perpetrator), (b) sex (male vs. female), (c) gender (dominant vs. submissive), (d) emotional responsivity (caring vs. uncaring), (e) relationship quality (healthy vs. unhealthy), and (f) strength (weak vs. strong). Dichotomization was often based on experiences with and messages from a parent. Control was a key feature in participants' beliefs and expectations about relationships. For instance, Anya explained, "Men are there to humiliate woman and use them. So . . . the world is really hostile . . . men and women . . . are enemies."

Shame-Based Role in Relationships

Difficulty forming and maintaining relationships

Participants expressed difficulty forming new friendships and intimate relationships. This might have been due to shame-based social anxiety, which

participants experienced to different degrees. For Anna, social anxiety became quite debilitating and isolating:

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

Jack put it a different way:

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

Difficulties with emotional intimacy

Participants described previous relationships that were volatile, codependent, abusive, and emotionally distant. Anya described a lack of connection in previous relationships:

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

Participants described a lack of emotional intimacy with their parents. Communication was limited, and participants lacked emotional closeness and sharing of thoughts, feelings, desires, and dreams. Jane described her mother as emotionally cold. Through direct teaching and behavioral modeling from her mother, Jane outlined the lessons she learned, that disclosing oneself to others leaves one open and vulnerable to harm:

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

Isolation

Participants reported that difficulties forming, maintaining, and deepening relationships led to isolation. They described feeling lonely, isolated, unloved, and unsupported. Kate explained, "I'm sort of in limbo at the moment without any friends . . . it's hard to strike up something new." A lack of love and support characterized participants' relationships with their parents. This influenced adult relationships. Tara described her relationships with her husband and children:

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

Internalization of parents' relationship

Most participants described one parent as dominant and controlling and the other parent as submissive. Jane's experience was illustrative:

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

In their own relationships, participants internalized these models of relationships and developed expectations about control. Anna explained:

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

Participants lacked control in their relationships with their parents and in their lives in general. Tara stated this most poignantly: "All this stuff had been put on me, and there was no control in my life. I couldn't control the pain. I couldn't control anything." Participants believed that they would assume a submissive role in any relationship. This might be because they internalized their parents' relationship. Jack expressed concerns about being controlled in intimate relationships. He feared his partner would be like his mother: "It might be quite easy that you could get very much into your wife telling you to clean your things up, like your mother, and how much I'd handle that I don't know."

DISCUSSION

The aim of this study was to explore perceptions of self, others, and relationships in individuals with a history of chronic, parental, childhood PM. Four superordinate themes were identified: (a) shame-based perception of self, (b) self-protection from emotional pain, (c) limited awareness of others, and (d) shame-based role in relationships. Many of the superordinate and

subordinate themes overlap with DeRobertis's (2004) earlier qualitative work exploring the long-term impact of chronic maternal childhood PM. Evident in both studies were the themes of shame, self-blame, inhibition, withdrawal and avoidance, mistrust, dichotomizing others as victim or perpetrator, and loneliness. Emerging from both the DeRobertis (2004) study and this study were the internalization of abuse messages, development of a false self, and difficulties with self-disclosure. The high number of overlapping findings lends credibility to the rigor of both studies and suggests that identified themes might be evident in others with histories of PM during childhood.

The emergence of shame-based perceptions of self is consistent with previous findings that PM is associated with shame (Wright et al., 2009). Shame can occur when an individual perceives that he or she has failed to live up to personal or others' expectations (Van Vliet, 2009). Bowlby (1969) suggested that through the internalization of repeated interactions with the caregiver, a child will begin to form an internal representation of self and others. Bowlby (1969) labeled these internal representations of the self and others as *internal working models* (IWMs) and asserted that these IWMs are incorporated into the child's personality and form a basis for his or her behavior. For current participants, shame occurred as a result of internalizing parents' chronically critical statements. Parents provided rigid, unrealistic standards and expectations regarding the participants' behavior but also held rigid beliefs about what the participant should think, feel, and desire. Failure to achieve these standards and expectations produced feedback from parents that was chronically negative and fit the criteria for PM (e.g., degrading, belittling, and spurning). Such experiences stifled the development of a positive coherent sense of self and resulted in a low sense of self-worth, and ultimately a deep-seated, stable, global sense of shame. The internalization of parents' beliefs, standards, and expectations continued to contribute to the stability and longevity of the sense of shame. For most participants, this sense of shame was so powerful that they blamed themselves for events beyond their control.

Mistrust of others was a significant theme that emerged for participants and is consistent with previous work (Crawford & Wright, 2007). Arguably, because of their strong sense of shame, their ensuing intense self-blame, and the interactional patterns modeled to them by their parents, participants expected others to treat them with invalidation, betrayal, rejection, and a lack of respect. In his psychosocial stages of human development, Erikson (2000) defined the first two stages as struggles between trust versus mistrust, and autonomy versus shame and self-doubt. Blatt (2008) suggested that trust versus mistrust is the basis for developing a sense of self in relation to others. Autonomy versus shame and doubt is the basis for the development of the capacity to be self-defining and self-directed. The emergence of mistrust and shame in adults psychologically maltreated as children suggests that such experience impacts on the foundations of intra- and interpersonal development.

Emotional pain was a significant factor in the childhoods of participants. Several described themselves as especially sensitive to emotional pain. Participants adopted strategies to protect themselves from interactions with their parents that could cause emotional pain. These strategies were subsequently extended to relationships with others. In childhood, such strategies might have been adaptive by limiting the amount and severity of emotionally painful interactions with parents or providing a sense of hope and control (Harter, 1999). However, in adulthood, they are maladaptive, as they limit both the frequency and quality of interpersonal interactions that would serve to increase the individual's awareness of self, others, and relationships.

Participants might have felt driven to please people to avoid conflict, embarrassment, shame, and rejection. They might have developed a false self to please and appease others, and prevent anticipated experiences of emotionally painful interactions. Participants developed a need for privacy and boundaries around their own thoughts, feelings, and beliefs. They seldom expressed themselves openly to others. In anticipation of emotionally painful interactions, participants chose to avoid or withdraw from interpersonal contexts.

Herman (1992) suggested that persistent attempts to please and appease the primary caregiver, along with the desire to hide the rotten inner self, leads to the development of a stable pattern of false-self behavior. This false-self behavior can extend to a range of different false selves for different contexts (e.g., parents, friends, work colleagues; Harter, 1999). The need to please others and the possibility of simply choosing to withdraw from relationships rather than face further anticipated abuse, neglect, or emotional pain, have both been associated with PM (Crawford & Wright, 2007). An association has also been found between PM and inhibition of emotional displays to avoid displeasing others (Crawford & Wright, 2007). For the current participants, their need for self-inhibition extended to the need to keep private any thoughts and feelings of emotional significance. In the past, their inner experiences were belittled, invalidated, or rejected, thus enhancing their sense of shame and expectation of the same reaction from others. Participants developed a wall around their inner selves, giving little information about themselves to others. This coping strategy impeded development of emotional intimacy in relationships and limited their ability to develop an increased awareness of others.

Participants spoke of dichotomizing people into opposing groups: healthy and unhealthy, dominant and submissive, caring and uncaring, weak and strong. They characterized themselves as unhealthy, submissive, weak, and caring. This would appear consistent with a shame-based self-perception. Given the participants' preoccupation with self-protection from emotional pain, it could be that dichotomizing others was originally an adaptive mechanism for quickly identifying threatening people.

Participants expressed difficulty in developing and maintaining relationships as well as difficulty with emotional intimacy. Bartholomew and Horowitz (1991) theorized that individuals with a history of childhood maltreatment develop a negative perception of self and others that impacts adult interpersonal functioning. For current participants, another factor that impinged on their adult interpersonal functioning was their internalization of the fraught relationship between their parents and their own dismissive relationship with their parents. A shame-based sense of being submissive or controlled pervaded.

Participants experienced feelings of isolation, and they wanted friendships, healthier relationships, and loving, healthy, intimate relationships. Yet they experienced fearful, negative perceptions of others and relationships. Bartholomew and Horowitz (1991) proposed that individuals with both a negative perception of themselves as unworthy and a negative view of others as untrustworthy and rejecting would desire relationships. Relationships have the potential to provide the external validation needed to gain and maintain a positive self-perception. However, these individuals also avoided relationships with others to avoid the expected pain of rejection. Protection might come from developing a strong sense of independence. The results reported here would support the view that intimate relationships were both craved and feared. This is reminiscent of the first two of Horney's (1937) three personality styles that can emerge from experiencing childhood in a "neurotic" family: (a) moving toward, (b) moving away, and (c) moving against others.

Several limitations were evident in the study. Qualitative methods make no claim of generalizability to wider populations, focusing on thorough accounts of a small number, which might prompt subsequent exploration (Smith & Osborn, 2003). Yet, representativeness could be important for generating further research questions or developing hypotheses for quantitative investigation. The majority of participants were female, and there were some differences between the accounts of Jack and the female participants. For example, Jack's presentation style was more reticent than that of the female participants. Further work could explore potential narrative and thematic differences across gender for PM. Moreover, the perspectives and narratives of participants might have been influenced by counseling. Therapy and self-growth ensured that participants were stable enough to cope with the emotional rigors of the study. The lived experience of individuals for whom their histories were still raw might not have been captured. Finally, a question for future research is the nature of narrative change in survivor perception of PM with time, reflection, and counseling interventions. It should be noted that the perceptions described by the participants could have been tainted by hindsight and counseling as much as these perceptions might have become clearer.

CONCLUSION

Emerging from the data in those with PM was a shame-based perception of self. Arguably promoted in part by this self-perception was the adoption of shame-based roles in relationships, thwarting intimacy and heightening relationship fears. Limited awareness of others was associated with perceived threat and concerns about their motives, which hampered relational connections. Self-protection from emotional pain further impeded authentic interpersonal bonds. Participants were affected into adulthood by the emotional pain suffered during their childhood. Subsequent perception of themselves, others, and relationships, as well as ensuing adult interpersonal functioning, were compromised by these experiences. The complex, dynamic processes characterizing PM and its impact on intra- and interpersonal functioning warrant further investigation.

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