MONASH UNIVERSITY
THESIS ACCEPTED IN SATISFACTION OF THE
REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY
ON..... 4 October 2002 .....
.....
Sec. Research Graduate School Committee

ERRATA

p.72. line 1: 'in a given hierarchy' for 'in a God given hierarchy'.

p.127, line 20: 'the data were' for 'the data was'.

p.127, line 6: 'affecting' for 'effecting'.

p.128, line 10: ' ...that they have difficulty' for 'that they difficulty'.

In all direct quotes where the word 'man' or 'men' has been used, insert [sic] after the use of these terms.

JUST BEING A GIRL:
FEMALE CHILD SEXUAL ABUSE AND THE PROBLEM(S) OF EMBODIMENT

KAREN JEANNE SUTHERLAND

Submitted in total fulfilment of the requirements of the degree of Doctor of Philosophy

June, 2002

Department of Social and Political Enquiry
and Department of Social Work
Faculty of Arts
Monash University

ABSTRACT

This thesis explores the experience of women who have been sexually abused in childhood, focusing on the ways the abuse has shaped their perceptions of their bodies. A qualitative study involving in-depth interviews with ten women, the thesis challenges previous conceptions of abuse impact that privilege the psychological consequences of childhood sexual abuse for victims. Rather, this study demonstrates the significance and centrality of the body for women who have been sexually victimised in childhood, revealing the body symptoms and problems of embodiment that dominate women's lived experience, and the ways in which women's experience of their bodies is inextricably entwined with their sense of personal identity and with broader social constructions of the female body.

Historically, the clinical literature on childhood sexual abuse has focused primarily on how childhood sexual victimisation compromises psychological functioning, largely ignoring the ways in which the body informs personal experience and identity. More recent literature from the trauma field challenges disembodied notions of identity, explicitly underscoring the significance of the body and its physiological operations in constituting a victim's experience. Rather than ignore the body altogether, or privilege its status as biological entity, the study includes and explores the myriad ways in which the body is experienced by women in the aftermath of childhood sexual abuse.

While the study highlights the centrality of the body, and of physical, bodily experience for those traumatised by childhood sexual abuse, it challenges purely biophysiological representations of the body, examining the modes by which women's body symptoms and problems of embodiment are shaped and constituted by personal and social meanings attributed to the body. The study also challenges representations of the body which implicitly deny its sexual specificity. Rather than assuming that traumatised bodies are sex and gender neutral, the study illustrates how women's experience of their bodies following childhood sexual abuse is inextricably tied to their constructions about female identity and embodiment. For many women, living comfortably in the body becomes

problematic, not just as a consequence of biophysiological changes occasioned by trauma, but because of how symptoms and body problems are interpreted and understood. Moreover, the body becomes symptomatic and problematic precisely because of what it means to have and live in a female body in Australian culture.

To reach these conclusions, the study draws on, critiques and adds to prevailing discourses interested in theorising the subjective and embodied experience of women who have been traumatised by childhood sexual abuse. In particular, it attempts to reposition the body as a site of significance for such women, to reconceptualise the body as lived, material, physical reality and personally and culturally constructed entity, to situate the sexed body at the core of theorising about self, identity and trauma, and to reimagine traumatised bodies and female embodied consciousness. Drawing predominantly on trauma theory, feminism and postmodern discourses of the body, the study seeks to problematise the violated body and to argue for a reconfiguration that can embrace individual female embodied experience and the social and cultural significance of the female body.

DECLARATION

This declaration is made to certify that the thesis comprises my original work, that due acknowledgment has been made in the text and bibliography to all other material used in the preparation of the thesis, and that the thesis is less than 100,000 words in length excluding tables, maps, footnotes, bibliographies and appendices.

Signed: [redacted]

Karen J. Sutherland

ACKNOWLEDGMENTS

There are many people whom I wish to thank for the help and support given to me throughout the years it took to complete this thesis.

I want to thank the ten women who so generously shared their painful stories about childhood sexual abuse because they wanted to help and support other women who have endured similar experiences, and because they wanted to enrich the understandings of the many professionals who work with victims of trauma and sexual abuse. I hope this work captures your integrity and courage.

Thank you to Dr Denise Cuthbert, Associate Dean, (Graduate Research), Faculty of Arts, Monash University for encouraging me to apply for an A.P.A. Scholarship. Without your support and your endorsement of my application, I would not have been successful in being granted the A.P.A. that made my studies towards a Ph.D. possible.

Without the assistance of an A.P.A. Scholarship, I could not have undertaken a Ph.D. I am especially grateful for the precious opportunity that the scholarship has afforded me to devote to my study.

Thank you to The Creswick Foundation who also generously supported my research with a grant for overseas study that permitted visits to sites that were centres of excellence in the assessment, treatment and research of child sexual abuse and trauma.

My colleagues at The Bouverie Centre have provided me with ongoing support and encouragement. In particular, I am grateful to Dr Colin Riess for his patience and flexibility in allowing me time to complete my thesis, and to Pam Rycroft for her sensitivity to my thesis-induced stress states, and for helping me organise my work at Bouverie around the various stages of my thesis.

My friends and colleagues in the sexual abuse team at Bouverie, Jenny Dwyer, Robyn Miller, Anne Welfare and Robyn Elliott have continued to inspire and stimulate me with the intelligence, thoughtfulness, creativity, and skill they bring to the work, and with how generously they give of themselves to others.

I also want to thank my friends Franca Butera-Prinzi and Anita Hallam whose warmth, kindness and friendship has nurtured me throughout the research process.

The help and support of my supervisors Dr Helen Johnson and Dr Chris Goddard has been invaluable. Helen's conceptual clarity greatly assisted me throughout the writing of the thesis and Chris's faith in the value of my work encouraged me towards completion. I am especially grateful to Helen for the detailed reading of my inumerable drafts, for the expediency with which she read and returned my work and for her thoughtful and encouraging feedback.

Finally, I want to thank my parents who have consistently encouraged my progress, taken pride in my educational achievements, had confidence in my ability, and sustained me with their love and support through some of the difficult times that have coincided with my writing the thesis. To my daughter, Janine, I thank you for being the sunshine in my life. Your love and patience has made it possible to continue and to bring this work to completion.

TABLE OF CONTENTS

PREFACE

'... it's a weird thing to say, but it was like my body was the enemy. It's just, it was being a woman was the enemy. Being who I was. Just being a girl.'(P8).

Background To The Study

My interest in women's experience of their bodies following childhood sexual abuse arose as a consequence of my clinical work as a social worker and family therapist. In therapy with women who had been sexually abused in childhood, I found myself constantly listening to and witnessing women's painful struggles to live comfortably in bodies which had been physically and sexually violated. In turning to the clinical literature to better understand the difficulties women faced, I was confronted by a dearth of writing on the bodily experience of childhood abuse victims, and by conceptions of the traumatised body that appeared to disconnect the body from its personal and cultural meanings. This finding was at odds with my own experience of women, whose bodies were central and significant to their experience of childhood sexual abuse, and were deeply embedded with meanings that shaped their behaviour and identity. I became increasingly aware that symptoms and difficulties women presented in therapy were primarily to do with the body. I became more attuned to the ways that women's experience of their bodies, and the beliefs and meanings attributed to their bodies, problematised female embodiment. My preliminary observations and thoughts intersected with my interest in recent feminist theorising about the body. I was attracted to the way in which postmodern and poststructural feminist writings situated the body at the analytic centre of women's experience and by their attempts to reconceptualise the female body. I was also interested in theoretical bodies of knowledge that examine the fundamental role of social phenomena in the creation of psychiatric symptoms. Such theories have been largely ignored (Tomm, 1990) and the sexual abuse field is no exception. Consequently, I became curious about the usefulness of feminist reconfigurations of the body for women whose bodies had been violated by sexual abuse.

Focus Of The Research

From preliminary research three major research questions emerged:
What effect does childhood sexual abuse have on women's experience of their bodies?;
What meanings do women ascribe to the violated female body and are these meanings adequately represented in the clinical literature?; and
What do such experiences and perceptions suggest for further feminist theorising about women's experiences?

My Position As Researcher

My research project evolved from a number of experiences that shaped the topic selected, the research process, my conduct of the interviews, and importantly, the way I have understood and conceptualised each woman's story. The research therefore reflects my experiences, values and worldviews, as well as my interpretations of the women's stories. Impossible as it is to give a fully conscious account of the personal and professional journey that has shaped my project, it is important to articulate what I consider to be three significant factors that have influenced my project.

First, throughout my years of working as a therapist I have seen detailed evidence of the profound and complex ways in which childhood sexual abuse has affected the lives of victims. I was drawn, in particular, to the significance of the body for victims of sexual abuse because I had witnessed clients' vivid bodily re-experiencing of the abuse in powerful visual, auditory and somatic flashbacks in the therapy room. I had seen their struggles to articulate feelings and sensations that were deeply felt in their bodies but were not available in words. I had heard about strategies used to punish, harm, purge, starve, disguise, discipline and leave the body, and about attempts to induce bodily feeling through self-inflicted pain. I noted the fears, contradictions, complexities and dilemmas that having a female body posed for many victims. All these struggles pointed to problems with living comfortably in a body violated by abuse.

When turning to the professional literature I found that the body of victims had received little attention. I therefore wanted to hear women's stories about their experience of their bodies following childhood sexual abuse and for their stories to be heard and understood by others.

Second, feminist ideas have significantly influenced my thinking and practice. I do not believe sexual violence can be understood without an analysis of power differentials between men and women and the ways in which social structures and ideologies create gender inequalities. However, I was troubled by the focus on gender that appeared to limit considerations of the body, and by oppressor/oppressed models that foreclosed reflection on the ways women's subjectivity could maintain their oppression. Postmodern and poststructuralist feminist writings interested me because of their primary concern with body and with the role of the body in constructing female subjectivity. I sought to make sense of the questions; what is it about the way in which society constructs female bodies that provokes childhood sexual abuse to bodies of little girls? And, what do the bodies of girls and women violated by childhood sexual abuse tell us about the experience of female embodiment, and of having a female body in Australian culture? I wondered if the theoretical formulations made possible by recent feminist theorising on the body would improve understandings of women's experiences of childhood sexual abuse.

Third, the stories of each of the women interviewed constitute an overt presence in the work, yet my presence as author is less explicit. Their stories are written about, mine to a large extent is not. They have shared much about their personal journeys, their pain, their struggles and their successes in intimate and revealing ways. I have not. There are many differences in my story and the stories I have constructed from my conversations with the women in this study. There are differences in age, in social location, in family background, in cultural background, in education. Yet, I believe there are also many similarities in the space the informants and I occupy, and in the narratives created which then become the basis for arguments. At times, I too have experienced the struggle to live comfortably in my body. I have felt deep ambivalence about having a female body in my

culture, have wanted to deny, punish and disown my body, and ignore or overcome its needs and desires. I have wanted to conceal the femaleness of my body to protect myself from unwanted attention, harassment and intimidation. I have wanted to discipline my body and keep it strictly under my control. I have not listened to my body's knowledge and essential truths and have privileged my intellect and my mind. I have also felt things so deeply and profoundly in my body that they are not available to me in words, and have struggled to express my feelings in words rather than in bodily symptoms or signs. In other ways, I have trusted the seemingly fundamental knowing of my body, and valued the clarity and unambiguousness of the material reality of my body when all else seemed incomprehensible. I too have found exhilaration from physical strength and endurance in exercise, and have also found comfort in the everyday pleasures of embodiment. The process of generating meanings, understandings and knowledge in my research has involved the process of co-creation. The stories of the women interviewed for the project and my own story are therefore incorporated in the thesis.

Thesis Outline

Chapter one reviews the clinical literature on child sexual abuse, focusing on the way in which women's bodies have been conceptualised in discourses on child sexual abuse. Chapter two examines three epistemological perspectives on the body for their relevance to this research. The ontological and methodological issues that frame my research are outlined in Chapter three, including an explication of feminist research methods and the particular details of the research process implemented in the study. In Chapter four, I introduce the study and the participants.

Chapter five begins the findings section of the thesis. In this chapter I highlight the significance of the body to child sexual abuse, examining in particular, the impact of trauma on the body of victims, the physical nature of trauma and its consequences, and the centrality of women's embodied experience of trauma in shaping their perceptions of themselves and their bodies in the aftermath of abuse. Chapter six examines the importance of the body to gendered subjectivity and the significance of sexed identity to

trauma and violation. Chapter seven focuses on the social dimensions of the body problems experienced by the women in my study, highlighting the relationship of problems of embodiment to broader social discourses on the female body and femininity.

The personal meanings women attach to their bodies following the trauma of sexual abuse are examined in Chapter eight where I explore the notion of the body as a symbolic site and discuss the complex but meaningful bodily configurations of sexual abuse and its impact. Chapter nine is concerned with the role of materiality and culture in women's stories of recovery from the effects of child sexual abuse. It draws on feminist theory to examine the centrality of the body to identity and the relationship of female identity to culture. I conclude the thesis by summarising the major findings and exploring the implications for further research and theorising about the body of women sexually abused in childhood.

GLOSSARY

Child Sexual Abuse - As definitions of child sexual abuse vary in the literature, I utilise the definition provided by the Department of Human Services, Victoria (1991) which states that: 'A child or young person is sexually abused when any person uses power over the child to involve that child in sexual activity. Child sexual abuse involves a wide range of sexual activity including fondling genitals, masturbation, oral sex, vaginal or anal penetration by a finger, penis or any other object, voyeurism and exhibitionism. It can also include exploitation through pornography or prostitution' (p.1).

Diagnostic Statistical Manual of Mental Disorders (D.S.M.) – The D.S.M is a document published by the American Psychiatric Association that identifies and classifies mental illnesses and provides descriptions of the constellation of symptoms found in each mental disorder. The manual is updated periodically and the edition number is quoted after the abbreviated title eg. D.S.M.IV.

Embodiment -The Collins Dictionary (1979) defines the term 'embodiment' as 'the giving of a tangible, bodily or concrete form to an abstract concept' (p.478). Young (1992) uses 'embodiment' to refer to the realm of the self, experienced in and through the body' (p.90). I adopt Young's definition of embodiment as it is consistent with the dictionary's definition, from which I take the 'abstract concept' to refer to notions of 'self' that are given form through bodily experience.

Eye Movement Desensitisation and Reprocessing (E.M.D.R.) – Discovered by Francine Shapiro in 1987, E.M.D.R. involves the use of rapid eye movements to desensitise disturbing psychological material in traumatised individuals. It has proved especially useful in reprocessing traumatic memories in rape and sexual abuse victims. Since initial efficacy studies, E.M.D.R. has had more published case reports and research to support it than any other method used in the treatment of trauma.

Experience -Throughout the thesis reference is made to women's experience/s. There has been a valuable feminist critique that has problematised the notion of 'women's experience'. The critique has demonstrated that there is no common or unified female experience or identity, and that to so assume, ignores fundamental and important differences in women's lives that are a product of culture, location and history, thereby marginalising specific groups of women. I use 'women's experience' to refer to the events that have occurred in individual women's lives that are of relevance to the discussion. I do not intend to assume sameness, to blur difference or to subsume women's experiences under unifying propositions.

Incest - In this work, incest denotes the familial nature of the sexual abuse. Controversy exists in the literature about the use of the term 'incest'. Some writers have suggested that the use of the terms 'incest', 'sexual misuse', 'sexual molestation', and 'child sexual abuse' dilute and minimise the reality of the behaviour (Brownmiller, 1975; Ward, 1985). Other writers have argued for distinctions between 'rape' and 'incest' on the basis of differing abuse dynamics (Courtois, 1988). I have used the terms 'sexual abuse' and 'incest' synonymously.

Posttraumatic Stress Disorder (P.T.S.D.) – P.T.S.D. has been identified as a diagnosable psychiatric disorder since its inclusion in the D.S.M. in 1980. It refers to a specific constellation of symptoms suffered by individuals who have been exposed to trauma or traumatic events.

Trauma -When Post Traumatic Stress Disorder was first defined in the Diagnostic Statistical Manual in 1980, traumatic events were characterised as being outside the range of usual human experience. However, in the succeeding years, studies have demonstrated an alarming prevalence of traumatic events, suggesting the original definition of these experiences being outside the province of most people's lives was erroneous. More recently, trauma has been defined as an event or events that involve actual death or physical injury, or threat to the bodily integrity of oneself or others. The International Classification of Disorders (I.C.D.,1992) describes these events as exceptionally

threatening or catastrophic and likely to cause distress to almost everyone. Trauma is here defined as those events that involve actual physical injury, threat to one's life, threat of injury or harm to one's bodily integrity or that of a loved one.

Victim/Survivor -The terms victim/survivor are used interchangeably throughout the thesis. The use of the term 'survivor' is preferred by many feminists interested in the sexual abuse area because of its connotations of endurance and courage in the face of suffering. However, for some of the women in my study whose lives were still plagued by the extensive negative effects of sexual abuse, the word 'victim', at times, more accurately reflected their experience.

CHAPTER ONE
INTRODUCTION

The impact of childhood sexual abuse on victims is the subject of an extensive and burgeoning clinical literature. The 'first wave' of research into child abuse in the 1970s and 1980s was primarily concerned with the nature and prevalence of child sexual abuse and with explanations about how and why it occurs. The 'second wave' of research focused primarily on the effects of child sexual abuse on victims. I do not broadly review studies on the prevalence and incidence of child sexual abuse, nor do I critique the numerous theoretical accounts which have been advanced to explain the phenomenon of child sexual abuse, as such appraisals exist elsewhere (Finkelhor, 1986, Russell, 1983, 1986; Sanderson, 1990; Herman, 1992).[1] Rather, I examine the clinical literature on the impact of childhood sexual abuse. I focus on how the victim's body has been addressed and portrayed and on the conclusions drawn about women and their bodies following childhood sexual abuse.

The clinical literature on effects of childhood sexual abuse has been generated from two sources; initially from the self-disclosures of adult women who publicly revealed and plausibly attributed many of their current personal difficulties to their incestuous abuse as children, and subsequently by the observations of professionals caring for abused children. The emerging adult-focused psychiatric discourse on effects of child sexual abuse reflected the tendency of victims to focus on psychological problems and the therapeutic contexts in which such revelations were often disclosed to mental health professionals. Early research into the effects of child sexual abuse frequently employed groups of adult psychiatric patients[2] which further reinforced the emergence of an adult focused psychiatric discourse about child sexual abuse. Studies demonstrating the relationship between child sexual abuse and adult psychopathology have since proliferated, affirming both the deleterious effects of childhood sexual abuse on children,

[1] A comprehensive review of the current literature on child sexual abuse has been completed for this thesis, titled Appendix 1. Due to its length (approximately 20,000 words) it has not been included in appendices but is available upon request.

[2] Carmen (Hilberman), Ricker, & Mills (1984); Mills, Ricker & Carmen (1984); Bryer, Nelson, Miller &

and the dominance of psychiatric discourse in explicating and conceptualising the effects. More recently, the clinical literature has conceptualised child sexual abuse as trauma, focusing on a specific set of trauma-induced symptoms that negatively impact on healthy adult psychological functioning. However, I contend that the primacy ceded to the psychological ramifications of child sexual abuse in earlier and more current discourses has produced little acknowledgment of the embodied dimensions of abuse impact.

1.1 Historical Formulations of Child Sexual Abuse: The Absent Body

The earliest proposed theory relating to childhood sexual abuse set the precedent for focusing on the psychopathological manifestations of childhood sexual abuse. Freud's work on the psychosexual development of personality and on hysteria with predominantly female patients proposed that the cause of hysteria and neurosis was not hereditary or biological factors, but childhood sexual abuse. Freud presented the causal relationship between childhood sexual trauma and psychic damage in a group of papers entitled '*The Aetiology of Hysteria*' (1896), in which he cited numerous cases to support his premise that at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience belonging to the earliest years of childhood. The publication of Freud's theory, which became known as the 'seduction theory', created controversy in Viennese society and amongst his peers. The resulting furor, coupled with Freud's personal discomfort with the high prevalence of incestuous abuse reported by his patients, led him to abandon his theory (Masson, 1984). It was replaced with the 'Oedipal theory', in which patient's experiences were disbelieved and relegated to the realm of fantasies and unfulfilled desires. Girl children were perceived to fantasise about sexual activity between father and daughter, and their experiences were denied.

Freud's decisive and permanent decision to withdraw the seduction theory, and to relegate sexual abuse stories to the realm of hysterical women's fantasies had far reaching consequences (Masson, 1984; Sanderson, 1990). Critics of psychoanalytic formulations of child sexual abuse have argued that conceiving of child sexual abuse as a

---

Kroll (1987); Craine, Henson & Colliver (1988).

fantasy rather than a reality has allowed for the continuation of incest and society's denial of it. The construction of children as 'seductive' and desirous of sexual contact with adults, and mothers' as 'collusive', has made children and women responsible for incest while adult male perpetrators have been exonerated. Moreover, by relegating child sexual abuse to the private, individualised realm of psychoanalysis, it has been withdrawn from the public sphere and from broader political and social analysis (Masson, 1984).

As Freud's theories had substantial influence in the literature, thinking and practice of psychoanalysis, many women's childhood sexual abuse experiences were invalidated. Freud's disavowal of childhood sexual abuse, relegated women's lived, embodied experience of sexual violation to the realm of fantasy. In so doing, women's bodies were portrayed as relayers of illusory or fictitious experience, at worst, untrustworthy and unreliable, and at best, irrelevant to subjective experience and the formation of consciousness. Freud's renunciation of childhood sexual abuse therefore effectively denied the reality of bodily experience for those whose bodies had been violated in childhood, and in doing so, he effaced the violated female body.

Early psychoanalytic theory also reflected and advanced various conceptualisations that relegated the body to a position that was subordinate to psychical significance, and subsumed the 'lesser' female body under the superior masculine norm (Vice, 1998). Retaining a commitment to the psycho-physical dualism inherited from Cartesian philosophy, Freud's emphasis was primarily and explicitly on psychological investigation (Grosz, 1999).[3] The hysterical phenomenon of bodily symptoms with a psychic rather than organic cause suggested to Freud a psyche divided between conscious and unconscious realms. The psyche was considered to be allied with the mind and opposed to the body. Moreover, Freud's theory of the Oedipal complex and infantile sexuality relegated the female body to a position as the inferior 'second sex'. While violated female bodies were seen not to exist, female bodies in general were superceded and

[3] Grosz (1999) notes that despite Freud's avowed commitment to dualism, there are moments in his writings when he presents an implicit critique of dualism. Grosz argues that although much of Freud's work makes biologistic presuppositions, he presents alternative accounts of a socially, historically and culturally sexed body in specific tracts of his work.

subsumed by masculine minds.

Psychoanalytic theory has since been the subject of extensive feminist critique and revision (Bowlby, 1992; Breen, 1993; Minsky, 1996). Furthermore, in reconstructing psychoanalysis, feminist theorists have enlisted its insights, in particular the concept of the unconscious, and the idea that gender is a psychic not a biological entity (Vice, 1998). Feminist writers have also worked towards a reconstruction of the psychoanalytic model as it is applied to victims of childhood sexual abuse, validating the reality of their claims, attending to the abuse impact, and suggesting therapeutic practices that are central to recovery (Courtois, 1988; Gil, 1988; Dye and Roth, 1990; Rose, 1991). Despite significant reconfigurations of psychoanalytic theory, its legacies include the disavowal of the sexually violated female body, the privileging of psychological processes, fantasies and desires over the material reality and lived experience of the body, and a partiality to focusing on the psychopathological manifestations of childhood sexual abuse. Furthermore, the historical influence of psychoanalytic ideas ensures they are writ large in broader psychiatric discourse.

1.2 Psychiatric Discourses on Child Sexual Abuse: The Object Body

Various legal, medical/psychiatric, child protection and feminist discourses on child sexual abuse characterise the contemporary context. However, the prominence of adult psychiatric discourse in conceptualising the effects of child sexual abuse has been consolidated by a substantial body of clinical literature testifying to the correlation between childhood sexual abuse and the development of psychopathology. The results of the research have repeatedly documented considerable and extensive negative effects for victims, in the form of mental health problems that may persist in frequency and severity in adulthood, and significantly impair healthy adult functioning.[4]

[4] For comprehensive reviews of the impact of child sexual abuse see Adams-Tucker (1982), Browne & Finkelhor (1986), Schetky (1990), Briere & Runtz (1993), Beitchman, Zucker, Hood, DaCosta, Akman & Cassavia (1992); Berkowitz (1998); Read (1998); Rodriguez, Vande Kemp & Foy (1998) Mullen & Fleming (1998) and Allen (2001).

A stunning array of psychological problems have been found to be directly linked to childhood sexual abuse including anxiety, depression, somatisation, dissociation, eating disorders, sexual dysfunction, self mutilation, drug and alcohol abuse, suicidal ideation and suicide, multiple personality disorder, borderline personality disorder, rage, social isolation, sleep disorders, and conversion disorder.[5] There is also growing evidence that the most serious long term psychological effects result from highly intrusive sexual abuse such as oral, anal or vaginal penetration; abuse that is violent, forceful or sadistic in nature; abuse that continues over many years; and intra-familial abuse, particularly when the perpetrator is a parent, step-parent or parent figure (Schetky, 1990). The frequent occurrence, serious and long term consequences of childhood sexual abuse prompted Salter to state that; 'Clinicians in the fields of drug addiction, prostitution, psychiatric in-patients, psychiatric outpatients, physical abuse, eating disorders and chronic mental illness, would be well advised to have some acquaintance with the field of sexual abuse since it may affect half or more of their clients' (1992:26).

The consequences and psychiatric implications of child sexual abuse have received substantial attention in clinical literature. Some writers have suggested that the emphasis on the psychological consequences of sexual abuse has overshadowed the physical, behavioural and developmental consequences of abuse (Browne and Finkelhor, 1986) and the impact of abuse on interpersonal, social and sexual functioning (Mullen and Fleming, 1998). Young (1992) argues that the emphasis of psychiatric discourse on the psychological problems experienced by adult survivors of child sexual abuse has largely obscured consideration of the effects of sexual abuse on embodiment.

Whilst body problems associated with childhood sexual abuse may have been overlooked in favor of the elucidation of psychological difficulties, the body is apparent in psychiatric conceptualisations of somatisation. Somatoform disorders are described as 'physical symptoms suggesting physical disorder...for which there is no demonstrable

[5] See Meiselman (1978); Herman (1981); Jehu & Gazan (1983); Bagley & McDonald (1984); Briere & Runtz (1985); Goodwin (1985b); Bagley & Ramsey (1986); Steele (1986); Friedrich, Urquiza & Bielke, (1986);Courtois (1988); Gil (1988); Rinza & Berg (1988); Morrison (1989); Wurtele, Kaplan & Kearnes (1990); Herman (1992); Mullen (1993); Vanderlinden et al. (1993); Mullen et al. (1994); Zlotnick et al.

organic findings or known physiologic mechanisms, and for which there is positive evidence, or strong presumption, that the symptoms are linked to psychological factors or conflicts' (D.S.M.III-R, 1987:255).[6] They include conversion disorder, somatisation disorder, somatoform pain disorder, hypochondriasis, body dysmorphic disorder, and undifferentiated somatoform disorder. However, many other psychiatric syndromes have somatic symptoms as a significant part of their clinical presentation (Loewenstein, 1990). In the tradition of the classic concept of hysteria, somatoform disorders presume the development of physical symptoms as a form of communication about psychological difficulties or conflicts.[7]

Studies have indicated a relationship between a history of childhood sexual abuse and somatoform disorders (Draijer, 1989; Morrison, 1989; Jungjohann, 1990; Loewenstein, 1990). Many support Freud's early idea that somatoform symptoms represent disguised symbolic communication ultimately related to experiences of childhood sexual trauma and abuse. An alternative explanation is given by Briere and Runtz who propose that the heightened concern with bodily processes and their vulnerability to disease and dysfunction, may arise, in part, 'from the experience of physical invasion and vulnerability involved in sexual victimisation, processes that may increase the salience of bodily stimuli' (1988:52). The first explanation gives primacy to understanding psychological conflicts reflected in body symptoms, while the second emphasises the physiological reactivity of the body in the process of somatisation. Both explanations assume the body to be a solely biological entity that provides the basis for the formation of psychological difficulties. The body remains secondary to psychical significance.

Embedded in adult psychiatric discourse on the effects of childhood sexual abuse are two central and apparently contradictory implications about the body of victims. Given the

---

(1994); Schwartz & Cohn (1996); van der Kolk (1996); Friedrich (1998).

[6] D.S.M.R.III-R refers to the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Association of Psychiatrists, third edition, revised. The document identifies, classifies and describes recognisable mental disorders and is utilised widely by mental heath professionals in diagnosing psychiatric disorders.

[7] There are a number of different subliteratures on somatisation with different sets of implicit and/or explicit theoretical presumptions and clinical preoccupations. See Loewenstein (1990).

scant attention paid to the body and embodiment, and the concentration on psychological difficulties suffered by victims, the first implication is that an individual's psychological life is separate from, or uninformed by their body, a conceptualisation that presupposes a disembodied consciousness. An alternative reading is that the body is largely irrelevant, unacknowledged because it is conceived of as secondary to the mind. The body is merely biological machine, driving the functioning of bodily organs and processes and housing the all-important mind. The body is therefore an 'object body', distinct and separate from the workings of the mind, or subject to and acted upon by the mind. This conceptualisation replicates the dualism inherent in Western philosophical traditions.[8]

Psychiatric discussions of somatisation, however, do attend to the body, presupposing that it informs consciousness in a variety of complex ways and that it is implicated in psychological difficulties. For victims of sexual abuse, all body symptoms are understood to represent the conversion of internal psychological difficulties surrounding the abuse experience. While acknowledging the body, the notion of somatisation rests on a limited conception of the body. The body constitutes the biological base for psychological difficulties that are then privileged over any broader conceptualisations of the body that may be relevant to the experience of victims. The meanings attached to the body in and of itself, and the meanings created in the aftermath of the trauma of sexual abuse are minimised, as is any theorisation of the body's intersection with culture. Psychiatric discourse also appears to assume a neutrality to the body, focusing attention on the natural human body, rather than the constructed or sexually specific body.

More recently, research has considered the relationship of childhood sexual abuse to specific physical and medical health problems. Findings have indicated significantly increased levels of self-reported physical complaints, measurable disease entities, or both, in women with a history of childhood sexual abuse, in addition to more problems in respiratory, gastrointestinal, musculoskeletal, neurological and gynaecological functions (Lechner et al, 1993). In the studies, conceptualisations of the body take three apparent

[8] See Chapter two (pp. 31-37), for a discussion of dualism and Western philosophical constructions of the body.

forms. The first is the view of the body as machine, whose parts and functions break down as a result of the unhealthy lifestyles led by those who have been sexually abused (due to increased likelihood of smoking, drug and alcohol abuse and self-harming). The body is viewed as a limited biological and physical entity. The second, is that of an unruly object which is out of control and subjected to the dominating influence of psychological factors or conflicts which destabilise it and cause it to 'malfunction'. The view presumes the body to be unmanageable, but as not driven by behaviour, but by the powerful psychological forces of the mind. The third, evident in psychosomatic explanations of medical problems suffered by survivors, is that of the body as symbol; as a metaphor for the pain and damage of the sexual assault, expressed in tangible, physical ways. Again, in medical discourse, the body is primarily conceptualised as 'an object body', acted upon by the victim. The body may also be a personal symbol, as opposed to a symbol with social meanings, but it remains subordinated to the mind, and to psychological processes enacted upon it.

1.3 Child Sexual Abuse As Trauma: The Natural And Unsexed Body

In the clinical literature, extensive writings on trauma and childhood sexual abuse have emerged which somewhat parallel and overlap with adult psychiatric discourse. Responses to trauma have been described over several centuries, becoming more clearly identified as a set of symptoms through the work of Freud on female 'hysteria'. Freud concluded that hysteria was caused by psychological trauma, and through the careful reconstruction of the stories his patients told, Freud offered 'premature sexual experience' as the etiology of hysteria (1933). He later abandoned his theory in favour of the notion of 'fantasy' (Masson, 1984). Though trauma theory had its genesis with understanding women's experiences of child sexual abuse, the connection between recognisable symptoms and a history of child sexual abuse was lost for most of the twentieth century. After Freud's recanting of the 'seduction theory', trauma theory was not applied again to sexual assault until 1974 when similarities between the experiences of rape victims and war veterans were identified (Burgess and Holstrom, 1974). Subsequent research demonstrated the similarity in responses of Holocaust survivors,

victims of catastrophe and disaster, and rape victims, leading to the recognition of a cluster of symptoms as being characteristic responses to trauma. In 1980, this resulted in the inclusion of Post Traumatic Stress Disorder (P.T.S.D.) as a diagnosis in the 3rd edition of the *Diagnostic Statistical Manual of the American Psychiatric Association* (van der Kolk, Weisaeth and van der Hart, 1996).[9]

Since this time, the nature of child sexual abuse, the severity of impact and persistence of symptoms experienced by survivors has prompted the contemporary use of a 'trauma' framework by theorists, clinicians and researchers in the field. It is used as a means of both conceptualising and treating the range of psychological, emotional, cognitive/ perceptual, physical, sexual, interpersonal and behavioural difficulties affecting survivors (Ellenson, 1986; Salter, 1992; Herman, 1992, van der Kolk et al. 1996b). Amongst claims that the psychiatric system inadequately considered previous histories of child sexual abuse[10] and mistakenly diagnosed as psychoses particular trauma-induced symptoms such as perceptual disturbances that were attributable to the abuse[11], trauma theorists have been keen to identify and describe a constellation of symptoms indicative of trauma.

The Diagnostic Statistical Manual of the American Psychiatric Association (1980) has conceptualised responses to trauma under three main headings: hyperarousal, intrusion, and constriction. Hyperarousal refers to the persistent expectation of danger; intrusion to the indelible imprint of the traumatic moment; and constriction to the numbing response of surrender (Herman, 1992:35). Such symptoms mean that victims are in continuous states of physiological and psychological arousal in perpetual readiness for the 'flight' or 'fight' response; reacting with flashbacks or intrusive sensations to general stimuli not related to the trauma or to specific triggers which are reminiscent of the event (smells, sounds, sensations, people, locations, situations), or adapting by numbing both physical and emotional feelings to avoid stimuli which trigger a response. Both reactions are problematic for survivors of trauma. While victims may remain vigilant to avoid

---

[9] The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* (D.S.M.111).

[10] See Carmen, Reker & Mills (1984); Salter (1988); Herman (1992); Meyer, Muenzenmaier, Cancienne & Streuning (1996).

reminders, traumatic memories are unlike other memories in that they lack narrative and sequence, and are more likely to be experienced as images and sensations (Herman, 1992; van der Kolk, 1996), prompting victims to move from stimulus to response without the usual process of making meaning about the current events.

At the core of trauma literature have been studies that have sought to explain the bio-physiology of trauma and account for the complex interplay between the physiological reactions to trauma and the resulting symptoms experienced by victims. For example, much attention has been paid to the process of dissociation as a defence mechanism used by victims when faced with the intolerable physical or psychological pain associated with trauma.[12] Dissociation is the process in which information is not stored, associated or retrieved in the usual way and the psychic material is perceived to be compartmentalised and split off from consciousness. The concept of dissociation was first discussed in a systematic fashion in the 1880s, in the work of Frederick Myers in England, and that of Jean-Martin Charcot, Gilles de la Tourette and Pierre Janet in France. Myers was probably the first to demonstrate the degree of dissociation of memories, faculties and sensibilities in patients with multiple personalities. Charcot noted that 'by reason of the easy dissociation of mental unity, certain centres of the psychic organ may be put into play without the other regions of the psychic organ being made aware of it and called upon to take part in the process' (quoted in van der Kolk et al, 1996). Janet became the first systematic investigator of the relationship between dissociation and psychological trauma, coming to believe that dissociation was the critical factor in determining the eventual adaptation to a traumatic experience. Trying to account for what causes people to dissociate, Janet wrote: 'I was led to recognise in many subjects the role of one or several events in their past life. These events, which were accompanied by vehement emotion and a destruction of the psychological system, had left traces. The remembrance of these events absorbed a great deal of energy and played a part in the persistent weakening' (1932:128, quoted van der Kolk, 1996). According to Janet, the intensity of a 'vehement emotion' depends both on the emotional state of the victim at the time of the

[11] See Ellenson (1985, 1986).
[12] See van der Kolk & Saporta (1991); Coons & Milstein (1992); Atchinson & McFarlane (1994); Calof

event and on the cognitive appraisal of the situation. Thus the intensity of emotional reaction - determined by the meaning attributed to the event, rather than the event itself - eventually accounts for the resulting psychopathology; 'The individual, when overcome by vehement emotions, is not himself. Forgetting the event which precipitated the emotion has frequently been found to accompany intense emotional experiences in the form of continuous and retrograde amnesia' (Janet, 1909b: 1607, quoted in van der Kolk et al, 1996). As Janet alleges, in such cases the person is 'unable to make the recital which we call narrative memory, and yet he remains confronted by the difficult situation'. The resulting 'phobia of memory' prevents the integration ('synthesis') of traumatic events and splits off the traumatic memories from ordinary consciousness (Janet 1898:145, quoted in van der Kolk et al, 1996).

In recent years, psychiatry has rediscovered how dissociative processes play a critical role in the development of trauma-related psychological problems (eg. Speigel, 1990, Speigel and Cardena, 1991; Briere and Conte, 1993). Bio-neurological studies demonstrate that physiological arousal during the traumatic event has consequences for managing consequent memory and affect, which impacts upon the way traumatic memories are encoded and retrieved (van der Kolk and Saporta, 1991; van der Kolk, 1994). The memories do not appear to be accessed in the same way as normal memories. Rather, traumatic memories appear to be based on an altered neurophysiological arousal which makes them inaccessible to normal memory, unavailable to words, and remaining in feeling states that are expressed somatically (Herman, 1992; van der Kolk, 1994). Studies on the biological response to trauma also demonstrate that trauma induces the body to produce opioids (morphine like substances), which have an anaesthetising effect (van der Kolk, 1994, 1996). On the basis of such findings, trauma theorists have concluded that trauma involves the fragmentation of the normally integrated functions of emotion, cognition, memory and physiological arousal (Herman, 1992; Figley, 1995; van der Kolk, 1997).

(1995); Lynn & Rhue (1995); van der Kolk & Fisler (1995).

Trauma research has also demonstrated an increased understanding of the interplay of child and adult trauma and specifically how the reverberations of childhood trauma compromise adult functioning (van der Kolk et al, 1996; Mullen and Fleming, 1998). A substantial body of research reveals that childhood trauma, which occurs at an early age and is prolonged, has a profound effect on the child's ability to regulate feelings and affective responses (Monahon, 1993; Briere, 1996; van der Kolk, 1996). Victims can experience acute and chronic disturbance to the ability to self-regulate (control emotional and physiological responses to stimuli) and can react to this with attempts to self-regulate which in themselves are destructive. Self-harming activities such as self-mutilation, starving, purging, substance abuse and alcohol abuse are well documented examples (Salter, 1992; Wolf, 1995; Schwartz and Cohn, 1996; van der Kolk et al. 1996). Most studies have concluded that Post Traumatic Stress Disorder, dissociation, somatisation and affect dysregulation represent the spectrum of adaptations to trauma, which may occur together, in various combinations, or over lengthy periods of time. These disturbances, accompanied by the disruption they imply for normal development and for healthy and appropriate interpersonal relating and social competence, leave victims with impairments that substantially impede healthy adult functioning.

The ability of trauma theory to account for a range of disturbing physiological and psychological symptoms has opened up new ways of thinking about and treating victims of sexual assault (Haaken, 1996). However, the use of the P.T.S.D. diagnosis has been criticised on two fronts. One is the domination of the P.T.S.D. diagnosis in understanding traumatic responses. The other is the inadequacy of the diagnosis itself. The D.S.M.IV is a socially constructed document which represents current agreement by a body of psychiatrists on what constitutes a psychiatric disorder (Tomm, 1990). As a diagnostic manual it attempts to describe sets of behaviours which are identified as symptoms, and which are seen as characteristic of a particular disorder. Numerous writers have pointed out that, despite the reified status of this document and the 'knowledge' it contains, its truths are socially derived and located (Tomm, 1990; Weitzel, 1991; Jimenez, 1997). Further criticism has focused on the individualistic orientation of the D.S.M.IV, and its inherent presuppositions that human behaviour, the mind and its disorders are based in

the individual. Other theoretical bodies of knowledge that examine the fundamental role of social phenomena in the creation of psychiatric symptoms are ignored (Tomm, 1990). Critics have challenged the power of the document to define P.T.S.D., to reify P.T.S.D. as the sole response to trauma, and to individualise and pathologise human responses to trauma. Other writers have argued that the trauma of sexual abuse leads to responses that are not adequately encapsulated by the P.T.S.D. diagnosis. Trauma theorists such as Herman (1992) and van der Kolk (1994, 1996) argue that this is because the diagnosis is inadequate, not trauma theory itself. However, child sexual assault theorists argue that victims' responses are not adequately explained by trauma theory, rather they consist of a more complex set of responses (Salter, 1992; Mullen and Fleming, 1998).

While early researchers suggested that P.T.S.D. was a universal response to childhood sexual abuse (Frederick, 1985; Lindberg and Distad, 1985), more recent research indicates that the development of P.T.S.D. is likely to be dependent on the nature and severity of the abuse. If the abuse involved penetration, victims may be almost twice as likely to develop P.T.S.D. symptoms (Saunders, Villeponteaux, Lipovsky, Kilpatrick and Veronen, 1992), and to have more severe symptoms (Briggs and Joyce, 1997). Estimates of how many victims suffer from P.T.S.D. vary from 10-60% (Salter, 1995). Further, disagreement exists about the ability of trauma theory to account for the range of symptoms exhibited by victims (Finkelhor et al, 1990; Mullen et al, 1994; Salter, 1995). The diagnostic criteria for P.T.S.D. rests on the presence of '...intrusions, avoidance and hyperarousal,' which van der Kolk has argued '...does not begin to capture the complexity of long term adaptations to traumatic life experiences, particularly in children and in adults who were traumatised as children' (1996:183). Trauma theorists assert it impedes the development of normal interpersonal skills, and continues to resonate in the conduct of relationships with others, in issues of trust, control and intimacy (Monahon, 1993; van der Kolk, 1996). Mullen et al (1996) argue that while P.T.S.D. is useful in conceptualising immediate responses to child sexual abuse and other trauma, it neither adequately accounts for longer term difficulties, nor the notion of P.T.S.D. as a chronic condition. They claim that there is no obvious relationship between initial trauma symptoms and ongoing problems. Rather, the occurrence of childhood sexual abuse is

seen to impede and interfere with subsequent healthy social, sexual and emotional development, which is the key to later disruption. Mullen et al (1994) found that the women with a history of childhood sexual abuse began to experience problems when confronted with a range of expectations and tasks which characterised adult life. This prompted them to conclude that, '...the acute response may well conform to P.S.T.D but it is the developmental disruption which in most cases will induce the vulnerability to later disorder' (Mullen et al.,1994:18). Their finding suggests that the importance of P.T.S.D. may be in the ways it influences and organises a victim's initial responses to the abuse. Salter also argues that P.T.S.D. inadequately describes the symptoms commonly associated with childhood sexual abuse, claiming that suicidality, drug addiction, alcoholism, and revictimisation are outside the diagnostic criteria, but are frequently found to be the sequelae of childhood sexual abuse, and that, '... the cognitive affects of child sexual abuse, the internalised voice of the offender, the struggles with meaning making, cognitive distortions, or shattered assumptions cannot be easily explained by reference to P.T.S.D.' (1995:195).

Many writers agree that the current P.T.S.D. conceptualisation has limitations (Herman, 1992; van der Kolk, 1996). Some authors have argued that since the P.T.S.D. diagnosis was created, it no longer adequately describes the variability and complexity of responses (Herman, 1992; Figley, 1995; Reviere, 1996). Other authors have seen the diagnosis as the problem rather than trauma theory itself, and have made attempts to demonstrate the link between typical symptoms of P.T.S.D. and the longer-term impacts often seen in victims (van der Kolk, 1996). The connection between dissociation and later substance and alcohol abuse, as a form of numbing by self-medication, is one such observation (Herman, 1992, Matsakis, 1995; van der Kolk, 1996; Epstein, Saunders, Kilpatrick and Resnik, 1998). The frequency of self-harming and self-mutilating behaviour in victims, as a longer term response to childhood abuse, has also been linked to dissociation (Halpern and Henry, 1994; Calof, 1995), and hyperarousal, where it is used as a tension reducing strategy (Briere, 1992; Briere and Gil, 1997).

Other writers have been keen to point out that 'trauma' is not confined to the actual abuse, but also includes the responses of others (Monahon, 1993; Matsakis, 1996). Experiences of 'secondary wounding' and retraumatisation can occur when children's disclosures are not believed, when they are blamed for the abuse, when the disclosure results in placement away from the family, when they are subjected to multiple intrusive interviews, and when parents' and siblings' distress is so severe and dramatic that the child feels responsible for the parents' pain (Monahon, 1993). In adult life, 'secondary wounding' can occur at the hands of partners and loved ones when the survivor is rejected or blamed at the time of disclosure, when the survivor is encouraged to 'forget' or 'get over' the abuse experience, when difficulties with intimacy or sex are labelled as frigidity or lack of love, or when the survivor herself engages in destructive behaviour that is harmful to partners or children (Miller and Sutherland, 1999). These aspects of trauma are not accounted for in P.T.S.D. formulations. Agreement about the limitations of P.T.S.D. have prompted a critique of the D.S.M.IV diagnostic criteria for P.T.S.D. and arguments for the integration of other diagnostic categories which encompass the range of victims' symptoms (somatoform disorders, dissociative disorders, borderline personality disorders) (van der Kolk, Pelcovitz, Roth, Mandel, Mc Farlane and Herman, 1996). While acknowledging its limitations, and cautioning about its overuse, the majority of theorists and clinicians who specialise in the treatment of child sexual abuse victims, adopt the trauma framework (Herman, 1992, Salter, 1995, Matsakis, 1996; van der Kolk, 1996).

One further complication in applying a trauma model to child sexual abuse is that, according to Russell (1986), while 'abuse' is always 'exploitative', it is not always perceived as 'traumatic'. For some victims, abuse experiences are not regarded as traumatic, as is the case, at times, in sibling incest and in father-daughter incest. However, several writers argue against using the victim's belief about whether the abuse was damaging or not as the only guide (Russell, 1986; Salter, 1995; Mullen et al., 1996). Other measures need to account for the age difference between the victim and offender, whether the experience was wanted or unwanted, whether there was distress at the time, whether the event caused longer term effects, to what extent the child 'accommodated' to

the abuse in order to survive, the methods used to entrap or groom the child by the offender, the relationship with the abuser and the ongoing access of the abuser to the victim. These complexities mean that the perception of and meaning attributed to childhood sexual abuse may be ambiguous, may be ambiguously traumatic and may therefore result in ambiguous responses (Dwyer, 1999).

The clinical literature on trauma has consequently focused extensively on elucidating the ways in which the experience of trauma can leave profound and lasting traces in the psyche and behavior of victims. The bulk of the studies investigate the biophysiological effects of trauma, examining how physiological responses to trauma inform and shape the behaviour of victims. Significantly fewer studies direct themselves to uncovering the personal, interpersonal or cultural meanings of trauma and how these meanings interact with the traumatic event to produce psychological or body problems for victims. The concern of trauma theory has therefore been with the natural or biological body of the victim, assuming that when biophysiological functioning is uninterrupted by traumatic events, normal and healthy psychological functioning will follow. The body is understood primarily in terms of its instrumental and organic functioning and positioned as part of the natural order, where its physiology poses similar questions to those raised by animal physiology. The body's sensations, activities and processes become 'lower-order' natural phenomenon, part of an interconnected chain of organic forms. The meanings of the traumatic event itself, the meanings attached to the body prior to and after the trauma, and the ways in which the body is inscribed with cultural meanings are overshadowed by biologistic conceptions of the body.

Arising from trauma based approaches are models which have explained victim trauma as resulting from psychological reactions to captivity, domination, the absence of freedom or hostage situations (Herman, 1992). While such explanations move away from biological constructions of the body and its' central role in trauma, they are replaced by analyses that disavow the body and privilege the mental and psychological constructions held by victims. Again the body becomes an 'object body', acted upon by perpetrators of the abuse, and a purely biological container for the psychological responses of victims.

Such a description forecloses alternative ways of viewing the body, such as the 'subject body' or the 'active body', imbued with some forms of agency and choice (Fox, 1996). Importantly also, the sexed nature of the body is seemingly irrelevant to conceptions of the body offered by trauma theory, which presumes a common or neutral body rather than a sexually specific body. The literature does not question the relevancy of a female or male body to how people experience trauma and to considerations of its impact. Hence, I now examine feminist theories of sexual violence and the body.

1.4 Feminist Constructions Of Sexual Violence: The Female Body And Culture

Feminist contributions to theorisations of sexual violence have been substantial. They have taken the form of critique, deconstructing existing explanatory, theoretical and treatment paradigms, and reconstruction, offering a coherent sociological and political analysis of women's social position and of violence against women in particular.[13] The proliferation of feminist theory and practice has been extremely influential in the socio-political contextualisation of sexual abuse, and in turning the private areas of intimate violence into public concerns (Atmore, 1997).[14] Feminist perspectives examine child sexual abuse within its wider social context, advancing a set of beliefs about the nature and causes of child sexual abuse and drawing attention to its' astonishingly high prevalence in Western society. While several different feminist perspectives of child sexual abuse exist, all emphasise the sources and consequences of male power in society. It has been primarily radical feminists who have written about the sexual abuse of children. Central to their thesis is the premise that the sexual abuse of children is a manifestation of the oppression of females inherent in patriarchy. As Rush comments, 'the sexual abuse of children, who are overwhelmingly female, by sexual offenders, who are overwhelmingly male adults, is part and parcel of the male dominated society which overtly and covertly subjugates women' (1980:73). The radical feminist perspective

[13] For a thorough analysis of the social and political status of women in Australia and the nature and patterns of family violence in Australian society see *Family Violence: Everybody's business, somebody's life* (1991), edited by the Family Violence Professional Education Taskforce. Sydney. The Federation Press.

[14] See Atmore (1994,1996,1997 &1998) for several interesting analyses of media representations of child sexual abuse.

considers the interrelationships between the power of men in wider society and in the family, and the corresponding oppression of women. The nuclear family is seen as a training ground for female subordination and exploitation in which females internalise inferiority and powerlessness. Feminists have also identified the role of the media in the sexual objectification of women and children, the implications of female and male role socialisation, and the ways in which the social construction of masculinity and male sexuality all establish, reinforce and perpetuate a context in which child sexual abuse occurs. In summary, for radical feminists, patriarchy provides the social opportunity to commit child sexual abuse, the social construction of masculinity, the motivation for abuse, and male sexual socialisation the direction for expression of the motivation. Radical feminist perspectives have developed as a critique of other theories and an account of the ways in which society furnishes men with the opportunity to abuse young females. They have failed however, to explain why some men are abusive and not others and more generally, to extend feminist analyses of child sexual abuse beyond that of critique, description and explanation.

Importantly, feminists have expressed concern about psychological theories that decontextualise abuse, 'medicalising' and 'pathologising' problems which are a consequence of the conditions of women's lives and which reflect broader socio-political inequities (Braverman, 1986; Kelly, 1988; Lerner, 1974, 1988; Chesler, 1992; Kelly, Regan and Burton, 1994). Black women writers, however, have been more apt in placing private enactments of violence within a broader dehumanising context (Butler-Evans, 1989). In Toni Morrison's *The Bluest Eye* (1970), for example, the rape of Pecola by her father, Cholly, dramatises a violence that neither begins nor ends with the broken body of the young girl. While the narrative forcefully conveys the horror of the rape, its trauma emerges out of a larger web of destructive experiences and unbearable losses that grip both father and daughter.

In the early period of mobilisation around incest, women spoke out publicly and in consciousness raising groups, supporting each other in defiance of cultural mandates to remain silent (Alcoff and Gray, 1993). As women entered mental health professions in

larger numbers, the climate of therapeutic receptivity to child abuse allegations also shifted. Women turned private remembrances into social testimonials, refusing to remain the guardians of their fathers' secrets. While black women writers have woven accounts of sexual violence into the larger fabric of cultural critique, the trend with the incest recovery movement has been toward a more narrow psychologising of sexual abuse (Haaken, 1996). Over the past decade, the clinical literature on sexual abuse has extended this stance of 'believing women's stories' to include clinical exploration of sexual abuse that is hidden behind the presenting clinical symptoms. A vast literature has developed to identify sexual abuse survivors, including those survivors who do not recognise the imprint of their abuse experiences in their clinical symptoms (Courtois and Sprei, 1988; Maltz, 1988; Fredrickson, 1992; Bass and Davis, 1994).

1.4.1 From Politics To Pathology

Psychological theories were initially welcomed as a means of explaining how women became entrapped in violent relationships and resorted to killing their tormenters in self-defence (battered women's syndrome), and why children failed to disclose abuse or retracted disclosures (child sexual abuse accommodation syndrome). While successfully utilised in legal contexts, such theories came to represent a psychological and pathological view of abused women and children, rather than a critical reflection about social frames within which they were living. Armstrong (1994) traces the history of the psychologising of child sexual abuse, lamenting the loss of a coherent political focus as the 'culture of recovery' envelops the incest survivor movement. She argues that terms such as 'healing' and 'journey', robbed of any meaningful content, offer women illusory solutions.

1.4.2 From Politics And Pathology To Psychic Trauma

The contemporary use of trauma theory and the diagnosis of posttraumatic stress disorder have raised similar concerns (Kelly, Regan and Burton, 1994; Haaken, 1996), shifting earlier feminist conceptualisations that situate abuse within a broad configuration of

relationships within the patriarchal family, to psychological approaches based in the trauma/dissociation model. There is now an extensive clinical literature based on the trauma/dissociation model (van der Kolk, 1987, 1994), with Judith Herman's (1992) pioneering work analysing the political implications of this transition and reconciling feminist/political and psychiatric/clinical traditions.

The trauma frame has, it seems, constituted a mixed blessing for survivors of child sexual abuse. The concept of psychic trauma has been progressive in normalising psychiatric conditions that historically have been viewed as reflecting some form of personal maladaptation. The trauma model represents a revolt against biological psychiatry, with its traditional emphasis on pathological symptoms as deficits, as well as a reaction against Freudian psychoanalysis. Given the oppressiveness of the 'faulty machine' model of biological psychiatry, diagnoses that restore the humanity of mental patients are an advance. The post traumatic stress diagnosis (P.T.S.D.), the clinical offspring of trauma theory enshrined in the D.S.M.1V in 1980, enabled even seemingly bizarre symptomatology to be understood as a normal response to an abnormal situation and as a means of coping with the disturbing memories of trauma. Further, the capacity of the mind to preserve a coherent representation of a past disorganising event, a premise of the trauma model, means that the patient carries within him/her the key to unlocking the source of later difficulties. The diagnosis redefines symptoms once attributed to hysteria, personality disorders and psychoses as reactions to traumatic events (Briere, 1992; Herman, 1992; Randal, 1994). While the assumption that pathological symptoms had an original adaptive value has historically been a tenet of psychoanalytic thinking, trauma theory goes much further in asserting the 'internal wisdom' and essential normality of the patient's symptomatology (Haaken 1996).

Feminists have a special affinity with the trauma/dissociation discourse because of its emphasis on the ability of the trauma survivor to preserve memories as veridical accounts of external events, despite the devastating effects of the trauma (Root, 1992). The model assumes that dissociative responses involve disturbances in the capacity to integrate memory, feeling and identity but that the mind does retain - in a fragmented form -

specific parts of the traumatogenic past. The approach provides, then, a language for articulating the pain and injury of women while preserving women's essential normality and rationality. If women's stories of victimisation are to be taken seriously the legacy of feminine hysteria must be debunked. Applying understandings from trauma discourse makes this possible.[15]

While the use of trauma theory has normalised and depathologised women's responses, and 'debunked' the myth of women's hysteria (Haaken, 1996:1078), the focus on victim's responses to trauma can sever the trauma itself from the social dynamics and context in which it occurs. It is particularly important that the focus on the psychological and physiological responses of victims of child sexual abuse not narrow the enquiry to the extent that gender and power inequities inherent in abuse become invisible to analysis. The traumatic responses of women to child sexual abuse can only make sense when socially located and when understood as embedded within a complex array of personal, social and cultural meanings (Culbertson, 1996).

Several feminist writers, while valuing the notion of trauma for its potential to normalise the behaviours and symptoms of women, have been critical of trauma as a theoretical framework on a number of grounds. First, the trauma discourse continues to medicalise and individualise the impact of child sexual abuse and to remove it from the socio-political realm (Kelly et al, 1994). Second, it fails to take account of the different dynamics involved in child sexual abuse compared to those in other trauma experiences, such as the use of sexuality as a form of domination, the deliberate betrayal of trust and the internalisation of confusing rationalisations about the abuse by the victim (Kelly et al, 1994).[16] Burgess and Holstrom (1994) point out that even apparently 'like' experiences

[15] Showalter (1985) presents a historical analysis of hysteria, focusing on both the psychiatric use of the diagnosis to silence feminine protest and the prepolitical language implicit in hysterical symptoms.

[16] Kelly et al. (1994) suggest that interpersonal violence, including child sexual assault, is different from other traumatic events in that the actions are planned, deliberate and involve the betrayal of trust and some form of domination. Moreover, they are private acts often enshrouded in secrecy in which victims are troubled by internalisations of responsibility and the rationalisations of the abuser. In a similar vein, Herman (1992) argues that the discrete trauma of war, upon which the P.T.S.D. category was based, does not account for repeated trauma, which is characteristic of sexual abuse, and more apt to lead to P.T.S.D. among women. She also argues that the survivor of acute trauma experiences a temporary loss of self, recognisable in the characteristic symptoms of P.T.S.D., whereas the survivor of chronic trauma sustains a

may be profoundly different. The response of a woman to stranger rape, for example, may be more similar to the experience of war veterans, than to the response of a child who has suffered prolonged abuse from a father whom she also experiences as loving and affectionate. To adequately account for the differences, all the aspects of the trauma experience, not just the psychological response, need to be understood. Third, the trauma model does not explain how trauma memory is transformed into narrative memory, nor does it explain how the 'body memories' stored in the brain as physiological markers of forgotten trauma are subsequently retrieved through language (Haaken, 1996). Fourth, the trauma model does not attend to the symbolic processes of mind and to the processes by which traumatic events are transformed over time, foreclosing the analysis of mediating factors such as the social context (Haaken, 1996). Fifth, the trauma model fails to take account of the complexity and variability of victim/perpetrator relationships (Herman, 1981, Starzecpyzel, 1987). Sixth, and of central importance, is its failure to account for the interpersonal dynamics of trauma (Herman, 1992, Haaken 1996). There has been some increased recognition of the relationally complex experiences involved in trauma with a shift in attention from theories of physical impact and 'sensory overload' (van der Kolk, 1994) to models of captivity and domination (Herman, 1992). However, models focused on captivity, domination or 'hostage theory' present a slippage in how feminists understand power within the family. The concept of power becomes located not in material differences in a father's privileges or access to resources, including the capacity to make use of others toward some identifiable end, rather, it is described as a primary drive to dominate or a spiritual impulse toward evil (Haaken, 1996). The master/slave paradigm does not allow exploration of the conflicting or ambiguous aspects of feminine subjugation within the family, or of children's agency, choice and sexuality (Fox, 1996). Finally, trauma theory fails to adequately address the complex social and developmental meanings of trauma for the victim. The personal and social meanings of abuse and violation are inextricably entwined, prompting Culbertson to state:

---

deeper disturbance of self and identity, 'she may lose the sense that she has any self at all' (Herman, 1992:86). On the basis of these differences, feminist clinicians have argued for the inclusion of 'complex

> Wounding exposes the problematic nexus of the cultural and the experiential, the biological and the social, in the memory of violence, making it clear that violence is about pain and wounding and dissolution, and that communication about it happens between the poles of the body and culture, themselves wrapped in meanings created or destroyed in the moment of harm. (1996:173)

1.4.3 Feminist Therapy And Child Sexual Abuse: Reconciling Politics And Pathology

Feminist clinicians have consequently been faced with the need to 'integrate clinical and social perspectives without sacrificing the complexity of individual experience or the breadth of political context' (Herman, 1992:4). In many ways, my project reflects this struggle. In attempting to reconcile clinical and political interventions in female child sexual abuse, feminist clinicians are faced by several significant constraints. First, while providing a detailed social analysis of child sexual abuse and its causes, feminists have paid less attention to how child sexual abuse should be addressed. Debate exists among feminists over the validity of individual approaches to treatment for victims and over the priority afforded to social and individual interventions. Second, while positioning the female body at the centre of causal explanations of abuse, feminists have failed to extend their analysis of the significance of the female body to the consequences of sexual victimisation. Third, for feminists who are interested in assisting individual victims, the critical question becomes: how is this best achieved? For some, embracing any approaches that categorise child sexual abuse and its effects as 'illness' are untenable, promoting as they do the pathologising of women, the psychologising of symptoms, the medicalisation of the body and the reinforcing of the power of white, male medical and psychiatric discourses over female bodies. The alternatives suggested may involve women's self-help and consciousness raising groups and/or promoting and endorsing victim's knowledge about the impact of sexual abuse and strategies for healing. For other feminists, especially clinicians, the serious and intractable problems suffered by women who have been sexually victimised in childhood suggest limitations to both the above approaches. Some feminist therapists have responded by utilising revised psychoanalytic

---

P.T.S.D.' in the D.S.M.

frameworks and practices for treating victims. Others have been circumspect about psychoanalysis' historical denial of sexual abuse, wary about the use of interpretation to define patients' reality, and reluctant to pathologise women and to psychologise or medicalise the effects of sexual abuse. Many feminist clinicians have turned to trauma theory in an attempt to reconcile psychiatric and political conceptions in female maladies. Trauma stories have become a unifying vehicle for expressing female disturbances within a narrative that wards off the social denial of sexual abuse, the pathologising of women's symptoms, and the blame of the victim. Consequently, clinicians have advocated recognising victim's suffering, special forms of social support, and legal recourse and compensation for victims. Individual and group therapists have encouraged victims to assume a special identity as 'survivor', and therapists have often cast themselves in the role of 'bearing witness' to survivor's trauma stories.

Haaken (1996) is critical of therapists' use of the trauma framework, asserting that there are problems associated with the 'special identity' attributed to and embraced by survivors, with subsuming a broad range of experiences and symptoms under the rubric of trauma, with therapy focused on the retrieval or recovery of trauma memories, and potential difficulties in therapist/client relationships inherent in the application of a trauma based approach. Haaken's concerns centre on the lack of attention paid to important aspects of the survivor's experience that are concealed in the application of the trauma framework. Absent from the formulations of the trauma model is the consideration of female fantasy, female conflict (ie. with other survivors, with non-offending mothers and with therapists), female aggression and destructive impulses, alternative explanations for disturbing mental representations, body symptoms and memories, symbolic communication, the role of neglect and physical abuse, and the effect of therapeutic suggestion. For Haaken (1996), the trauma/dissociation discourse has been important in bridging feminist clinical and political practice and in retaining a conception of women as both rational agents and damaged victims. At the same time however, it is limited by its reinforcement of traditional constructions of female experience that deny a complex female subjectivity, by its lens on pathology associated with the sexual abuse event(s) which obscures other troubling currents in women's

experience, and by its use of medicalised and limited narratives (Haaken, 1996).

On the basis of my findings, I support Haaken's view that trauma theory provides a narrow construction of female subjectivity. My work reveals four significant limitations in this regard. First, participants' accounts revealed that trauma is not reducible to physical impact or sensory overload as the trend in more recent trauma research has implied. Trauma also involves the subjective experience of being implicated in a destructive experience and the accompanying meanings that are attributed to the sexual abuse and its effects. Second, trauma theories limit their discussion of the body to its physiology, failing to offer broader conceptualisations of the body or to adequately theorise the body and its role in the construction of subjectivity. Third and importantly, trauma theories fail to acknowledge the sexed nature of the body in considering the effects of childhood sexual trauma, ignoring or neutralising sexual difference in their consideration of the traumatic effects of sexual abuse. For the women in my study, the sexed nature of their bodies was intrinsic to their traumatic experience and its effects. In failing to undertake an analysis of the way in which the sexed body informs and configures abuse and its' effects, important specificities of female survivors' experience are lost or subsumed under generalised descriptions of the human/male body. Fourth, trauma theory, while identifying and explaining the biophysiological aspects of trauma has neglected to explore the ways in which bodily symptoms are linked to broader social discourses on the body. 'Disturbances' in and of the body can carry other potential and potent meanings for women, including (as the women in my research articulated), struggles over sexuality, prohibited desire, submission, domination, rage, guilt and agency. Moreover, these struggles cannot be separated from the cultural context that gives them meaning and significance.[17] Such an analysis thus far has not been applied to the body problems experienced by female victims of sexual abuse whose bodies, I argue, are also inscribed with cultural significance.[18]

---

[17] The extensive feminist analysis of anorexia nervosa is one example of the sociopolitical theorisation of women's bodily struggles.

[18] Interestingly, an extended feminist analysis of the way in which childhood sexual abuse is constituted by the construction of female bodies in Australian culture, and the way in which problems of embodiment following the violation of sexual abuse reflect personal and social meanings about femaleness and the female body is, thus far, not widely accounted for in present feminist constructions of sexual violence.

To capture the significance of the sexed body and complex subjectivity (the relevance of which is illuminated by the accounts of female victims in my study), trauma theories must go beyond representations of the female self as the repository of trauma. I argue that what are needed are broader and multiple conceptualisations of the body. Multiple readings of the body are important because they disrupt dominant medical and psychiatric paradigms and open up a space for victims' knowledge. Moreover, they encompass conceptualisations of the body which acknowledge its historical and cultural situatedness and its sexual specificity, making way for more extensive and complex theorising about the personal and social meanings attached to trauma that is enacted on the specifically female body. They also make possible theorising not only about women's bodily oppression in response to the effects of childhood sexual abuse, but also for conceptualisations of the female body in childhood sexual abuse that are associated with resistance, transgression and recovery.

Postmodern and poststructuralist feminist ideas have been helpful here, theorising power with greater complexity than the earlier oppressor/oppressed model offered by radical feminists, and emphasising the important role of women's subjectivity in colluding with or challenging their oppression. Specific attention has been directed to the significance of the sexed body and to female sexuality and to the way in which cultural formulations of the sexed body position the female body as site of oppression and/or resistance. The analysis has extended previous feminist conceptualisations that presumed the body to be simply a biological base, object, or blank slate upon which social lessons are inscribed and enacted (Gatens, 1990). Although extensively used to theorise the female body and female sexuality, the conceptualisations inherent in postmodernist/structuralist theorising have not been widely applied to sexual abuse and the violated female body. Yet, on the basis of my findings, I contend that these ideas have application to the female violated body.

1.5 Summary

Psychiatric discourses dominate the field of enquiry in child sexual abuse, particularly with respect to the effects of child sexual abuse on victims. To a large extent, the body has been omitted or marginalised in psychiatric and psychological approaches. The body has been attended to more directly in recent medical and trauma discourses, which have focused on, respectively, the significantly increased levels of physical health problems and disease entities reported by victims, and on the biophysiological consequences of trauma. However useful, this kind of analysis is limited by its construction of the body as solely a physical entity and its inherent medicalisation of symptoms (Kelly, 1988; Haaken, 1996; Harrison, 1998). Feminist theories have contributed an important cultural analysis which locate gender at the centre of understandings of sexual violence. Although feminists have been critical of medicalisation which transforms social and political concerns into individual pathology and have challenged medical discourse for its power to name, explain, study and control female bodies and symptoms (Robertson, 1992), feminist clinical approaches to child sexual abuse are predominantly anchored in medical or psychiatric theories, which implicitly objectify the body and ignore its sexual specificity. More recent feminist theories have focused on the centrality of the female body, however, these analyses have not been applied to sexual abuse and the violated female body.

1.6 Discussion

The above literature review illuminates important factors in any consideration of child sexual abuse. First, the analysis reveals that, despite the centrality of victims' bodies to the experience of child sexual abuse and its impact, the body is often absent from or secondary to the psychological in child abuse impact studies. The bodily experience of victims and the testimonies they give about the problematic nature of embodiment post childhood sexual abuse is not substantive or valued knowledge in contemporary discourses on child sexual abuse. Second, the body, when it is acknowledged in such studies, is predominantly envisioned as a physical body or an 'object body' that is

disconnected from any unified sense of self. As a purely biological entity the body is either marginalised or acted upon by psychological states or behavioural activities of a 'separate self'. Such a dualistic view reinforces other dichotomies and disconnections at the heart of child sexual abuse dynamics; subject and object, victim and offender, dominance and submission, biological and cultural, body and mind, power and weakness. The 'object body' represents a narrow and limited way of conceptualising the body, grossly oversimplifying the complexities attached to victims' bodily experience, and concealing the important personal and social meanings of the body for victims. For female victims of sexual abuse, numerous 'bodies' are evident in their stories, the physical body, the socially constructed/ imaginary body, the symbolic body, the sexed body and the body politic.[19] Each dimension of embodiment is evident in victims' experiences and perceptions of their bodies and each are linked through the reciprocity of body, mind and language. In foreclosing multiple understandings of the body and its meanings more complex ways of thinking about the nature of abuse, the bodily experience of abuse and the various dimensions of embodiment for victims may be overlooked, limiting opportunities for understanding, analysis and helpful intervention. Third, the above analysis reveals that certain pervasive, unspoken assumptions regarding the body exist in current discourses of knowledge on child sexual abuse. To a large extent these suppositions remain implicit and therefore unacknowledged. They do however, silently shape the way female bodies and children's bodies are viewed when they have been subject to the violation of sexual abuse, and construct 'received knowledge' on child sexual abuse. It is in deconstructing received knowledge that both possibilities and limitations can be revealed and opened for exploration. One significant and unarticulated assumption implied by psychiatric and trauma discourses is that the violated body is a 'human' body, its sexual specificity irrelevant to the abuse and its impact – a presumption that is challenged by my findings.

For the women in my study who were sexually abused in childhood, their bodies and their bodily experiences were much more complex, ambiguous and multilayered than the

[19] Throughout the thesis I argue that there are various 'bodies' evident in victim's stories. I illustrate this proposition in my analysis of women's stories, using the word "bodies' to highlight this theoretical idea.

above theoretical frames allow. Their stories reveal multiple, complex, and at times simultaneously opposing meanings of the body, as well as richly textured layers of meaning attributed to body symptoms and problems of embodiment, and the complex interweaving of personal and social dimensions of meaning and significance. Consequently, my study seeks to avoid four common features of other writings on the impact of sexual abuse. First, I am concerned not to conceal corporeality, nor to obscure the powerful experience of women's bodily knowledge. Second, I resist the medicalisation and pathologisation of the bodies of victim. Third, I reject the tendency to suggest that while body symptoms experienced by survivors are understandable in the context of childhood abuse experiences they represent individual manifestations of psychopathology or illness, or solely the biophysiological ramifications of trauma. Fourth, I move beyond medical, psychiatric and psychological explanations of victims' body symptoms and problems of embodiment to reveal multiple dimensions of embodiment. My understanding seeks to embrace the personal and social meanings survivors themselves attach to their bodies, to identify the existential choices they make about living in their bodies, and to illuminate the process victims use in moving beyond the bodily impact of abuse. I propose that body symptoms and problems of embodiment experienced by survivors of sexual abuse embody more than the individual search for connections between body and self, that rather, they reveal attempts to synthesise elements in the social position of females and their victimhood.

CHAPTER TWO
THEORIES OF THE BODY

2.1 Introduction

In this chapter I review and deconstruct received concepts about the body by examining three epistemological approaches central to my work. It is beyond the scope of my thesis to offer a comprehensive review of all the philosophical, biomedical, sociological, anthropological, scientific, semiotic and political discourses on the body. Hence, I have focused specifically on existential–phenomonological, structuralist-symbolic, and poststructuralist paradigms of embodiment. I do so because my study reveals that in order to more fully appreciate women's experience of embodiment after sexual abuse there is a need to envisage the body in broader terms than those offered by limited psychiatric/medical conceptions of the physiological/object body. The approaches I review here allow me to theorise the body as it is felt, experienced and rendered meaningful, and also to theorise the processes by which the subject is marked, written upon, transformed or constructed by society, or by various regimes of power, as a particular kind of body.

In extending conceptualisations of the body, I also seek to problematise the body. By revealing the various ways in which the body may be viewed and attending to the consequences of each perspective, I disrupt discourses which disavow the body, which separate body from mind, and which resort to limited biophysical reductionism or naive social constructionism. Women's stories suggested to me that such polarised and limiting views of the body do not capture the multiple and complex layers of experience and meaning that they attached to their bodies and to embodiment after sexual violation. Rather, their stories called for more fluid and multifaceted conceptions of the body - as simultaneously a physical and symbolic artifact, both naturally and culturally produced, as securely anchored in a particular historical location and time, and, as central and significant to their everyday experience.

2.2 Philosophy And The Body

The tradition of Western metaphysics has been sadly negligent in its treatment of the body. Grosz (1994) argues that since its inception as a separate and self-contained discipline in ancient Greece, Western philosophy has established itself on a deep fear and loathing of the body, evidenced in philosophical works from Plato and Aristotle through to the tenets of Christian thought. Cartesian philosophy reinforced the antipathy for the body, regarding it as a source of interference in, and a danger to, the operations of reason, and as an object that needed to be subjugated and controlled to maintain social order. The deep suspicion of the body resulted in its separation from the mind (which became equated with self and society), and its consequent relegation to the natural realm as merely physical mechanism or machine.[20]

The profound and enduring legacy of Cartesian philosophy has been the separation of body and mind, of soul and nature, and the creation and reinforcement of the corresponding binary oppositions between nature/culture, reason/emotion, seen/unseen, natural/supernatural, rational/irrational, real/unreal, theoretical/practical and fact/value. Moreover, Descartes succeeded in linking the mind/body opposition to the foundations of knowledge itself, a link which placed the mind in a position of hierarchic superiority over and above nature, including the nature of the body. His theories of embodiment also set the context for the achievements of modern medicine by opening up the possibility that scientific mathematical-causal theories could be applied to the human body and to physical functioning. Viewed as a machine, the body could be tested experimentally and studied anatomically, could be divided into organ systems and parts to be repaired,

---

[20] Descartes distinguished two kinds of substances: a thinking substance (*res cogitans*, mind), from an extended substance (*res extensa*, body). The human body, identified with passive nature, a mere *res extensa*, manifested no intelligence or power of self-movement, functioning as a machine, a mechanical device, according to causal laws and the laws of nature. The mind, the thinking substance, the soul, or consciousness, had no place in the natural world. Instead the mind, *res cogitans*, was regarded as the essence of self and the divine aspect of the human being. The mind and body, as two separate entities, shared no qualities, no interaction or connectedness, and were defined in opposition to each other. The purity of intellect was guaranteed by its ability to transcend the body. The mind was considered to be a natural and innate source of truth, capable of forming clear and distinct representations of reality, which were assured by the mind's purity. Its associated capacities; the physical, the emotional, the sensual, the associational, the personal or the spiritual were regarded as the chief impediments to objectivity and

surgically removed or technologically supplemented. Descartes was therefore able to legitimate the body as the domain of science.

Much recent work that focuses on the body attempts to undermine Western philosophy's neglect and devaluation of the body, and to reveal the consequences of its implicit conceptions of the body. Several writers have examined the implications of dualism documenting: the elevation of consciousness above corporeality (Lloyd, 1984; Gatens, 1986), the disavowal and neglect of the body in social theories (Shilling, 1993; Turner, 1984), the opposition between reason and emotion (Jagger and Bordo, 1989), the association of males with reason and intellect, and women with emotion and the body (Lloyd, 1984), the creation of stereotypes of masculinity and femininity (Lloyd, 1984), the exclusion of women from philosophical theories and from the creation of knowledge (Grosz, 1993; Grimshaw, 1986), the formation of other binary distinctions between nature/culture, individual/society, real/ constructed, fact/value, objective/subjective (Grosz, 1986), the structuring of distinctions between sex and gender (Gatens, 1986, 1988, 1990), the separation of body self and psychological self (Krueger, 1989), and the negation of emotional or embodied knowledge (Peile, 1998). Of particular interest to feminists have been the way dualistic systems of knowledge have acted as ideological vehicles of patriarchal societies, polarising the masculine and the feminine and rendering 'natural' the subordination of the feminine to the masculine (Merchant, 1980; Mc Millan, 1982; Lloyd, 1984). Science, having become the paradigmatic form of knowledge in the modern West, has also been complicit in this regard through its aspirations to 'objectivity' and its desire to eliminate the distortions inherent in subjectivity.

Attempts to overcome and reconcile the dualism that pervades contemporary conceptions of knowledge have often resulted in the reduction of either the mind to the body or the body to the mind, leaving their interaction unexplained or explained away (Grosz, 1994). Reductionism denies any interaction between the mind and body for it focuses on the actions of either one of the binary terms at the expense of the other. Alternatively, rationalism and idealism result in explanations of the body in terms of mind, ideas or

---

knowledge.

reason. Conversely, empiricism and materialism represent attempts to explain the mind in terms of bodily experiences or matter. Both forms of reductionism assert that either one or the other of the binary terms is 'really' its opposite and can be explained by or translated into the terms of its other. Applying reductionist solutions to the dualist dilemma does not, however, provide a way of resolving the separation of mind and body. As soon as terms are defined in mutually exclusive ways, there becomes no way of reconciling them or of understanding their mutual influences or their apparent parallelism (Butler, 1990; Grosz, 1994). Ironically, conscious attempts to temper the materialism and the reductionism of biomedical science or the implicitly rationalist accounts of sociological and psychological perspectives, often inadvertently recreate the mind/body opposition in a new form.

The mind/body opposition is evidenced in psychosomatic medicine and psychoanalytic psychiatry in the late 20th century. Despite beginning the task of reuniting mind and body in clinical practice, both tended to categorise and treat human afflictions as either wholly organic or wholly psychological in origin (Scheper-Hughes and Lock, 1987). Human pain and suffering was seen as being either in the body or in the mind. For example, Corbett (1986) in an analysis of multidisciplinary case conferences on chronic pain patients found the intractability of Cartesian thinking among sophisticated professionals. Pain was for social workers, psychiatrists and psychologists, physical or mental, biological or psychological - never both, nor something not quite either. Similarly Eisenberg (1977), in an effort to distinguish the biomedical conception of abnormalities in the structure of functioning of human organs (disease) from the patient's subjective experience of malaise (illness), elaborated the distinction between disease and illness.[21] Despite creating a useful and important way of conceptualising human pain for clinicians and social scientists, the illness dimension of human distress (the social relations of sickness) became individualised, medicalised and psychologised, while the disease dimension was ascribed to the body.

[21] Corbett (1986) and Eisenberg (1977) are studies cited in Kleinman (1988).

Foucault (1973) describes this as a process of subjectification, where certain aspects of social behavior become transformed into private concerns, subject to the authority of others, and where the self-understandings of individuals then become mediated by an external authority. He argues that the dividing practices and classifications of disease and the creation of 'patients' by medicine created a discourse which then analysed its own creations as the objects of study. As the discipline developed, the 'patient' as a complete and single entity became less visible. The body therefore became an object of power of medical discourse and the patient became the carrier of pathology, inhabiting a docile body with a disease (Armstrong, 1982). With the emergence of psychoanalysis in the 1930s the mental functioning of patients came increasingly under the medical gaze and notions of the role of the unconscious mind extended the medical gaze to include aspects of the patient's personality.

Psychoanalysis, as a pre-eminent and influential discourse on lived bodies, reflects the Cartesian legacy, tending to privilege the mind over the body and the social and cultural dimensions of pain, suffering or illness. Freud, as the originator of psychoanalysis, was considerably influenced by the scientific theories of Darwin and by the founders of the physicalist tradition (Smyington, 1986). In his early works he attempts to explicate the clinical phenomena of hysteria according to a physicalist model (Freud, 1895). However, in later works, Freud concedes that the available knowledge was not sufficiently advanced to be able to tie down psychological states to specific organic transactions, and confines himself to strictly psychological models detached completely from physiological models (Freud, 1915). There is no attempt to locate the 'unconscious', 'preconscious' and 'conscious' with their organic counterparts until 1923, when, with the publication of The Ego and the Id Freud adopted a model of intentionality.

Different schools of psychoanalysis have followed one or other of Freud's models (Smyington, 1986). Since Freud (1923) recognised the ego as first and foremost a body ego, the consensus of most psychoanalytic theorists has been that it is through body sensations and experiences that reality is first tested, and through the body and its

evolving mental representation that the foundation of a sense of self is constituted.[22] The body is seen as the primary instrument through which we perceive and organise the world, then we gradually test what is inside and outside the body, integrate outer and inner experience, make psychological distinctions between self and non self, experience the body as a container for psychological self, and merge body self and psychological self to form a cohesive sense of identity (Lichtenberg, 1978; 1985, cited Weiss and Fernhaber, 1999). Other models of psychoanalysis have eschewed the physicalist tradition, utilising concepts such as the 'unconscious', 'preconscious' and 'conscious' to understand mental processes and psychological states. Largely detached from the body, the approaches privilege the mind and favour psychological constructions of the self and reality. Smyington (1986) observes that Freud's works reveal at times a startling flip from scientific explanation to psychological causality.

Lacking a precise vocabulary with which to deal with mind/body/society interactions, medical and psychiatric discourses have been prone to view human beings' experience of suffering and illness in Cartesian terms, or to employ fragmented concepts such as the 'bio-social', the 'psycho-somatic' and the 'somato-social' to express the ways in which the mind speaks through the body and the ways in which society is inscribed on the body (Corbett, 1986; Scheper-Hughes and Lock, 1987; Kleinman, 1988; Krueger, 1989). Consequently, medicalisation inevitably entails a missed identification between the individual and the social bodies, and a tendency to transform the social into the biological. Similarly, the psychologisation of human pain and distress individualises and internalises problems, transforming the physical and social into mental processes removed from their collective and political context.

Despite efforts to counter historical disregard for the body, to undo the dualistic tradition and to mediate its consequences, oftentimes the mind/body split has been unwittingly engendered. A conception of the body as purely physical object, subsumed by mental

[22] Fenichel (1945) indicated in psychoanalytic writings four decades ago that in the development of reality, the conceptions of one's own body plays a very special role, and described the stages of development involved in moving from the experience of body self to the integration of psychological self and a consequent cohesive sense of identity.

processes has persisted. Consequently, the body and its relationship to individual subjective experience and broader social context has remained, until more recently, largely undertheorised.

2.3 Discourses Of Embodiment

Despite the historical neglect of the body, there are notable exceptions and developments in thinking about the body that I now examine for their relevance to my work. Three epistemological discourses appear to have dominated contemporary Western thought on the body. Each discourse, the 'individual body', the 'social body' and the 'body politic' has represented diverse ways of thinking about the human body, and its' relationship to the individual and society. Phenomenological epistemologies have suggested conceptualisations of the 'individual body', employing a focus on the lived experience of the body-self. The body is viewed as a phenomena that constitutes the centre of human presence in the world, that orients our experience of the world, that guides spatio-temporal relations with the world, and all intuition, perception and action. Discussions of the 'social body' arise from structural epistemologies, which refer to representational uses of the body as a natural symbol with which to think about nature, society and culture. These approaches examine the social, symbolic and structural meanings of the body between the natural and social world. The third discourse is the 'body politic'. Encompassed by poststructuralist thought, it analyses the regulation, surveillance and control of bodies (individual and collective) in reproduction and sexuality, in work and leisure, in sickness and other forms of 'deviance' and human difference. Each contributes to an understanding of the ways in which the women I interviewed experienced their bodies following childhood sexual abuse.

2.4 Existential-Phenomenology: The Individual Body

The existentialist endeavour has been to repair the split between body and mind, to represent 'man' and the world as not two separate entities but a single unified reality, and to reconcile the split between the cognitive and the senses. In the twentieth century, arising diversely out of existentialism, Husserlian phenomenology, and German

philosophical anthropology, a new concept of the body emerged. Two of the most original and articulate spokesmen of existential theory have been Erwin Straus and Maurice Merleau-Ponty, who share many similarities in their approach to an understanding of the body. The analysis of lived embodiment was primarily employed by these thinkers to criticise traditional philosophical and psychological approaches to the person, and the accompanying cultural commitment to mind/body oppositions. Though others such as Buytendijk (1974) and Plugge (1970) (cited in Weiss and Fern Haber, 1999) have sought to apply similar concepts to physical medicine, Straus and Merleau-Ponty worked extensively in this area.

Both Straus and Merleau-Ponty grounded their initial work in a careful, at times laborious critique of the Cartesian portrayal of the mind and its influence on current psychologies. In their view, the Cartesian categories lead to descriptions of human activity as merely mechanical and as arising at all times out of explicit judgements and acts of will. The approach they advance is most frequently referred to as the 'lived–body', in which they argue, contra Descartes, that bodily acts are not solely automatic, and that not all acts with cognitional volition status are truly 'mental', as Descartes envisioned them. Rather, in phenomenological terms, the body is not just a caused mechanism, but an 'intentional' entity always directed toward the world. It is the body that first understands the world, grasping its surroundings and moving to fulfil its goals. This bodily intentionality is termed 'sensing' in Straus's seminal work, *The Primary World of Senses* (1963) while Merleau-Ponty examines much the same phenomenon under the name of *Perception* (1962). The act of sensory perception is analysed by both men as primarily neither a mechanical process nor a type of thought, the Cartesian alternatives. Rather, sensing exhibits a bodily intelligence and affectivity.

For Merleau-Ponty perception is basic bodily experience, where the body is not an object but a subject, and where embodiment is the condition for us to have any objects – that is, to objectify reality – in the first place. His work suggests that culture does not reside only in objects and representations, but also in the bodily processes of perception by which those representations come into being. Influenced by the findings of gestalt psychology,

Merleau-Ponty (1962) shows how sensing already recognises a set of meanings, in so far as part of the perceptual field leaps to the foreground as the centre of significance – that which we sense grabs the interest, calls for further investigation, attracts or repulses. But this can only be for an active body, one that can move toward, around or away from the object. The sensing of the lived body is revealed as the result of the capacity of self-movement, its movement the result of sensing. It is through our capacities of sensing and moving that we first acquire and inhabit our surroundings. The parameters of this existence are set by our physical body, re-envisioned not just as a biological but intentional structure. Furthermore, the lived–body is the ground not only of our predelineations, but also of our flexibilities and individuality. We develop corporeal skills, habits, styles of expression that set apart who we are and the world in which we live. Ultimately the lived-body constitutes our being in the world (Merleau-Ponty, 1962). Merleau-Ponty states that, 'Our own body is in the world as the heart is in the organism: it keeps the visible spectacle constantly alive; the body animates and nourishes the world inwardly, and forms with it a system' (1962:203). Applying this view, Merleau-Ponty explores the role of embodied sexuality in coloring our world (1962), while Straus analyses modes of spatiality and communication yielded by the different senses (1963) and how our upright posture opens distance, initiates a battle with gravity, and frees the laboring, exploring hands (1966). For both theorists, the 'object body' of Descartes always remains derivative, arising secondarily out of the experience of the lived body (Merleau-Ponty, 1962: 67-71, 90-97).

The theories introduced by Merleau–Ponty and Straus have been used to challenge Cartesian notions of embodiment and to enrich understandings of the body, especially the body in illness and suffering.[23] Nowhere do questions of embodiment become more primary than in situations of illness or bodily invasion (Gadow, 1980; Leder, 1984). For if, as Merleau-Ponty claims, we act through our bodies towards the world, then in

[23] Medical ethicists, in particular, have applied a phenomenological frame to define the dimensions and processes of human embodiment (Tristam-Englehardt, 1975; Schenck, 1986), to distinguish the vocabularies used in the naming and discussing of bodies and bodily experiences (Leder, 1984), to reconcile the 'object' (Cartesian) body often treated by doctors with the 'subject body' presented by patients (Gadow, 1980; Leder, 1984), and to conceptualise the psychological and psychosocial components of pain and sickness (Leder, 1984).

moments of resistance, disruption or disintegration we turn attention directly to the body, because no demands are so urgent, so undeniable as those of the body, the most intimate of wordly objects (Schenck, 1986). The intimacy of one's own body to oneself (an intimacy so deep that there is seldom any distinction to be made between self and body), means that all invasions of the body are extraordinarily serious matters (the seriousness of which are recognised in laws, taboos, and medical ethics). Similarly in the experience of illness, if the body maintains our entire life world, then a crisis of the body becomes, inevitably, a total crisis of that world. The body becomes at once our very self and our greatest obstacle, our most willing servant, and our most feared adversary, revealing a tensed duality as the very texture of embodiment (Tristam-Engelhardt, 1975, Gadow, 1980; Schenck, 1986). That the body is not mere extrinsic machine but our living centre from which radiates all existential possibilities is brought home in my participants' accounts of illness, suffering, and disabling body problems and conflicts that follow sexual violation.[24]

Emphasising that the body is intrinsic to illness, suffering and disability, several writers have advocated attending more fully to a discourse on the 'lived-body' (Tristam-Engelhardt, 1975; Gadow, 1980; Leder, 1984; Schenk, 1986). Some of their ideas, which I outline below, are of interest to my work in that they help to illuminate the experiences described by the women in my study.

2.4.1 The Lived-Body

To accept the phenomenological view that the essence of human existence is embodiment and that the self is inseparable from the body, or, as Schenck asserts, that 'it is only through the body that we are present in the world, only through the body that we carry out projects in the social and physical worlds, only through the body that we have a self' (1986:50), enables a positioning of the body at the centre of all human experience and action. In so doing, it is not possible to ignore the body, to isolate it from the essential

---

[24] In Chapter five to eight (pp.116-265), I discuss in detail numerous body symptoms and problems of

self and its life context, to divide it into isolable parts and functions, or to view problems of the mind and consciousness in abstraction from their existential ground; the body. My findings call for this repositioning of the body as a site of significance, as all the participants' stories revealed the body to be intrinsic to their experience of self and the world they inhabited, and central to their suffering and distress following childhood sexual abuse.

Utilising a discourse of the 'lived-body', and, in particular, the concepts of unity, purposiveness, 'enworldment' and intentionality may, Leder (1984) suggests, transform medical theory and practice in several ways. First, the paradigm of the lived-body provides a way in which culture can focus on the body as the centre of self-actualisation rather than solely on the body at the margins, in illness. Second, a view of body as a unity of sensori-motor intentionality, ascribed with the intentional attributes hitherto reserved for the mind, permits an emphasis on how subjective factors such as attitude and emotional state can play a crucial role in determining health. Third, if the body is not regarded as a passive, impersonal object, fit to be neglected or given over to professionals, but the centre of one's experience, one's moods, expressions and projects, then an increase in personal responsibility for bodily functioning and a heightened awareness of the body in health is called forth. Fourth, the paradigm of the lived body wherein subjectivity is always corporeally expressed addresses the role of physiological factors in the etiology of disease. When disease is seen as arising out of bodily intentionality it can no longer be seen as a merely mechanical event. The intention is in the body, articulating a pre-conceptual grasp of the world (Leder, 1984). Women's stories support each of Leder's contentions. Their accounts demonstrate their body's central role in recovery and healing, its integral relationship with beliefs, behaviours and emotions, its capacity to express the physiological aspects of trauma and pain, and to embody in bodily symptoms and problems of embodiment, problematic personal, social and symbolic attributions assigned to the body.[25]

---

embodiment described by participants.

[25] In Chapters five to eight (pp.116-265), these issues are discussed in detail.

2.4.2 The Dimensions Of Embodiment

The theory of the 'lived-body' has also been used as a basis for elucidating the core dimensions of embodiment (Tristam-Englehardt; 1975, Schenck, 1986). Deepening an understanding of the dimensions and process of embodiment helps to illuminate how and why participants' bodies were so significant in their accounts of sexual violation. Schneck (1986) considers embodiment to be constituted on the basis of the following tenets: the first that the body is the central reference point around which one's spatial world is arranged. The second that the body constitutes the most intimate of the wordly objects. Intimacy is reflected in the body's incorporation of both a 'wordly' aspect and an 'intentional' one, enabling the parts of the body to be so thoroughly integrated that boundaries of intimate spatiality are established. Such worldly and intentional intimacy is demonstrated in everyday movements. (If, for example, one wants to move towards a table, one does not command the leg to move, one just moves it. But neither intention or command will move the table legs. Rather, one must move one's legs over to the table in order to get to the table near the door). The third dominant feature of embodiment is that the intimate body is always in communion with the world, both the physical world and social world. It is through the body as physical thing that one has communion with the physical world, and that one is able to act effectively in that world, but the body is also inherently socially expressive. For example, posture and facial expressions 'convey' 'rage', or 'delight' to others, our body posture is our rage; and when we confront someone gesticulating wildly, screaming with face contorted, we are confronting anger itself - not the mere external expression of some inner 'feeling' of anger. The body is never non-expressive. It is not simply a tool for expression that may be set aside at will. It is literally our selves expressed, standing out in the world to be read, inviting response. As such, the human body is just as essentially social as it is physical: the body is just as essentially personal (that is, intimate to self) as it is social or physical. Schenck (1986) rejects the idea that either psychological conditioning or cultural indoctrination is responsible for the social and personal dimensions of the human body claiming, on the contrary, that the body itself is unrecognisable as human unless it is acknowledged as having at once social, personal and physical dimensions. Recognising that there are

multiple dimensions of embodiment opens a space from which to theorise the many layers of bodily experience and meaning that are evident in women's body symptoms and problems of embodiment after sexual abuse trauma.

Other theorists have considered embodiment as a process (Tristam-Engelhardt, 1975; Gadow, 1980), throughout which the body alters its significance, becoming categorically different or sustaining new and different claims and meanings over time. While the pre-established classifications of science presuppose a body whose reality either is already fully established or is developing along a typifiable course this, they argue, is not the kind of reality that characterises a subject. Categories which comprehend only a fixed, pre-determinable object are inadequate for perceiving and interpreting the development of the body as subject because it is designed to express only a finite reality and finite meanings, whereas the body, as self, develops its own reality and a multiplicity of meanings over time. For women who have been sexually abused in childhood, the body, from the moment of sexual violation and thereafter, is experienced in a profoundly different way and attributed with meanings hitherto unrecognised. The violated and traumatised body develops its own reality. Its responses, its meanings and its indivisibility from the context that inscribes it with significance, recreate victims' bodies. Participants' stories show how the process of embodiment and their subjective experience of their bodies is configured and reconfigured by the cultural context in which they were situated.[26]

2.4.3 The Object Body

Merleau–Ponty and Straus's theories have been used as a tool to analyse embodiment in the medical encounter (Leder, 1984). Several writers have argued that the medical encounter is characterised by the patient presenting the lived body for treatment while the doctor treats the Cartesian or object body (Gadow, 1980; Leder, 1984). While the patient seeks help for pain or discomforting sensations that result in changes in sensing and moving, and corresponding changes in the experience of spatiality and temporality, the

[26] Chapter five provides a discussion of trauma and its impact on the body (pp.116-167). Chapter seven examines how cultural context shapes the body and body problems of my informants (pp.197-230).

doctor examines a physical body, searching for the mechanical precipitant of disease. In so doing, the lived–body is de-emphasised.

The process of bodily objectification is furthered in the physical examination of the patient, in cooperation with the doctor in which the patient must take up this manner of self regard in the patient's delivery of a medical history, and in the administration and reporting back of treatments (Leder, 1984). The analysis of body experienced by the patient and the body treated by the doctor is marked also by the existence of two dominant languages for discussing bodies (Schenck, 1986). The most prestigious are those mathematico-mechanical languages of physiology and anatomy. The other languages are those of the everyday life world, the ordinary languages of common life, in which the body is spoken of in terms of its significance in our lives. The frustrations, delights, and capabilities of the body become translated into a medical discourse of symptoms, complaints and diagnostic categories.

While the body is scientific object beneath the dispassionate gaze of the doctor, it is, for the patient, the centre of living presence in the world, which through the process of objectification gradually becomes an 'other', a thing that is not self. The patient may already have come to regard his/her body in an objectified mode (Leder, 1984), a process often begun by illness or trauma itself; when suffering the body can come to appear as Other. The body can be experienced no longer as the immediate agent of our desires but as an alien presence we would rather be rid of. Similarly, the disabled body can appear as exterior to the self by virtue of frustrating personal intentions. Furthermore, the unity of the lived body can begin to fall apart as symptoms are experienced. The body then reveals itself as a nexus of semi-autonomous biological processes, the ever present 'organic' or 'pre personal' aspect of the lived body. Thus the Cartesian body, interpreted as 'thing', a mechanical collection of parts extrinsic to the self, is brought to the fore.

The process of bodily objectification is furthered when the patient seeks clinical assistance, for both the objectification inherent in the individual's own experience of the lived-body and the gaze of the Other reinforces bodily objectification. Detachment may

help the patient feel removed from suffering and attendant fears and may help the clinician keep emotional distance from a seemingly endless chain of suffering. Despite the tendency towards objectification in the clinical encounter, Straus (1963) observes that the scientist/clinician, in conducting an investigation of the objectified body, always remains within his or her own body while proceeding with the exploration. Similarly, the trained, intelligent hands of the doctor, the skilful eye, are not just bones, tendons, muscles, but a paradigmatic instance of the lived–body in praxis. For the patient, the lived-body cannot be escaped because pain, while alienating the self from its corporeality, is also an irrefutable experience of mind-body unity.

The conflict of embodiment that can arise in the clinical encounter is however, often resolved largely in favor of hegemony of the object body despite the pre-eminence of the lived-body for doctor as well as patient (Gadow, 1980, Leder, 1984). Likewise, participants' stories are characterised by bodily objectification and by the supremacy of the object body. For most, the body was experienced as 'not self'. Since the moment of initial trauma, some had separated themselves from their bodies. For some, ongoing and distressing bodily symptoms led to bodily objectification, while for others, the seemingly irreconcilable difficulties of continuing to live in a body that was felt to be dangerous, untrustworthy, symptomatic and unruly, prompted a deep and lasting separation between self and body. Bodily objectification and detachment did provide an escape from the overwhelming physical, psychological and emotional effects of sexual trauma, constituting an 'attempted solution' to many of the dilemmas inherent in embodiment following sexual violation.[27]

2.4.4 Unifying Mind And Body

Several of the above theorists favor a discourse of the 'lived-body' because of its potential to effect a unity between mind and body. While many speak of 'dimensions' as aspects of embodiment that may be distinguished conceptually or analytically (Tristam-

[27] See Chapter five (pp.116-167), where I discuss participants' experiences of detachment from the body, and themes of bodily presence and absence.

Engelhardt, 1975; Gadow, 1980; Schenck, 1986), the body is perceived nonetheless as a complex whole whose unity has moments of great harmony and deep alienation. The features of embodiment are inseparable, incorporating the integration of willing and acting, in which mind and body come together to constitute an effective presence of person-in-the world. Gadow (1980) provides a phenomenological elucidation of distinct relationships between the self and the body in an attempt to locate, better understand and transcend the 'body' that is experienced by a patient and the one treated by a doctor, that is, the subjective, immediate body versus the body as object, abstracted, examined and treated. She suggests four levels of relation between the self and the body that operate in dialectical progression rather than opposition to the other: (i) primary immediacy: the lived body (ii) disrupted immediacy: the object body; (iii) cultivated immediacy: the harmony of the lived and object body, and (iv) aesthetic immediacy: the subject body, as exemplified in aging and illness.

The 'lived-body' is the most fundamental body, characterised by the conscious capacity to act and the experiencing of my actions as one with myself, as well as by the consciousness of being vulnerable to the world's impact. When the body experiences itself as unable to act, as acted upon in ways that are not desired, or as acted upon by itself, the primary immediacy of the body is disrupted ('disrupted immediacy'). Disruption effects a split between self and body reflected in an ensuing struggle between the self experienced as free subjectivity and the body as a vehicle or instrument to be controlled through discipline, habituation, illness or symptomology. The body present at the level of struggle and subjugation is the 'object body' - reflecting the existential 'otherness' of the self. Attempts to restore unity between the self and the object body lead in two possible directions: the first to a new dichotomy, the second to a new unity. The first pathway leads to attempts by the self to master the body through scientifically comprehending it, through relegating it to the world of objects and categories, or through the abstraction of the self from the presenting ambiguity. The second involves cultivating a lived harmony or unity by overcoming the struggle. Such 'cultivated immediacy' involves experiencing the body and self as distinct, no longer as opposed, but rather, as mutually enabling. This model is applied to the 'normal' process of embodiment but has

particular significance to the body in illness, suffering and aging, where the 'subject body' expresses itself as a reality with its own meanings, values and purposes. The possibility of learning to live in aesthetic relation to the body, in anticipation of sustained relationship to the body as an 'aesthetic object' is also suggested by the transformations involved in suffering, pain, illness and aging.

Gadow's analysis offers a useful frame from which to theorise aspects of victims' experience. First, the act of sexual violation can be regarded as disrupting the 'primary immediacy' of the body. The body is acted upon in ways that are not desired, it is physically violated and the boundary between 'inside me' and 'outside me' is not simply crossed but 'disappeared', 'made–never-to-have-existed' (Young 1992:92). As Young writes, 'What is 'outside of me' has now seemingly, entered me, occupied me, reshaped and redefined me, made me foreign to myself by conflating and confusing inside me with outside me' (1992:92). Moreover, as a consequence of traumatic bodily reactions, many participants experienced their bodies as acting upon them. Second, the disruption is reflected in the split victims' effect between self and body and the resulting objectification of their bodies. As their accounts illustrate their bodies become 'other than self', instruments to be controlled through subjugation, discipline, punishment, mastery or symptomology. Third, Gadow's approach is also useful for understanding women's stories of recovery. The stories of recovery from serious problems of embodiment and body symptoms that women in my study told were characterised by the integration of body and mind. Women 'cultivated' a harmony with their body through a number of bodily practices such as running, swimming, yoga and body therapies. Experiencing the body as in 'immediate' accord rather than in opposition with the self, recreated a unity between self and body.

Also hoping to demonstrate the centrality of 'the lived body' to the human experience, and the integrated nature of mind and body, Leder (1984) offers a perspective in which he illuminates the sensori-motor intentionality involved in disease. He describes situations in which a person may express a subliminal grasp of the world as overpowering and the self as inadequate before it, by assuming a stooped posture. Years later the person's chronic

back brings them before an orthopedic surgeon. Or, another person may take up a pose of fight or flight in stressful situations. The internal hypermobility may lead to gastritis, high blood pressure or heart attack developed by the oversecretion of acid that exhibits the expressiveness of bodily movement no less than the motions externally manifested. Another person who is restless and unable to sleep or eat may develop a viral illness. His/her past experience, future projects, entire being in the world are expressed in their bodily tension. Their over-alertness leads the body to reject food and sleep and ultimately to embrace illness with its attendant possibilities of rest. Leder offers further examples, such as when, distracted or eschewing the normal self preserving reactions, the body may become involved in a serious accident, or, when another body, experiencing primordial emptiness, seeks to fill itself with food or smoke, leading to the medical problems of obesity, cancer or emphysema. All these examples exhibit illness as a disordered way of being in the world where, in response to its perceived situation, the body expresses itself in habits of posture, tension, and relaxation, sleep, exercise, emotionality, alertness, diet and substance use that play a crucial role in determining its health history.

While Leder (1984) examines the body as agent of personal expression, and the ways in which the lived-body shades into thinking, consciousness, speech and signification, he also acknowledges that the lived-body exhibits a pre-personal or organic side, which is relatively autonomous in the face of our motives. Current treatment models frequently reflect this duality in separate physicalistic and mentalistic approaches. The first often do not address the intentionality behind disease, the second, as primarily actualised in a pre-linguistic bodily expressiveness, may not always be transformable through language and introspection. Leder (1984) cautions therefore, that one must look at a human not just as body but as body and mind, or as a complex interdependency of body, mind and spirit. The concept of the lived-body asserts the unity of the body and mind, emphasising the need to embrace organic and personalised features of embodiment.

While offering some useful insights, phenomenological perspectives are limited in their conceptualisations of the body. The view that the body is a given entity and follows the laws (of anatomy and physiology); and [that] our bodily experience is the perception of

this pre-given entity presupposes an essentialist notion of the body. As such, 'the body is represented as being outside any existing structure, practice or discourse, [as] an externality registered by making the body natural or pre-social' (Brown and Adams, 1979:36). Moreover, a discourse on the 'lived body' also fails to address how natural and social factors and physical and mental factors interconnect, to consider the body's relation to language and thought, or the body's relation to society and culture.

2.5 Structuralism And Symbolism: The Social Body

While existential-phenomenological approaches focus on the intrinsic qualities of the body, how the body is felt and experienced, and how it is rendered meaningful by the individual, structuralist and symbolic approaches are concerned with the social nature of the body and the ways in which the body reflects and is constructed by particular societies and cultures. Symbolic and structural anthropologists have attended to the representational uses of the body as a natural symbol with which to think about nature, culture and society, demonstrating the constant exchange of meanings between the 'natural' and social worlds (Douglas, 1971; Bourdieu, 1977; Mauss, 1985; Freund, 1988, 1999; Kleinman, 1988). While for the psychoanalyst social practices are referred back to the unconscious representations of the experience of self with the body, and for the existential phenomenologist experiences are grounded in the 'lived-body', symbolic anthropologists take the experiences of the body as a representation of society.

Hertz and Mauss first emphasised the relationship of the physical body and the social body of society, suggesting that we cannot understand the body outside culture. Their theories contradicted common sense understandings and phenomenological explanations in which knowledge of the body is seen to arise directly from its physical reality. Mauss (1943) explicates how each society has its own special habits and methods of bodily movement and expression, claiming that,

> These habits do not just vary with individuals and their imitations they especially vary between societies, educations, proprieties, fashions and prestiges. In them we should see the techniques and work of collective and individual practical reason rather than, in the ordinary way, merely the soul and its repetitive faculties. (1943:73)

Mauss (1943) advocates a consideration of physical, psychological and social elements to explain the phenomena, which he ultimately resolves by claiming that no action, movement or technique of the body is 'natural'. Instead, all modes of bodily action are social, imbued with imitation, tradition, and ritual. He validates his claim through a detailed classification of techniques of the body and through an examination of how these techniques are fundamentally different in various cultures and societies. He concludes that even the apparent simplest of bodily activities (for example, when we drink) is constituted by a combination of actions, 'that are assembled for the individual not by himself alone, but by all his education, by the whole society to which he belongs, in the place he occupies in it' (1943:76). The actions are more or less habitual and more or less ancient in the life of the individual and the history of the society.

2.5.1 The Body As Symbol

Mauss' (1943) analysis of the social body has been extended by theorists who have conceptualised the body as a symbol. Anthropologist Mary Douglas envisages the body as a metaphor or image of society whose 'main scope is to express the relation of the individual to the group' (1971: 387,389). She writes,

> The body is a model which can stand for any bounded system. Its' boundaries can represent any boundaries which are threatened or precarious...We cannot possibly interpret rituals concerning excreta, breast milk, saliva and the rest unless we are prepared to see in the body a symbol of society, and to see the powers and dangers credited to social structure reproduced in small on the human body. (1966:155)

Conceived as a natural symbol, Douglas (1970) argues that the body is used as a cognitive map to represent other natural, supernatural, social and spatial relations and as a channel of communication. Asserting that it is the body that mediates the social situation, Douglas explains that the body does this in three ways. First, the body is the field in which the feedback interaction takes place. Second, the body can be tender for exchanges which constitute the social situation, and third, the body can become the image of the social situation.

It has been the third dimension that symbolic anthropologists have attended to, demonstrating the ways in which the body, in diverse cultures, is a representation of society. Studies, primarily of non-Western cultures, have illustrated richly detailed symbolic uses of the human body in classifying and 'humanising' natural phenomena, human artifacts, animals and topography, and demonstrate how the human organism and its natural products act as metaphor for society. Douglas (1970) contends that cultural constructions of and about the body are useful in sustaining particular views of society and social relations, however, insofar as the body is both physical and cultural artifact, it is not always possible to see where nature ends and culture begins in their symbolic equation. As Douglas writes 'just as it is true that everything symbolises the body, so it is equally true that the body symbolises everything else' (1966:122).

Of particular interest to medical anthropologists has been the frequently encountered symbolic equations between conceptions of the healthy body and the healthy society, as well as the diseased body and the malfunctioning society. The body in health offers a model of organic wholeness; the body in sickness offers a model of social disharmony, conflict and disintegration. Reciprocally, society in 'sickness' and in 'health' offers a model for understanding the body.

Kleinman (1988) construes disease as the embodiment of the symbolic network linking body, self, and society. Illnesses therefore, have meanings that are polysemic or multivocal, that radiate (or conceal) more than one meaning. The appreciation of the meanings attached to illness is, according to Kleinman, bound within personal and social

relationships. The first kind of illness meaning analysed by Kleinman (1988) is the symptom, which cannot be regarded as 'natural' but rather as formulated by standardised 'truths' in a local cultural system, implicit in which are accepted forms of knowledge about the body, the self, and their relationship to each other. The second meaning that illness has is cultural, in that symptoms and illnesses are imbued with particularly powerful cultural significance. While giving examples of the cultural meanings of symptoms in various non-Western cultures, Kleinman (1988) also acknowledges the symbolic significance attached to Western disorders such as cancer, heart disease and sexually transmitted diseases. He emphasises that the special significance of symptoms is not just determined by the society as a whole but in the distinctive worlds shaped by gender, age, class, ethnicity and race. Social differences also imply that people vary in the resources available to them to resist or rework the cultural meanings of illness. The third level of meaning involves the way in which illness is imbricated by personal and social significance from the world of the sick person. Unlike cultural meanings of illness that carry significance to the sick person, the third, intimate type of meaning transfers vital significance from the person's life to the illness experiences.

2.5.2 The Body As Metaphor

Jackson (1983) theorises the body as metaphor via the symbolic correlations between the personal body and the body of the world. He proposes a mode of thinking about the body in which speaking, thinking and acting, correspond or coalesce with personal, social and natural aspects of being. Citing examples from ancient Greek philosophy, from the hermeneutic tradition of Medieval and Renaissance Europe, from Chinese philosophy and art, from Vedic hymns and Hindu scriptures, from Tantric thought, from the world view of the Dogon of Mali, and from the metaphors recognised in English poetry, Jackson identifies the metaphorical correspondences that link personal, social and natural bodies. In each example there is a conception of the world as a resonant whole and evidence of various correlations between the human body and the landscape, between parts of the body, parts of speech, and parts of the world or between the human body and the state. The world of things is merged with the world of being, and as a consequence,

things like stones, hillsides and whales assume the status of 'signs' whose decipherment mediates understanding and action in the human world.

A corporeal way of 'reading' what the world means, Jackson (1983) asserts, presupposes a continuity between language, knowledge and bodily praxis, noting that continuity is characteristic of preliterate societies where knowledge and speech cannot be readily abstracted from contexts of practical activity. In such societies, knowledge is articulated in skills, formula and routines upon which physical livelihood directly depends, it is logical for preliterate people to emphasise the embodied character of knowledge and speech. Thus, metaphor is situated and discloses the functional interrelations between proper knowledge, reproductive activity, correct speech and socio-physical wellbeing. Metaphor is therefore not merely a figure of speech, an analogy or a resemblance for the sake of verbal effect. Rather, metaphor refers to a view that the body, world and idea are equated, that the world of physical things is continuous with the animate and articulate world of the mind.

His analysis also considers the social and psychophysical aspects of metaphor in everyday language, providing evidence that the world of the body shares common attributes with the body of the world. He gives examples of 'angry skies', 'stars looking down', 'brooding landscapes', 'social ills', and economic 'depression' and 'recovery', as if these natural or social phenomena were themselves possessed of consciousness and will. Reciprocally he cites the 'shoulder of a hill', 'the foot of a mountain', of being petrified with fright, having roots of being turned on, switched off, burnt out, as if the body of the earth and the actions of a machine were somehow connected to the world of the human body. He cautions that in analysing these metaphors that it is not enough to say that they arise because subjectivity can identify itself only through external objects, or that they arise through the naming of objects of the perceived world, or that they reflect the fact that the first language of life is gestural, postural and bodily. For, to emphasise the psychophysical or social aspects of metaphor construction and use is unhelpful as long as it implies a dualistic conception of human behavior and a linear form of reasoning which, in the case of metaphor, makes one aspect of the trope prior or

primary. Rather, metaphor must be apprehended non-dualistically. Idea or sensation and its bodily complements (social, mechanical, physiological, geographical) betoken, not an arbitrary or rhetorical synthesis of two terms - subject and object - which can be identified more realistically apart from each other, but a powerful interdependency of mind and body, self and world. The potential of metaphor is in the way it reveals unities.

Jackson's work explores the variability of metaphoric value through an examination of quiescent and active metaphor, claiming that the derivation of the most abstract words often refers us to the body, and that the embodied intentionally of human being seems to be inextricably tied to our views of the world. It is because human consciousness is intentional and embodied that such metaphors are readily constructed by thought, although such metaphoric references to the body are implicit and usually below the threshold of awareness. We are seldom mindful of the actual links between the mental or emotional attitude signified and the bodily praxis which does its signifying, although sometimes these mundane metaphors are activated and realised in quite extraordinary ways. Jackson (1983) concludes that metaphors which are ordinarily quiescent (yet are the verbal correlates of actual bodily dispositions) are activated in crisis situations and critical occasions to mediate changes in people's bodies and experience, as well as alter their relationships with one another and the world. Anthropomorphic thinking is often prompted by crisis, when the logical or social structure of the world breaks down, but such recourse to metaphor is usually dismissed as neurotic, regressive or erroneous. I argue, however, that recourse to metaphor is, for victims of sexual abuse, a meaningful, symbolic communication about the experience of living in and with a violated female body in Australian society. Their problems of embodiment are both real and symbolic struggles that reflect the negotiations of personal and social body.

From a detailed analysis of Kuranko people of Sierra Leone, Jackson (1983) contends that metaphor is a correlate of patterns of bodily action and interaction and shows how verbal metaphors are correlates of patterns of social interaction and bodily disposition within the habitus, explaining individual psychophysiology and revealing social relationships. Metaphors emerge from a reciprocal anthropomorphism whereby an

element in the shared material habitus is internalised by individuals, and thereby becomes part of a collective ideology of the self, 'a common knowledge'. Metaphors mediate relationships between conceptual and physical domains of the habitus in a dialectical manner, acting as crucial synthesisers because they link the body to the social and natural environments. It is in this synthetic function that their power lies, they can 'make over' the person to the social world and reciprocally 'imprint' the social world upon the person's body. Because metaphors refer simultaneously to the self and to the socioeconomic habitus they are instrumental in mediating between ideology and economic infrastructure (1983).

Jackson argues therefore that metaphor is the bridge between social reproduction and the reproduction of certain moral and ethical values. He elucidates the interrelation among bodily praxis (ie. postural sets of patterns and movements), subjective cognitive-emotional states, and social reproduction. Social patterns of movement (eg. dance) produce cognitive-emotional states and are ways of embodying moral-ethical values. Of interest to my thesis are Jackson's (1983) comments on the inseparability of conceptual and bodily activity, specifically the notion that metaphors often mediate forms of human illness and suffering. It is not untypical, according to Jackson, for the contradictions of the familial or social environment to be reflected in human symptoms. These symptoms may embody compliance with cultural injunctions, or contradictions and dilemmas inherent in these directives, or may reflect personal, social and cultural concerns. Several writers have applied the construction of 'the body as metaphor for society' in theories about anorexia nervosa (Celermanjer, 1987; Bordo, 1988; Banks, 1992), illustrating the ways in which the anorexic body reveals contradictory cultural injunctions about femininity. Other writers have focused attention on a more general analysis of the female body in Western culture (Bordo, 1993), arguing that the scripts of femininity demand bodies and bodily practices which symbolise a precise crystallisation of culture. For Jackson (1983), in so far as cognitive and physical aspects of being in the world are inseparable, it is impossible to accept the view that 'illness is not a metaphor and that the most truthful way of regarding illness - and the healthiest way of being ill - is one most purified of, most resistant to, metaphoric thinking' (Sontag, 1988:3).

Jackson (1983) criticises modern medicine for its reluctance to range over all the domains of being - personal, social, natural - in diagnostic and therapeutic work, for its doctrinal inflexibility and prevailing absolutism, in which specific symptoms are assigned determinate causes, and in which doctors scorn alternative medicine. Advocating the use of metaphor as a key instrumentality in modern medical practice, he argues that metaphor is a crucial means of locating areas that we can act upon and those areas where we have lost the power to act. He suggests that the devalorisation of metaphor may also be a way of taking away from the patient a means of participating in his or her own diagnosis and treatment, and making the doctor the sole actor in diagnostic and therapeutic practice. Conversely, using metaphors as if they are real is a recognition of cosmic wholeness, not a sign that a person is stuck in one domain of the world, possessed by it and unable to move. For many participants, recovery was linked to recognising body symptoms and problems of embodiment as meaningful and congruent configurations of the impact of their abuse. Moreover, understanding problems of embodiment as context-bound 'existential choices' or as 'attempted solutions' for living in their bodies after violation, rather than as signs of 'craziness', or 'illness' was central to self compassion and healing.[28]

Jackson (1983) is critical of intellectualistic tendencies to assimilate bodily experience to conceptual and verbal formulations and to regard practices as 'symbolic' of something outside themselves. Douglas (1971) is also critical of the positioning of body praxis as secondary to verbal praxis and of the emphasis on speech as the privileged means of human communication. Both writers contend that the subjugation of the bodily to the semantic is empirically untenable because thinking and communicating through the body precede and to a great extent always remain beyond speech, meaning should not be reduced to a sign which lies on a separate plane outside the immediate domain of an act, and meaning of body praxis is not always reducible to cognitive and semantic operations. Each of these three factors were significant for the women in my study. First, I found that

[28] For a discussion of body symptoms and problems of embodiment as 'existential dilemmas' faced by women in the aftemath of abuse, see Chapter seven (pp.194-219). For an examination of women's stories of recovery and the way in which attributing meaning to symptoms was important, see Chapter eight, pp. 220-252.

most of the participants reported not having words to describe their experience. Words were either inaccessible or inadequate for communicating the depth of feeling or the embodied nature of experiences following sexual abuse trauma. Second, meaning was communicated and enacted by the body and activities of the body that were frequently symbolic. Third, women's stories of recovery reveal the centrality of bodily praxis, of physically experiencing the body in a different way, as significant to bodily transformation and healing.[29]

Using Merleau-Ponty's concept of the 'lived body' and Bourdieu's notions of 'habitus', Jackson (1983) moves away from what he calls the unduly abstract semiotic models which have dominated anthropological research, developing an analysis which emphasises patterns of bodily praxis in the immediate social field and material world. Jackson elucidates a phenomenological approach to body praxis which shows how human experience is grounded in bodily movement within a social and material environment, and which shows the interplay between the habitual patterns of body use and conventional ideas about the world.[30]

2.5.3 Non-Western Epistemologies Of The Body

While my interest lies with Western conceptions of the body, it is important to acknowledge that Western epistemologies are but one of many systems of knowledge that theorise the relations among mind, body, culture, nature and society. Non–Western civilisations have developed alternative epistemologies that tend to conceive relations among similar entities in monistic rather than dualistic terms. In non-Western epistemologies representations of holism and monism tend toward inclusion rather than exclusion. Two representations of holistic thought are particularly common. The first is a conception of harmonious wholes in which everything from the cosmos down to the

[29] The limitations of speech and narrative following trauma are discussed in Chapter five, see pp.159-165. In Chapter six to eight (pp.168-265), I examine in detail the symbolic enactments of the body and in Chapter nine (pp. 266-291), I reveal the centrality of bodily praxis in women's accounts of recovery.
[30] In Chapter nine (pp.266-291), I examine the importance of bodily praxis in women's recovery from the impact of sexual abuse and its links with transforming victims' ideas about themselves and the social world they inhabit.

individual organs of the human body are understood as a single unit (as in Islamic cosmology where all existence is essentially monistic, a unity of spirit and body, world and hereafter, substance and meaning, and natural and supernatural). A second representation of holistic thinking is that of complementary (not opposing) dualities, in which the relationship of parts to the whole is emphasised (as in for example, ancient Chinese yin/yang cosmology). The concept in Western philosophical traditions of an observing and reflexive 'I', a detached and objective, mindful self that stands outside the body and apart from nature can be contrasted with, for example, Buddhist notions, in which interiority and subjectivity are connected to, and indeed identical with, the essential being of the cosmos.

In Western conceptions of the person or self, the relation of individual to society is based on a perceived 'natural' opposition between the demands of the social and moral order and the egocentric drives, impulses, wishes and needs of the self. The individual/society opposition that is fundamental to Western epistemology is also unique. The Western conception of the person as a bounded, unique, integrated motivational and cognitive universe is an uncommon view within world cultures. Indeed, the modern conception of the individual self is of recent historical origin. Locke's *Essay Concerning Human Understanding* (1690) first identified a detailed theory of the person in which the 'I' or the 'self' was equated with a state of permanent consciousness, unique to the individual, stable throughout the life span and physical changes until death. The assumption that humans are endowed with a self consciousness of mind and body, with an internal body image, and with a proprioceptive sense of self awareness, of mind body integration and of being in the world as separate and apart from other human beings has continued to govern Western views of the person. Until the advent of recent poststructuralist thinking, the 'person' was seen to be constituted by the intuitive perception of the body self, a universal precultural given (Winnicott, 1971), and by a distinguishable social self, constructed by a constellation of jural rights and moral accountability (Mauss, 1985).

Closely related to conceptions of self is what Western psychiatry has termed 'body image', referring to the collective and idiosyncratic representations an individual

entertains about the body and its relationship to the environment, including internal and external perception, memories, affects, cognitions and actions (Horowitz, 1966). Ethnoanatomical perceptions, such as body image, offer a rich source of data both on the sociocultural meanings of being human and on various threats to health, well being and social integration. In Western literature, body imagery is analysed predominantly in psychiatric texts, which have focused on body boundary conceptions, and on distortions in body image and body perceptions arising from neurological, organic, or psychiatric disorders. Sacks (1973) has written about rare neurological disorders which can play havoc with the individual's body image, producing deficits as well as excesses, as well as metaphysical transports in mind-body experiences. While profound distortions in body imagery are rare, neurotic anxieties about the body, its orifices, boundaries and fluids, are quite common. Fisher and Cleveland (1955, 1968) demonstrated the relationship between patient's 'choice' of symptoms and body image conceptions, and Kleinman (1988) has attended to the social dimensions and collective representations of body imagery.

The major differences between Western and non-Western ethnomedical systems is that in the former, body and self are understood as distinct entities; illness resides either in the body or in the mind. Social relations are seen as partitioned, segmented, and situational –generally as discontinuous with health and sickness. By contrast, many non-Western ethnomedical systems do not logically distinguish body, mind and self, and therefore illness cannot be situated in mind or body alone. Social relations are also understood as a key contributor to individual health and illness. In short, the body is seen as a unitary, integrated aspect of self and social relations. It is dependent on, and vulnerable to, the feelings, wishes, and actions of others, including spirits and dead ancestors. The body is not understood as a vast and complex machine, but rather as a microcosm of the universe. What is most significant about the symbolic and metaphorical extension of the body into the natural, social and supernatural realms is that it demonstrates a unique kind of human autonomy that appears to have disappeared in the modern industrialised world.

Existential psychiatrists have expounded at length on the contemporary themes of self alienation, and its pathological consequences, expressed in a sense of disembodied self,

or a selfless body, or to use Laing's term 'a divided self' (1965). More recent writings from existential-phenomenological therapy insist on viewing human beings from a relational rather than an isolated perspective, speaking of existence as a co-constituting self-world, or self-other relationship, and advocate a reconsideration of the problems and dilemmas that are presented to therapy as dialogical statements that express various anxieties and insecurities of relational existence (Spinelli, 1997). The loss of bodily integrity, of wholeness, of continuity and relatedness to the rest of the natural and social world has been regarded as a cumulative effect of the Cartesian legacy and the materialism and individualism of biomedical clinical practice (Kleinman, 1988), as a result of capitalist modes of production in which manual and mental labors are divided, fragmented and ordered into hierarchy (Scheper-Hughes and Lock, 1987) and which result in reflected marked distortions of body movement, body imagery and self-conception, and as a result of the symbolic equation of humans and machines, originating in our industrial modes and relations of production and in the commodity fetishism of modern life in which the human body has been transformed into a commodity.

2.6 Poststructuralism: The Body Politic

Unresolved tensions in mind, body and social relationships also haunt the territory of more recent sociological and political writing on the body. For many theorists the relationships between individual and social bodies concern more than metaphors and collective representations of the natural and the cultural. The relationships are also about power and control.

2.6.1 Social Control And The Body: Early Writings

Early writings on social control and the body have emerged from social thinkers as different as Durkheim, Mauss, Marx and Freud, who each understood as inevitable and unresolvable the contradictions and universal categories of mind/body and nature/culture. Although Durkheim was primarily concerned with the relationship of the individual to society, he devoted some attention to the mind/body, nature/society dichotomies. In *The*

Elementary Forms of the Religious Life, Durkheim wrote that, 'man is double' (1961: {1915}: 29), referring to the biological and the social. The physical body provided for the reproduction of society through sexuality and socialisation, while for Durkheim, society represented the highest reality in the intellectual and moral order. The body was the storehouse of emotions that were the raw materials, the 'stuff' out of which mechanical solidarity was forged in the interests of the collectivity. Building on Durkheim, Mauss wrote of the 'dominion of the conscious (will) over emotion and unconsciousness' (1979{1950}: 122). The degree to which the random and chaotic impulses of the body were disciplined and restrained by social institutions revealed the stamp of higher civilisations. For Marx and his associates the natural world existed as an external, objective reality that was transformed by human labour. Humans distinguished themselves from animals, Marx and Engels wrote, 'as soon as they begin to produce their means of subsistence' (1970:42). In *Capital* (1867), Marx wrote that labor humanises and domesticates nature. It gives life to inanimate objects, and it pushes back the natural frontier, leaving a stamp on all that it touches. For each of these theorists the body was seen as the biological base upon which the social was fashioned. The universal, unruly and precultural body was seen to be 'civilised' by society through a variety of means.

Freud introduced yet another interpretation of the mind/body, nature/culture, individual/society set of oppositions with his theory of dynamic psychology: the individual at war within himself. Freud proposed a human drama in which natural, biological drives locked horns with the domesticating requirements of the social and moral order. The resulting repressions of the libido through a largely painful process of socialisation produced the many neuroses of modern life. Psychiatry was called on to diagnose and treat the dis-ease of wounded psyches whose egos were not in control of the rest of their minds. Reich, Freud's student, attempted to develop a 'physiology of repression' which was missing in Freud's work. Reich's theory demonstrates an attempt to understand the neurohormonal, muscular, respiratory, and other physical consequences of social control and how these, in turn, affect social behaviour (Keat and Urry, 1986). Marcuse (1962), also following the Freudian tradition, historicised repression, arguing against the inevitable tension between 'eros and civilisation'. Such a tension was

regarded as a feature of particular social forms such as capitalism and its means of social control, which necessitated 'surplus repression' (Keat, 1986). In most historical works on social control and the body that emerge from a psychoanalytic tradition, there is little discussion of a 'physiology of repression'. Rather, these works basically adhere to an 'instinctual' version of human nature and focus their attention specifically on the social construction of sexual desire (Freund, 1988).

A more comprehensive vision of the relation between social control and the body comes from Norbert Elias's work on the 'civilising process' (Elias, 1979). Elias was perhaps the first contemporary sociologist to theorise about the relation between historically variable forms of social control and the way we move, express our emotions, and relate to our bodily functions. Elias developed a comprehensive sociological theory that analyses social control and its effect on the body. His approach was not Freudian or Marxist, yet his theory helped to emphasise that the changes that emerged with the development of pre-industrial capitalism and that paved the way for industrial reform were not only attitudinal in nature. Rather, these changes also involved an emphasis on internal control of bodily expression (eg. anger, body functions such as sexuality and elimination). These changes in bodily control are part of a 'civilising' process, the origins of which Elias traced to the sixteenth century and linked to the emergence of the modern nation state. By the eighteenth century changes could be seen in the way that aggression and other forms of bodily expression were regulated. Elias argued that with the ascendance of the modern nation state (which was largely related to bourgeois hegemony), new techniques of control were necessitated, because populations had to be pacified and domesticated to an unprecedented degree. The state assumed an increasing monopoly over violence, accomplished by imposing self initiated inhibitions on the 'spontaneous' display of various kinds of bodily expression. Elias's work has been described as 'the sociological analogue of Freud's *Civilisation and Its Discontents'* (Freund, 1988:844). Not limited to an analysis of libidinal impulses, Elias's theory emphasised the function of the 'civilising process' as a qualitatively different form of social control, which accompanied changes in the relationships of domination, and which later served the needs of capitalism admirably.

2.6.2 Social Control And The Body: Recent Writings

More recently, Michel Foucault's writings (1977; 1980) analyse changing forms of power and their relation to the human body, influencing many formulations of social control and the body. In *Discipline and Punish* (1977), Foucault examines control over space, time and motion and the relation of these controls to our bodies. He argues that by the end of the eighteenth century, the body became the focal point of a myriad of 'technologies of power' that regulated its rhythm and motions and that sought to impose, from without, a 'technology' that would penetrate the 'soul'. This disciplinary control involves, for instance, scheduled existence and a high degree of self-control over bodily expression. Although all societies control bodily expression, the new control associated with the ascendance of industrial capitalism is distinct. Now attention is paid to the individual body 'of exercising upon it a subtle coercion of obtaining holds upon it at the level of the mechanism itself - movements, gestures, attitudes, rapidity and an infinitesimal power over the active body' (1977:137). By the nineteenth century, the individual already was, 'subject to a whole set of 'micro-penalties' of time: lateness, absence, interruptions of tasks; of activity: inattention, negligence, lack of zeal; of behaviour: impoliteness, disobedience; of speech: idle chatter, insolence, of the body: incorrect attitudes, irregular gestures, lack of cleanliness; of sexuality: impurity, indecency' (1977:178). It is the complex managing of one's mind, body and emotions that characterises the current ethos. Foucault does not consider ideas about the body but bodies themselves. He comments,

> The purpose of the study is to show how deployments of power are directly connected to the body - to bodies functions, physiological processes, sensations and pleasures ...Hence I do not envisage a 'history of mentalities' that would take account of bodies only through the manner in which they have been perceived and given meaning and value: but a 'history of bodies' and the manner in which what is most material and most vital in them has been invested. (1977:151-152)

It is Foucault's emphasis on the construction of bodies and not of ideas about them that differentiates his work from other sociological perspectives on the body.

2.6.3 Social Constructivism And The Body

More recent writings on the sociology of the body have suggested that our perception of the body is 'filtered through' the structures of knowledge which categorise social life in a particular culture. Knowledge, including knowledge of the body, is mediated through ideology, rather than being a direct description of independently existing reality. To a great extent, biology and its influence has disappeared from sight and has been replaced by subscription to differing degrees of social constructivism, each level implying different conceptualisations of the body and its relationship to the individual and society. In the mildest form, all social constructivist approaches adopt the view that the nature of the body is defined in part by subjective meanings that are constructed by particular cultures in given historical periods. A middle ground constructivist position accepts an inherent and fixed difference between the bodies of men and women, which is then further constructed by acts, social meanings, identity and object choice, while the most radical form of social constructivism posits that there is no essentialised, undifferentiated identity, mental or physical, for men or for women, that is not constructed by culture and history.

For example, Mauss (1985) argues a mild form of social constructivism: that the body can be understood only through a physio-psychosociological analysis which studies the body from the three separate perspectives of sociology, physiology and psychology. In the middle ground social constructivist position, Polhemus (1978) calls for the integration of these three perspectives on the body, so that 'knowledge on each level of experience can inform the others' and so that sociological understanding can act in addition to, rather than as substitute for physiological and psychological understandings (Polhemus, 1978:9). He argues that 'the human body does not exist and is not understandable apart from 'the social construction of reality' (1978:9). Our bodies and our perception of them constitute an important part of our sociocultural heritage. They are not simply objects which we inherit at birth, but are socialised (enculturated) throughout life and this process of collectively sanctioned bodily modification may serve as an important instrument for our socialisation (enculturation) in a more general sense. That is, in learning to have a

body, we also begin to learn about our 'social body'- our society (1978:21). Turner (1987) takes a more purely social constructivist position focusing primarily on ideas about the body and their role in constituting bodies.

Turner (1984) argues that sociology's entirely legitimate preoccupation with the rejection of sociobiology has 'submerged' the body as an object of analysis in sociology. He recognises the centrality of the body for sociological theorising and proposes a theoretical analysis of the body as a social phenomenon and object of social control. Turner emphasises the socially permeated quality of nature, arguing that the body is both a material organism and a metaphor for society (1984:8). He claims that 'nature constitutes a limit on human agency, since, as part of a natural environment, we are subject to growth and decay...this limiting boundary is of course both uncertain and inflexible, because the limits of human 'natural' capacity constantly change' (1984:204). As such the body is both 'social' and 'natural'. Turner argues against a perspective which would see the body as entirely constructed by ideology/in discourse contending that this would ignore 'embodiment'- that is, the personal sensuous experience of physicality through which personal control of the body-as-environment or 'corporeal government' is developed, and which, he argues is 'the phenomenological basis of individuality' (1984:233, 245,251).

For Turner, the body is both socially mediated and individually perceived (1984:251). While there is some level of direct individual perception of physicality, it is our cultural understandings of the body that are dependent on social structure. Turner considers biology as a socially mediated classificatory system by which bodily experience is organised, rather than an 'unmediated reality', biological facts exist through classification. He writes, 'Human agents live their sensuous, sexual experience via the categories of a discourse of desire which is dominant in given societies... and which is ultimately determined by the economic requirements of the mode of production' (1984:14). Similarly, biological needs, perceived in bourgeois society as grounded in the 'natural' body, are also 'thoroughly penetrated and constituted by culture', their nature, context and timing being subject to symbolic interpretation and social regulation

(1984:30). For Turner, human biological experience 'is socially constructed and constituted by communal practices...biology and physiology are themselves classificatory systems which organise and systematise human experience, and they are therefore, features of culture not nature' (1984:246).

Turner amplifies Foucault's argument that the body is an object of power, proc ced so as to be identified and controlled (1979:35). In *The History of Sexuality,* Foucault (1980) argues that 'the classical age discovered the body as object and target of power...the docile body...[which] may be subjected, used, transformed and improved' (1979:136). Turner proposes that Foucault's work can clarify the historicity of the body. Power has been conceptualised by early feminists as repressing desire, which therefore exists outside of it. For F ault, however, power is constructive - desire is created by power, sexuality in modern societies being continually produced and examined in, specifically, medical and psychiatric discourses. In consequence, desire is a product of specific historical discourses rather than a 'unified phenomenon'. Turner argues the same for the body, suggesting that Foucault appears to see the body as a 'unified, concrete aspect of human history, a view that is at odds with his treatment of sexuality and desire and with the argument that the body is constructed in discourse' (1984:48). Turner argues against the notion that there is a conflict between civilisation and physical needs and desires and instead supports an understanding of the body linked to Foucault's concept of desire, namely that the body is also created through a discourse of power, and is created in order to be controlled. Social inequalities, Turner argues, are struggled over at the level of a micropolitics of deviance and desire (1984:114). Turner's perspective allows for an investigation and analysis of the cultural meanings contained in body concepts, whether dominant or oppositional, and thus provides a basic structure for sociological analysis of particular historical body concepts. However, subsequent feminist and poststructuralist writers have challenged Turner's theory, and in particular his notion of 'embodiment' and 'corporeal government'. The criticisms have been twofold. First, Turner (1984) arg es that our sense of being in control of our individual bodies is the basis of individuality. However, if the body exists objectively as well as symbolically (as Turner claims) the distinction between the 'natural', or individually perceived, and the 'cultural', or socially

structured sensuous experience is not quite so easily drawn. His argument presupposes that the body has analytically discrete physiological, psychological and social levels. Second, it is contradictory to argue that perception of personal sensuous experience is not as much a product of culture as any other apprehension of the meaning of physicality, or to argue that physiological or psychological experience can be understood outside knowledge which is socially produced. The phenomenological possession of the body through embodiment does not always entail ownership, especially for women, and often women can experience their bodies as alien, as 'not self'. The notion of embodiment and 'corporeal government' may instead be understood to depend as much on cultural as biological presuppositions. Or, as many postmodern writers have asserted, even biological descriptions of the body and its functions and processes can be deemed socially constructed and gender determined (Fausto-Sterling, 2000), so that the body is never unmediated by language, society and culture.

2.6.4 Bodies And The Reproduction Of Society: The Body As An Instrument

Douglas (1966) argues that when a community experiences itself as threatened it will respond by expanding the number of social controls regulating the group's boundaries, identifying, regulating and increasing surveillance at points where outside threats exist. This will be enacted irrespective of whether the threats to the continued existence of the social group are real or imagined. According to Douglas (1966), when the sense of social order is threatened, the symbols of self-control become intensified along with those of social control, boundaries between individual and political bodies become blurred, and vigilance over social and bodily boundaries becomes increased.

Social control, exercised to ensure the stability of the body politic, is employed in a variety of ways. A continuum of discipline ranging from physical force, to more subtle forms of coercion, from strategies of control and socialisation to the reproduction of desired bodies to serve the needs of the body politic, is enacted on individual and social bodies. Cultures provide the codes and social scripts for the domestication of the individual body in conformity to the needs of the social and political order. The use of

physical force and torture by the modern state provides the most graphic illustration of the subordination of the individual body to the body politic. Torture offers a dramatic lesson to the common folk of the power of the political over the individual body. The history of colonialism contains some of the most brutal instances of the political uses of torture and a culture of 'terror' in the interest of economic hegemony. Scarry (1985) suggests that unstable regimes increasingly resorted to torture in order to assert the incontestable reality of their control over the population.

The body politic can exert its control over individual bodies in a less dramatic and mundane, albeit no less brutal way. Foucault's analysis of the role of medicine, criminal justice, psychiatry, and the various social sciences in producing new forms of power/knowledge over bodies are illustrative. Control is expressed through the vehicle of the body, in psychiatry, medicine and 'corrections' which address both the soul and the body of the person, and which serve the goal of producing 'normal' and 'docile' bodies for the state. The proliferation of disease categories and labels in medicine and psychiatry resulting in ever more restricted definitions of the normal, has created a sick and deviant majority, a problem that medical and psychiatric anthropologists have been slow to explore (Scheper-Hughes and Lock, 1987). Radical changes in the organisation of social and public life in advanced industrialised societies, including the disappearance of traditional cultural idioms for the expression of individual and collective discontent have allowed medicine and psychiatry to assume a hegemonic role in shaping and responding to human distress. Apart from anarchic forms of random street violence and other forms of direct assault and confrontation, illness and somatisation have dominant metaphors for expressing individual and social complaint. Negative and hostile feelings can be shaped by doctors and psychiatrists into symptoms of new diseases such as P.M.S. and A.D.H.D.[31] (Scheper-Hughes, 1987). The funnelling of real but diffuse complaints into the idiom of sickness has led to the problem of 'medicalisation' and to the over production of illness in contemporary advanced industrial societies. The medical gaze is

[31] P.M.S. refers to Premenstrual Syndrome, a condition ascribed to women prior to the onset of monthly menstrual cycle and consisting of mood changes and fluctuations in hormone levels. A.D.H.D. refers to Attention Deficit and Hyperactivity Disorder, a disorder increasingly diagnosed in children who exhibit behavioural problems, sleep disturbance, restlessness, poor concentration and high levels of activity.

then, a controlling gaze, through which active (although furtive) forms of protest are transformed into passive acts of breakdown.

Other writers have asserted that in addition to controlling bodies in a time of crisis, societies regularly reproduce and socialise the kind of bodies they need (Foucault, 1977, 1984; Bordo, 1992). For example, the culturally and politically correct body for both sexes in many modern Western industrial societies is a beautiful, strong and healthy body that is a lean, muscular, androgynous and physically fit form through which the core cultural values of autonomy, toughness, competitiveness, youth, and self control are readily manifest. Many writers have interpreted eating disorders and distortions in body image expressed in anorexia and bulimia as a symbolic mediation of the contradictory demands of post-industrial Western society (Bordo, 1992).

2.6.5 The Body As Sign

Poststructural theorists have been concerned to centralise the body in formulations about the relationship of the individual to society. Unlike their social constructivist predecessors who have, until recently, given scant attention to the theorisation of the body, or seen it as largely irrelevant to the social construction of mind, the body is crucial to an understanding of psychical and social existence. Poststructuralists are concerned with the lived body, the active body and how it is represented and used in specific ways in particular cultures. The body is regarded as the political, social and cultural object *par excellence*, not as a product of raw, passive nature that is civilised, overlaid, polished and constructed by culture. Nor is the body precultural, presocial or prelinguistic. There is no 'pure body'. Rather it is a social and discursive object, bound up in the order of desire, signification and power (Grosz, 1994:18). Grosz asserts that 'the body is neither brute nor passive, but is interwoven with systems of meaning, signification and representation. On one hand it is a signifying and signified body; on the other it is an object of systems of social coercion, legal inscription, and sexual and economic exchange' (1994:18). Feminist poststructuralists, such as Grosz, have been keen to demonstrate that the structures of language and other signifying practices which code women's body are as

equally oppressive as the material and social structures that shape women's oppression (Butler, 1990; Grosz, 1994).

Far from being an inert, passive, non-cultural and ahistorical term, the body has been seen as the crucial term, 'the site of contestation (...with patriarchs), in a series of economic, political, sexual and intellectual struggles' (Grosz, 1994:19). Poststructural feminists have therefore set about rejecting and destabilising the dualism between sex and gender which places the body in a subordinate position to the social construction of the mind (Gatens, 1983), asserting and naming the ways in which women's bodies are mediated by language and discourse (Grosz, 1994), revealing the human body as a text, a sign, which is constituted by history, culture and language (Butler, 1990, 1993; Barrett, 1991), positively affirming differences between male and female bodies, which are seen as fundamental and irreducible (Grosz 1994), disrupting socially dominant constructions of female bodies and female sexualities (De Lauretis, 1987, 1988), and creating 'new' knowledges about female subjectivity, sexuality and desire (Cixous,1981; Irigarary, 1985). In addition to the critique of dominant, totalising structures such as language and knowledge, poststructuralist feminists have shared in the celebration of 'Otherness', begun by Simone de Beauvoir (1953).

The ways in which the body is viewed by postmodernist writers as historically situated, culturally specific, and constituted by discourse, has prompted the question: Are any 'direct', that is socially unmediated-physical experiences, possible? The question does not suggest that the body does not physically, biologically or objectively exist: rather that all knowledge of, ideas about, and feelings in 'objective reality' are constructed in ideology. For most postmodern theorists the body cannot be known or apprehended without being captured by language, there is no prelinguistic knowledge of the body.

Postmodernists envisage the body as a site or a text upon which various discourses are inscribed (Leonard, 1997). For some, the body is pictured as 'docile', while for others it is a potential site for resistance (Tayson, 1998). In both views critics have argued that the materiality of the body is neglected (Shilling, 1993), claiming that, at best, its fleshy

reality is relativised as just one possible discourse about the body. Radical poststructural feminists recognise the body as a site for alternative knowledge building and action (Healy, 1996). They suggest male and female bodies have different capacities which arise from different lived experience, but these capacities are not just inscribed in our consciousness, they are inscribed on the body (Healy, 1996). For postmodernist feminists, knowledge cannot be disembodied but rather, 'the inclusion of embodied experience is argued to be central to, and indistinguishable from, the knowledge making process' (Tayson, 1998:42). Knowledge is thus relativised as a consequence of the different embodied experience of different people.

2.7 Feminism And The Politics of The Body

Social science and the specific disciplines of psychology, anthropology, sociology and social work have been criticised for their neglect of the body (Turner, 1984; Kondrat, 1992; Shilling, 1993; Healy, 1996), for their 'disembodied' view of human beings and for their continued reliance on the mind/body dualism characteristic of Western thought (Turner, 1984; Freund, 1988).[32] Arguably, feminism has always attended to the body with the politics of the body being its chief concern. Despite inadequately theorising the body, feminists have, in the wake of postmodernism and its epistemological consequences, engaged in a radical critique of their own 'disembodied' forms of theorising and have worked to place the body at the centre of theorising about women, power and social order.[33] Yeatman (1994) claims these changes reflect a 'coming of age' for feminism, which now shows itself as 'a confident body of theory and politics, representing

---

[32] While the body is not totally absent from social scientific analyses and from psychological, anthropological and sociological perspectives (see for example, psychological studies on body image and self-concept, or Goffman's work on the body as medium of self-presentation, personal control and identity (1959, 1961,1963 & 1979), it has only been in the 1990s that a more detailed social scientific analysis of the physical body's relevance to the social order has been undertaken.

[33] Postmodernism has challenged the idea of rationality, the possibility of self-conscious actors and the desirability of any positions claiming universal applicability. The challenge has led to a crisis of reason and to the disappearance of critical praxis based on epistemological certainty. The epistemological uncertainty of postmodernism has opened up an interest in more marginal ways of knowing such as feelings and intuition (Ife, 1997). In addition, feminists have challenged the dominance of positivism (Harding, 1986), advocating more open epistemologies and the relevance of bodily and emotional knowing (Jaggar & Bordo, 1989; Grosz, 1993,1995). Both feminism and postmodernism have elevated the importance of the body and emotions for social theory (Healy, 1996. Tennant, 1998; Yatson, 1998), arguing they are a way of knowing

pluralism and difference, while reflecting on its position in relation to other philosophical and political movements demanding change' (Brooks, 1997). Consequently, the female body has been a central feature of postfeminist theorising, with specific attention directed to examining the ways in which the construction of female bodies and subjectivities has in the past and present contributed to the oppression of women.

2.7.1 The Female Body: From Feudalism To Capitalism

Constructions of the female body in medieval categorisations were grounded in the perception that people were part of nature. 'The elements of the human body were identical, it was held, with the elements forming the universe. Man's flesh was of the earth, his blood of water, his breath of air and his warmth of fire' (Gurevich, 1995:57). As the unity of nature and humanity was experienced in the feudal mode of production, a 'subject-object' relationship between humanity and nature was impossible. The concept of human labour as 'transforming' nature was meaningless. For such a separation to be possible, the 'distance', both ideological and material between humanity and the natural universe would have to increase. This, Gurevitch alleges, occurred with the transition to the capitalist mode of production, in which nature became 'manipulable' and 'transformable' by human labour.

> Man's practical activity became more and more complex and his effect on nature more direct and purposeful, thanks to the development of new tools and the invention of machinery which came to adopt an intermediary position between man and his natural surroundings...he detaches himself more and more from her [nature] and begins to look upon her as an object to be utilised. (Gurevich, 1995:90)

Capitalist production acted to separate humanity from nature and thereby constructed nature as outside the human subject, and as an entity to be used. With the transition from feudal to capitalist culture a transformation occurs not only in the relationship of humanity to nature, but also in social relations. Power, wealth and status, previously

---

which need to be valued equally with conceptual knowing.

vested in social roles, seen as entailed in the fixed place occupied in a God given hierarchy, comes to be understood as the result of individual endeavour. Each individual acts in pursuit of his/her own interests; his/her social position is not fixed, but can be improved with industrious effort. Each individual is the agent of his/her own destiny, the centre of their universe. Consequent upon these material and ideological changes the concept of the body undergoes a transformation, in which separation and instrumentality characterise the bourgeois body. The chains which bound it to nature and to the collective body of the people having been broken, the body takes on a new meaning in the construction of nature as object and humanity as subject: it is used as an instrument in the pursuit of individual self-interest.

The transition from feudalism to capitalism is, in bodily terms, the transition from the understanding of the body as a part and expression of nature, to the body as the vehicle through which the self expropriates and controls nature. Fundamentally separate from, and acting upon nature, the body becomes private property, individualised and owned - converted to an instrument. The emergence of the concept of the body as 'thing' or commodity is furthered by the secularisation of the body, in which the body is transformed from the 'object of a sacred discourse of the flesh' to the object of medical discourse which sees it as a 'machine to be controlled by appropriate scientific regimens' (Turner, 1984:36).[34] Hence the legal and medical discourse of capitalism 'creates' and controls the body - fostering the bodies desires in consumption while disciplining the body in production.[35] Although desire and the body appear 'natural', the 'suppression' of bodily desires at work and their 'expression' in the private sphere are seen as natural occurrences. The body, as a pre-given biological entity, and physical desires, as naturally arising from biological dictates or 'needs', exist apriori, to be used by the self as it chooses; the social construction of the body and of desire are rendered invisible.

---

[34] See Chapter two (pp.31-36), where I discuss the ways in which medical theory, influenced in the seventeenth and eighteenth century by Descartes, reinforced the privileging of the mind as the definition of the self and the relegation of the body to the role of machine, owned by the self.

[35] Turner follows Foucault (1979, 1981) in this argument, contending that desire is created and controlled through medicalised power, and must thus be correctly channelled into consumption while being controlled in production (1984:159-70, 200).

The concept of the individualised body, with its central and defining characteristics of separation and instrumentality, refers not to the ungendered individual, but to the masculine subject. The feminine body is either rendered invisible, merged with the masculine, or constructed in opposition to the individualised body – subsumed and acted upon rather than separate or active. Conceived of as 'other', as opposite, medicalised social control of women in the nineteenth century sought to contain her dangerous body and sexuality and to return her to her proper status as 'a reproductive machine', an 'inexhaustible and undemanding resource' (Barker-Benfield, 1976:305; 1973:383, cited Turner, 1982). The aim of control was for men to 'assimilate women's power to themselves just as they attempted to do with the rest of the resources of the earth': women's bodies and nature's body should be subject to masculine mastery (1976:202, cited Turner, 1982). Several contradictory notions that were ascribed to women's sexuality intensified the desire for control over women. Women were passive domestic beings naturally 'shrinking from sex' and insatiable drainers of masculine sexual energies, quiescent and virginal and also dangerously threatening to men, powerful enough to extinguish the self-contained masculine body and patriarchal order itself.

2.7.2 The Female Body: 20th Century Bodies

Perceptions of early twentieth century female bodies are dominated by sociobiological explanations which present the body as a purely biological organism that determines and affects social life and human behaviour. Women's bodies were viewed as an inherent limitation to women's capacity for equality. Early feminists sought therefore to overcome the constraints of the female body by supporting birth control and reproductive technologies, by privileging the unique character and special insight afforded to the female by her body, or by challenging sociobiological explanations, arguing that they naturalise existing social relations, maintain privilege and thus operate as social control. The female body and sexual difference therefore became subsumed under rationality, as liberal and egalitarian feminists sought equality with men on individual, humanist and intellectual grounds. Androgyny was seen as the solution to the patriarchal imposition of 'femininity' (Millett, 1977).

In rejecting biological determinist arguments, social constructivist feminists were able to focus on how female subjectivity is shaped and constructed by social ideology. Distinguishing between sex as a biological category and gender as social, gender, representing the social and the ideological was given primacy in explanations about women's oppression. Further attention was directed to the strength of patriarchal socialisation, to the power of social and psychological constructions of femininity (Chodorow, 1978; Goldner, 1985), and to the consequences of such arrangements for women and broader society. Radical feminists have alleged that definitions of femininity often centre on sexuality, on bodies. The social construction of gendered subjectivity conditions our perception of sexuality and the body. Just as 'individuality' and 'femininity' are understood by sociologists to be social constructions rather than naturally existing facts, so too are masculine and feminine desires and bodies. The self, the body and desire are socially constructed in a structure of meaning with men enacting dominant roles and women subordinate. The masculine/neutral self is constructed as independent: complete, separate, active and possessive, and the masculine/neutral body is constructed as impenetrable, active and intrusive; its imagery is of muscular action and phallic penetration. The feminine self is constructed as dependent: incomplete, responsive, seeking merger. Feminine desire is created as responsive; it allows possession but threatens to engulf. The feminine body is constructed as penetrable: simultaneously weak and threatening, its imagery is of orifices: mouth, vagina and womb. Masculinity and femininity are defined interdependently, through a series of differences or oppositions, but socially constructed gender and reproductive roles restrict women's identity and behaviour, and limit women's sexuality (Tong, 1995).

The female body, in such conceptualisations, provides the base for the inculcation of ideology. Bodies are a means of communication rather than the focus of ideological production. Thus the neutralisation of sexual difference and the reorganisation of beliefs and roles associated with masculinity and femininity are seen as the keys to social transformation. The female body is largely irrelevant to the political imperative of transformation at the level of gender. Like other twentieth century Western conceptions of the self, gender theory presupposes that the body is separate from the mind, and

capable of being acted upon.

Poststructural feminists have taken a different view of the female body, arguing that it is central to an understanding of women's oppression. The female body is regarded as a political, cultural and social product, created, shaped and moulded by specific cultures and historical periods, and changing over time. The body is inscribed by language, discourse and other means of signification, which through a myriad of modern technologies of power, produce and control female subjectivity and activity. The body is therefore acted upon both by the individual and by society in ways which serve the interests and needs of society. For example, the concept of the body at the centre of the 'fitness boom' of the 1980s and 1990s engages with the understanding of the body as the vehicle for the pursuit of individual self-interest. The fitness boom is now taken up by capital, the mass media, and the state and its market is expanding. Turner terms such practices 'forms of secular asceticism' and 'calculating hedonism', linking them with anorexia. Bordo (1992) details the way discourse and cultural constructions shape and influence dominant conceptions of the female body in Western culture, describing how the body is disciplined to consume more and how the female body is disciplined (by women and society) to conform to cultural stereotypes which perpetuate women's subordination.

In subtle contrast, Mac Sween (1993) asserts that the social meanings and 'functions' of body maintenance are more complex, leading to two views of the body which are ambiguous and to the gender variability of body maintenance. In body maintenance strategies the concern is to perfect the body as vehicle for consumption and individuation. If the body is fit it can do more, enjoy more, produce more, in short, act on its environment more intensively and for longer. Body maintenance strategies also encapsulate a sense of the body as last resort of the purely individual control of the environment. If we as individuals are relatively powerless to affect social structures we can at least control the environment of our bodies. The process represents a move from the body as centre from which we act to the body as locus in which we act, where the self acts on the body rather than on the world, living in rather than through the body. On the

level of the body, body maintenance strategies express the contradiction in seeing the body simultaneously as the vehicle for expansive action/consumption and the only environment over which the individualised self can exert any meaningful control. She argues that the message is, consume and control.

However, for women the ideology of femininity modifies these meanings in two ways. First, in bourgeois culture the feminine body is constructed as the environment on which the masculine subject acts, as the acted on rather than the actor, the consumed rather than the consumer. Women's arena for action is also limited to the private sphere. Thus, women's ambit of personal control is fundamentally constrained, and in this context, control of the body takes on a particular significance. Chapkis argues that 'the exercise of control over the body compensates for a basic sense of a life out of control' (1986:12). Second, for women the pursuit of fitness means fit to be looked at rather than fit to act. Thus the feminine body is constructed as 'inviting, available and welcoming' in opposition to the masculine body as self contained, active and invasive.

2.8 Conclusion

In this chapter I reviewed different theories of the body, focusing attention on three specific epistemological approaches to the body; existential phenomenology, structuralism/symbolism and poststructuralism. My discussion located each perspective historically, from traditional philosophical conceptions of the body to contemporary feminist theories of the female body. I examined the varying conceptualisations and understandings of the body suggested by each approach, uncovering varied ways of thinking about the body and aspects of bodily experience. In so doing, I referred to numerous 'bodies': the lived body, object body, social body, metaphoric or symbolic body, body politic, signified body, and sexed body, to appraise writings about the body that have relevance to my study, to deconstruct and problematise the body by revealing the multiple ways it may be understood, and to identify the theoretical territory which foregrounds and situates my study. From this array of discourses on the body, possibilities exist for theorising the female body that may more fully illuminate women's

experiences of their bodies after sexual violation. However, before examining participants' stories in detail, it is necessary to clarify the epistemological and methodological principles that guided my study.

CHAPTER THREE
THE EPISTEMOLOGICAL AND METHODOLOGICAL CONCERNS

3.1 Introduction

I appraise the ontological and epistemological assumptions that frame and guide my thesis in this chapter. I begin by examining theories about the nature of reality and power and the role of language in constructing and reflecting relations of power and in articulating considerations of equality, difference and gender, and by exploring notions of subjectivity and its relationship to knowledge and science. I then investigate the premises underlying qualitative research methodology and the specific assumptions guiding the research process.

3.2 Modernism To Postmodernism: From Reality To Language

Postmodernist deconstructions of philosophy have questioned the existence of a unitary and universal truth, reality or 'innocent knowledge', that is supposedly accessible through a homogenous form of reason. They reveal the idealising desire of philosophy and the discursive and historical practices that shape its knowledge base. Postmodernism, in positing that ideas are the creation of social beings has raised questions about totalising universal claims, about essentialised and uniquely human assertions about grand or coherent theories, and about the transcendental nature of mind and reason. All knowledge is seen to be an effect of discourse and power. Discourse, constituted by language, is not seen to represent an external reality or 'facts', but rather, is a reflection of individual subjective experience, understanding and meaning. Reality is therefore multiple and socially constructed, but also attached to relations of power, which serve to create and perpetuate dominant knowledges and to subjugate others.[36]

---

[36] See Lloyd (1984) and Flax (1990) who both provide detailed critiques of the Western philosophical tradition.

Feminist theorists have received postmodern theories with mixed responses. The deconstruction of philosophy and a questioning of the relationship between power, history, and subjectivity has led several writers to detail the intellectual affinities between contemporary feminism and postmodern theory (Flax, 1986; Di Stefano, 1990; Fraser and Nicholson, 1990). Others have welcomed postmodernist positionings of knowledge as plural and situated, and have used these concepts to advance discussions of discourse, deconstruction and difference (Butler, 1990; Barrett, 1992; Barrett and Phillips, 1992; Pringle and Watson, 1992). For other feminist theorists, postmodernism(s), with its commitment to the partiality and contingency of knowledge, and to the non-essentialised, non-naturalisable, fragmented identities of knowers, profoundly undermines feminist endeavors. With no unity applied to the 'self', to the group, to categories of race, class, or more pertinently, gender, to the ideal of a comprehensive politics or theory that can make truth claims, the political vision of feminism and the possibility of a reliable feminist epistemology, they argue, becomes destabilised. Similarly, postmodernist shifts from 'reality' to 'textuality', or to perceiving the world in terms of discourse or language, imply a repudiation or denial of the materiality of the social world and the corporeal and embodied experience of the individual subject (Walby, 1990; Fraser and Nicholson, 1992; Bordo, 1993). Other writers have warned of the dangers of relativism inherent in postmodern epistemologies (Ramazanoglu 1993; Benhabib, 1994). The dilemmas and contradictions posed by postmodernism(s) have meant that some feminists have perceived an impasse for feminism which is now confronted with its own epistemological demise. Others have accepted the incompatible positions that embed contradictions at the heart of feminist theories of knowledge and may limit the agency of feminist politics. Still others argue against a 'long term relationship' with postmodernist or poststructuralist theories and advocate continuing to struggle for an articulation of feminist epistemologies (Grosz, 1990).

These debates' contradictions are reflected in my thesis. Postmodernist arguments about the historicity, partiality and contingency of knowledge, about the power of discourse to create 'truth', and about the role of language in the construction of everyday realities, ground understandings about knowledge and reality in my project. Furthermore, feminist

discussions of discourse, deconstruction and difference, and the ways these concepts contribute to the construction of the 'real' both frame and orient my work. However, postmodernist assertions that all knowledge is textual, and that language constructs all perceptions of reality, are problematic assumptions for my thesis, anchored as it is in an exploration of the embodiment of women who were sexually abused as children.

Whilst accepting postmodernist claims that language actively constructs, defines, shapes, moulds and locates bodies, and that the body is a powerful symbolic form upon which the central rules and hierarchies of culture are inscribed, I acknowledge the material reality of the body and explore further the relationship between language and the body. By reversing postmodernist claims that discourse constructs the body (the body is purely a text of culture), I wish to posit that the body creates meaning, that cultural meanings in turn inscribe the body, and to consider the interdependency of body and mind. Rather than discourse determining bodily experience, bodily schemata already constrain discourse; because our understanding is 'our way of being in, or having, a world'; and 'this is very much a matter of one's embodiment, that is of perceptual mechanisms, patterns of discrimination, motor programs and various bodily skills, as well as being historically and culturally specific. In other words, language itself arises from bodily experience' (Johnson, 1987:137). 'Reality' is therefore known through body knowledge and mental knowledge. My use of a 'mutually constitutive body mind' is intended to extend and enrich other useful conceptualisations of the body: as medium of culture (Douglas, 1982), as direct locus of social control (Bourdieu, 1977; Foucault, 1979), as text of femininity (Bordo, 1993), and as site of submission and rebellion (Celermajer, 1986).[37]

3.3 Relations Of Power: From Structure To Discourse

Embedded in my thesis are certain epistemological assumptions about power, about how social power is exercised, and about how social relations structured around gender, class and race are organised. Early feminist writings discussed and analysed power through

[37] In Chapter two (pp.30-77), I have examined differing conceptualisations of the body.

notions of 'patriarchy', and explained power through structural analysis. Structural analyses privileged forms of power such as the capitalist mode of production, the nuclear family, and male violence against women, and were considered to represent structural relations of power in which women were subordinated and oppressed.[38] The ideological assumptions inherent in structural power differences between men and women and the political consequences were seen to reinforce and perpetuate male dominance over women. Anglo/American feminisms were especially concerned to develop political understandings of the body, (a 'politics of the body'), in which the definition and shaping of the material body was seen to be the focal point of struggles for power (Bordo, 1992). Mundane, 'trivial' aspects of women's bodily existence were seen to be significant elements in the social construction of an oppressive feminine norm and a reflection of the way female subjectivity is trained and subordinated by the everyday bodily requirements of 'femininity'. According to Bordo, '...Feminism imagined the human body as itself a politically inscribed entity, it's physiology and morphology shaped by histories and practices of containment and control, from foot binding and corseting, to rape and battering, to compulsory heterosexuality, forced sterilisation, unwanted pregnancy and explicit commodification' (1992:21). Moreover, feminists extended their analysis to include the voluntary behaviours of privileged twentieth century women, which ensured their continual enslavement in the tyrannies of 'femininity' through practices such as dieting and cosmetic surgery.

More recent feminist analyses of power have revealed the 'partial and politically limited analysis' offered by structural models of power (Weedon, 1987), and have, in attempting to formulate more complex understandings of the relations of power, investigated the implications of feminist poststructuralist perspectives. Of particular interest to feminist theorists have been Foucault's ideas about discourse and power, which constitute an alternative theoretical model to that of ideology and reflect a broader shift from ideology to discourse in social theory.[39]

---

[38] As previously discussed in Chapter one (pp.1-27)
[39] See Chapter two (pp.62-68), where Foucault's ideas on power are presented in more detail.

Foucault's analysis of power anchors my understanding of gender, power and female subjectivity because it illuminates the ways in which women become collusive in sustaining sexism and sexist stereotypes and the degree to which women participate in personal and cultural practices that continue to objectify, sexualise and oppress. It also explicates how normative feminine practices in our culture are reproduced through practices which define femininity, and which train the female body in docility and obedience to cultural demands while, at the same time, they are experienced in terms of power and control. Second, it shows how modern power relations are unstable and continually subject to penetration and reconstruction by marginalised values, styles and knowledges. Resistance is perpetual, hegemony precarious, and transformations may emerge through small shifts in power, thus opening the way for resistance and subversion to disrupt and undermine historically and socially pervasive constructions and practices of femininity. The contingent nature of power assists in an understanding of individual creativity, resistance and rebellion in the face of culturally dominant and powerful discourses about femininity that mark female bodies.

For my thesis, I view power through a lens that incorporates both a feminist structural analysis of power and a postmodern appreciation of the subtle, multifaceted and complex ways in which power is embedded in cultural and social relations. While a Foucauldian conceptualisation of power permits an analysis of the ways in which women participate in personal and cultural practices that perpetuate their oppression and subordination, not all female oppression can be understood this way. Women are frequently physically and emotionally restrained, coerced and terrorised, and financially trapped in unequitable relationships and low-paid jobs. In particular, the women I interviewed were physically and sexually violated as children by adult males, and their violations took the form of overt physical force through to more subtle forms of coercion. Clearly, power can be wielded through the ideological underpinnings of structural relations of domination and subordination that reinforce stereotypes of masculinity and femininity, entitlement and oppression. Furthermore, while a Foucauldian conceptualisation of power assists in providing a framework for understanding cultural resistance, through such means as subversive readings, heterogeneity, difference and the celebration of individual creativity,

it is limited by its failure to acknowledge that cultural resistance is not on equal footing with socially entrenched positions of domination and subordination sustained by networks of power. Powerful social and economic discourses and networks are clearly more dominant, strongly normalising, historically occupied and culturally entrenched, and are therefore more powerful and strongly invested in maintaining their positions of social dominance (Bordo, 1992). My thesis therefore employs a reading of power, which acknowledges the stable and concentrated forms of structural power, and the prevailing inequities between men and women, particularly in Australia as a patriarchal society, but also recognises the more complex and multifaceted nature of power, its embeddedness in culture and the interconnected webs of its functioning.

3.4 Discourse, Language And The Body

Much has been written about the relationship of language to reality (Weedon, 1987; Flax, 1990, 1992). The works highlight the following premises: that language plays a major role in generating reality, that without words to objectify and categorise our sensations and place them in relations to one another it is difficult to evolve a tradition of what is real in the world, and the scope of reality becomes much less clear. Where language was once thought to be a pure representation of reality and a reliable reflection of absolute truth, according to the modernist paradigm, from a poststructural perspective, language is seen to actively constitute the real in the process of describing and naming it. Language, however, describes and represents the real in less than neutral ways. 'The structure of language makes the world intelligible by differentiating between concepts, by constructing differences or signs that are defined by their difference from each other in the network of signs which is their signifying system' (Belsey, 1980:38). More directly, words have meaning in relation to other words through their difference: man/woman, reason/passion, fact/value, objective/subjective, real/ideal. Hierarchy is assumed in the difference, so differences are defined in a relationship that privileges one of the 'opposites'. In the case of gender, difference is set up as duality and hierarchy, where woman is what man is not, and where difference is viewed as 'deficiency'. According to Foucault, language defines, 'not the dumb existence of a reality, nor the canonical use of

a vocabulary, but the ordering of objects' (1972: 49). Hence language, being structured in and through a series of hierarchical differences, can be seen as both constituting and reflecting political relations that are defined through difference.

Language also does more than designate things; it systematically forms the objects of which it speaks. It crisscrosses the realm of 'fact' (the real), and 'interpretation' (the ideal), and interpretation contributes to how the real is known (Coward and Ellis, 1977; Eagleton, 1983; Showalter, 1985). A more complex relationship between language and truth is then revealed, in which language can be seen to embody a standpoint. Language then forms discourse and, as Belsey states, '...A discourse is a domain of language use, a particular way of talking and writing and thinking. A discourse involves shared assumptions which appear in the formulations that characterise it' (1980:5). It is through discourse that knowledge is produced, and circulated in societies. For Foucault, discourse is not just a concept, rather, 'discourses have an objective reality, and a quality of exteriority' that make them the bearers of power (1981b:60), and it is through discourse and discursive practices that power is exercised. Discourse is completely entwined with notions of language, knowledge and signs as a part of the domain of power, so that sometimes a discourse is a form of power; sometimes it just expresses a form of power. Discourse puts into play a particular set of viewpoints, just as it conceals others, and power is exercised to marginalise and subjugate less dominant discourses (Foucault, 1972).

According to Foucault, it is through discourse that power becomes dispersed and heterogeneous, spreading 'capillary' - like through discourses, bodies and relationships in the metaphor of a network (Ransom, 1993:129). Multiple sites of power, such as the family, the body, sexuality can all be seen to occupy positions within discourses which are imbued with power to construct social reality. Discourse and language are thus accorded significant power to name and create reality, to construct and order meaning, and to constitute and perpetuate what is accepted as knowledge. But it is also from discourse that power can be exposed, undermined and thwarted. Yet, while holding some potential for disruption, alternative discourses exist in relation to other discourses that

may occupy greater positions of power, and their strength to render fragile existing dominant discourses is debatable.

I use the recognition of how language is used to name, represent, create and shape reality because accepting the role of language and discourse in constituting reality and in constructing meaning relocates power from the realm of the 'real' and from a centralised and structural position, to the realm of the constructed and to diverse and heterogeneous sites. It also makes possible multiple meanings of the 'real', no single unitary truth, and the existence of only partial truths. This perspective reveals the more complex nature of power and embeds power firmly in language and it discursive capacity to construct 'reality'. It reveals the power of discourses to produce knowledge about all facets of social reality, about women, about gender, about violence, about the body, while at the same time revealing that knowledge is constructed, partial, ordered in a hierarchy of knowledges, and therefore contestable. Discourse, while powerfully constitutive, historically positioned and culturally embedded, can also be deconstructed, challenged and repositioned. Multiple and shifting meanings are possible. What is concealed (intentionally or not) is any notion of centralised power. The conceptualisation does not need to be represented in the form of hegemony or social, economic or political structures which dominate, but perhaps as an overarching discourse which centralises itself at the core of all other discourses (Eisenstein, 1988).

What is also concealed from this perspective is the degree to which language is seen to constitute reality. If language is seen to constitute only partial reality, how else is 'reality' constructed or formed, by what knowledges, elements and kinds of knowing? If language and rational constructions are alleged to constitute all of our perceptions of reality, what is omitted? A significant omission, I argue, is the body and its role in the construction and formulation of meaning. Such a consideration invokes the premise that not all knowing is in language, preceded by language, or bounded by language. Further, that not all meaning is created by the mind, but by the body, or through the interconnectedness and interdependence of mind and body.

I accept the theoretical assumptions made possible by poststructuralist and Foucauldian perspectives on language and discourse and welcome the theoretical analyses that they make possible. However, whilst acknowledging the plurality of power, I do not wish to foreclose a notion of power that explains power over others, as is the case with women sexually abused as children. I also do not wish to claim that all knowledge or knowing is apprehended through language and through the conscious, rational mind. I want to take care not to exclude the body from any consideration of knowledge and knowing and to allow for the body's role in constituting meaning and experience. As such, I am positioned in the tension between these locations, not fully aligned with one or the other. I have situated myself within a contingent acceptance of the possibilities of each and the contradictions and collisions between them, to construct ways of thinking about the meanings created through the experiences of the women I have interviewed for my study.

3.5 Subjectivity, Knowledge And Science

Any discussion of knowledge includes science, because science is used to represent the very conception of objectivity that defines the realm of the real and the natural in all aspects of social life. Feminisms link to several contemporary approaches that have emerged out of broader theoretical critiques of the scientific-positivist traditions in science. These critiques have sought to demonstrate that scientific knowledge in the natural sciences was far from being pure and objective, but was instead, socially constructed. Mendelsohn writes,

> Science is an activity of human beings acting and interacting. Its knowledge, its statements, its techniques, have been created by human beings and developed, nurtured and shared among groups of human beings. Scientific knowledge is therefore fundamentally a social knowledge. As a social activity, science is clearly a product of a history and of processes, which occurred in time and place and involved human actors. (1977:4)

Science, therefore, is not about the study of objective reality. Rather, paradigms are constituted through the power of scientific discourse, they operate to legitimate new realities, protect established paradigms of thought, and silence alternative phenomena (Kuhn, 1962).

Feminists have critiqued notions of scientific objectivity and demonstrated that how one defines knowledge and truth is gender related. Keller argued that despite its claim to be 'emotionally and sexually neutral, the scientific tradition of 'objectivity' represented a 'masculine bias', and that 'an adherence to an objectivist epistemology, in which truth is measured by its distance from the subjective, has to be re-examined when it emerges that, by definition, truth itself has become genderised' (1978:51). Feminist critiques of knowledge and of androcentric science have ranged from liberal to radical (Keller, 1983; Harding and Hintikka, 1983; Harding 1986, 1987). Liberal feminists have been concerned with political matters such as the exclusion of women from the sciences, the predominance of males in the sciences, and their dominance in positions of power within scientific organisations. Radical feminists have directed their critique to the traditional conceptions of science, claiming male bias in the choice and definition of research problems, male definitions and forms of explanation in allegedly value-neutral and objective science, bias in research design and interpretation of research findings, the perpetuation of dualistic modes of thinking and, most fundamental to this critique, has been the questioning of the assumptions of objectivity and rationality that underlie science.[40]

The ideal of objectivity has been so structured in science to reflect masculinised perceptions and to reinforce dualism, which serves the ideological purposes of patriarchal society, that feminists have wondered whether to abolish or revise the concept. Abolitionists suggest dispensing with the idea of objectivity altogether, given that all knowledge is seen as irremediably 'tainted' with subjectivity and unable to accurately represent reality. This viewpoint counters the tendency of powerful groups to claim as

[40] The critical appraisal of science emerged from a broader feminist critique of Western · :ophy and knowledge (Grimshaw, 1986), which I have discussed in more detail in Chapter two (pp.30ff)

uniquely true those bodies of knowledge which reflect their experience and serve their ideological purposes. In accepting that all knowledge is irremediably subjective, and that the knowledge of one group is no closer to some 'fictional' truth than the knowledge of another, relativism effectively deflates the pretensions of hegemonic bodies of knowledge, and affirms the validity of 'subjugated knowledges'. But in foreclosing the possibility of evaluating knowledge, relativism simultaneously negates the claims of subjugated knowledges to greater validity. In effect, by allowing greater validity to none, it is invalidating all, and thereby dissolving the epistemological dimension of political struggle. Feminists can no longer argue that patriarchy should be abolished in the cause of truth or knowledge, they can only point out that patriarchy cannot justify itself in terms of truth and knowledge, as it has in the past. With the possibility of any form of epistemological justification removed, power becomes the only criterion for determining which body of knowledge will prevail. Although stripped of their rationalisations, hegemonic forms of knowledge will remain hegemonic and subjugated knowledges will remain subjugated, without any epistemological cause to plead.

3.6 The Possibility Of A Feminist Science

The second feminist response to the question of objectivity has been to argue for a revision of the concept. Two positions may be defined. The first seeks to escape dualism by integrating the terms of dichotomies. The result will be the acknowledgment and reconciling of opposing gender perspectives, the cancelling out of ideological imbalances and the creation of a new, gender free and ultimately more objective form of knowledge. The second position seeks to escape from dualism by opening duality into plurality, acknowledging not only 'masculine' and 'feminine' perspectives but also an indefinite plurality of ways of knowing that are generated by and express different social identities. The integrative position includes many 'feminist standpoint theories', which attribute to women distinctive ways of viewing the world based on their experience and social practices (Rose, 1983; Hartsock, 1983; Keller, 1985). The aim is to dismantle the dualisms that vitiate science and in so doing create a feminist 'successor science', which, in eschewing detachment, is both dynamic (Keller, 1985), and ultimately more objective

(Keller, 1985; Harding, 1986, 1987). This approach has been challenged by feminist theorists who object to its fundamental presupposition that women share a common perspective irrespective of history, culture, race and social location. By making such claims to knowledge and speaking on behalf of all women, postmodernist feminists have argued that standpoint theories replicate the same power dynamic evidenced by traditional masculinist science. The pluralist approach also argues that it is mistaken to assume a commonality of the experiences of women, claiming it falsely 'essentialises' and 'universalises' the idea of womanhood. From this perspective, all subjects are necessarily split or fractured along various social and cultural lines, so it is important not to integrate dichotomous ways of knowing, but to resist hegemonic forms of power and ideology by opening dualism into pluralism. They argue instead for many different feminist standpoints, each of which provides a partial perspective on reality and change in response to historical forces. All knowledge is therefore seen to be 'situated knowledge' (Haraway, 1996) and must be understood as a collective rather than individual endeavour.

Feminist empiricism and feminist standpoint theories, despite providing some transitional epistemological frameworks for a feminist science, have been limited by internal inconsistencies which leave the inherent deficiencies of historically dominant forms of natural and social science intact (Harding, 1986). Claims about women's increased capacity for objectivity, the lack of contest of dualisms which structure sexual differences and scientific practices, and the undesirable dominance of one group by another, are specific difficulties which mar these epistemological formulations. Postmodernist perspectives, on the other hand, while arguing that the claim that women share certain experiences confers essentialism, fail to acknowledge that the characteristic profile of women grows out of women's social practice, and this may be universal but nevertheless contingent (Matthews, 1993). To convert the claim that women share commonalities in gender specific experience into a metaphysical claim that they have an innate nature or essence that fits them for doing so, is ideologically unsound. Further, the epistemological consequence of postmodern views of identity, where no 'human nature' or 'feminine nature' can be provided as a normative yardstick, means that no feminist project can be

evaluated or rated over the projects of male scientists or patriarchs.

Such contradictions and dilemmas embedded at the heart of feminist epistemological struggles to restructure and reinvent conceptions of knowledge and science have made it difficult to establish a solid epistemological foundation for feminist science. Despite this, feminist critiques of Western philosophy and of scientific paradigms of knowledge have provided crucial understandings about the nature of truth, the situatedness of knowledge, the legitimation of knowledge through hegemony, and the pretence of epistemological objectivity. Further, they have prompted critical and ongoing reflection about the assumptions inherent in theories of knowledge and the need for constant reflection and self-reflection about developing feminist epistemology. It is with incisive feminist critiques in mind, and with the accompanying complexities they imply for feminist epistemology, that I proceed.

3.7 A Methodology Of Difference

As I have argued, feminists have not limited their critiques of research to epistemological issues, they have also been concerned about the nature of a feminist science, and about how the above debates and dilemmas become translated into methodological issues for those doing research studies within a feminist perspective.[41] They have questioned what methods, modes of thinking, data collection and analysis should be used, and have focused attention on how problem definition, concepts, frames of reference and methods define and express the interests of and arise out of particular social institutions, values and contexts. The dilemmas inherent in their questions have prompted more recent writers to argue that it is not possible to establish a feminist method (Harding, 1987). To do so would be to cut across class, race, culture and historical differences which are critical variables in women's experiences, to exclude and marginalise differences

[41] As discussed previously (pp.88-90), efforts to establish a feminist 'successor science' have resulted in the articulation of 'feminist empiricism' and 'feminist standpoint theories' as possible epistemological and methodological bases for a feminist science, but these approaches have been undermined by internal theoretical inconsistencies, and by the advent of postmodernist challenges to purity of knowledge and the unity of the subject, prompting recent writers to argue that it is not possible to establish a feminist method (Harding, 1987).

between women, and to privilege western theories which then become mobile, territorially expansive and appropriative (Haraway, 1996).

Harding (1987) has argued against the idea of a distinctive feminist research method. Instead, she identified three distinctive characteristics that illuminate quality feminist research. First, to counter social science that has traditionally dealt with questions that are problematic within the social experiences characteristic of men, feminist researchers have insisted that their research must be based upon women's experiences as a source for research problems, hypotheses and evidence. Second, as traditional social research has been for men, feminist research must be for women, to deal with what they regard as problematic from their experiences. Third, in recognition that the cultural background of the researcher is part of the evidence that enters into the results of the research, the researcher must place herself in the same critical plane as the subject matter. This feature of 'good' feminist research avoids the 'objectivist' stance that attempts to have the researcher appear as an invisible, autonomous voice of authority. Introducing the 'subjective' element into the analysis reveals the researcher as 'a real, historical individual with concrete, specific desires and interests', increases the objectivity of the research and decreases the 'objectivism' which hides this kind of evidence from the public (Harding, 1987:9).

Other feminist writers, wary of dilemmas and inconsistencies associated with the task of research, have also explicated characteristics of feminist research rather than advocating a singular 'feminist method' or technique. They have suggested that the preconditions of a feminist science involve; a focus on women's experiences and their inherent diversity, acknowledgement of the pervasive influence of gender, attention to women's agency and resistance to oppression,[42] rejecting the separation between subject and object, regarding

[42] Explorations of women's agency and resistance are not limited to a search for individual psychological sources of feelings, actions and events. For while women are viewed as active agents in their own lives and as such constructors of their own worlds, their activity is not isolated and subjective. Rather, individual experience is located in society and history, embedded within a set of social relations which produce both the possibilities and limitations of that experience, and the central role of feminist research is to address the relations between the two (Acker, Barry & Esseveld, 1983).

nature as active rather than passive, rejecting the dualities embedded in science, privileging ethical concerns, and emphasising the empowerment of women and the transformation of social institutions (Stanley and Wise, 1983,1990; Cook and Furnow, 1986; Fee, 1986; Jayaratne and Stewart, 1991; Thompson, 1992).

My research project takes account of feminist critiques of the assumptions, theories and methods of traditional masculinist science, while also engaging in a continual and reflective process of interrogation of its own epistemological formulations, theories and methods. My project is grounded by assumptions that recognise differences between and diversity among women's experiences. Recognising the multiple and diverse meanings of difference challenges the traditional focus on difference as homogeneity, difference as opposition, difference as dichotomy, or difference as 'less than', as implied by traditional notions of gender difference (Guillaumin, 1985). A positive view of difference, rather than foreclosing, erasing, or decomposing gender identity, explicates multiple views, 'displaces the fixity of gender, and through the play of difference and division, simultaneously creates and uncreates gender, identity and meaning' (Jacobus, 1986:24). However, while seeking to focus on the diversity of differences, I do not overlook continuity and similarity in the experiences of the women I have interviewed. There are unities as well as diversities among their experiences. My recognition does not seek to imply a sameness of identity or character, but rather, is used to establish connections between the emerging themes that make up the threads of their stories. I also employ the principles of feminist research method[43]and in doing so, seek to develop new understandings that contribute to knowledge about, and improvement, in women's lives. My thesis is guided by the feminist epistemological assumptions and theoretical perspectives outlined as they lead to particular kinds of methodologies that form a logical 'fit' with the theoretical ideas of feminism generated by my study.

[43] The principles of feminist research are outlined on pp.91–92.

3.8 Feminist Methodologies

As I have argued, feminist research involves applying a critical eye to research methodology and to the assumptions underlying the method, and also involves employing alternative methods of investigation and analysis that reflect feminist critiques. The process is reflected in feminist critiques of traditional quantitative research[44] which identified contradictions between the methods employed in traditional science and the goals of feminist research, culminating in the advocacy of alternative research methodologies that were consistent with feminist epistemologies and values (Mies, 1983). Consequently, feminist researchers have been drawn to qualitative research methodologies as they actively address issues concerning problem definition, the relationship between the researcher and the subject, the power of the researcher, definitions of objectivity or 'reality', the role of the researcher in the co-creation of research knowledge and the processes of information gathering, presenting and analysing data (Keller, 1983; Hartsock, 1983; Harding, 1986, 1987). Moreover, qualitative research methods permit women to express their experience in their own terms, offer a less mechanical and more human and personal relationship between the researcher and the 'researched' (Oakley, 1981), and de-emphasise the critical focus on quantification (Stanley and Wise, 1983). While feminists have shown enthusiasm for qualitative methodology they have also identified several conceptual areas that require further explication and discussion. They have sought to clarify the terms used in qualitative and quantitative research (Harding 1987), to justify their critique of quantitative methods while debunking essentialist notions of 'women', 'feminism' and 'women's research', that characterised early feminist qualitative research (Mies, 1981; Lykes and Stewart,

[44] The initial critique of traditional research methodology derived from reports of negative personal experiences by participants, political concerns about the racist, sexist and elitist attitudes and practices involved in existing methodologies, and from philosophical disagreements, based on feminists' rejection of positivist empiricism (Jayaratne & Stewart, 1991). Feminist criticism of traditional research methodologies included noting the selection of sexist and elitist research topics (Frieze, Parsons, Johnson, Ruble & Grady, 1981; Jayaratne, 1983; Cook & Furnow, 1984; Scheuneman, 1986) and the absence of research on questions of central importance to women's lives (Roberts, 1981), biased research designs, some using only male subjects (Grady, 1981; Lykes & Stewart, 1986), an exploitative relationship between the researcher and the subject (Birke, 1986; Harding, 1987), the illusion of objectivity (Lykes & Stewart, 1986), the simplistic nature of quantitative data (Jayaratne, 1983), improper interpretation and over generalization of findings (Westkott, 1979) and, inadequate data dissemination and utilization (Jayaratne, 1983).

1986), to further examine the notions of objectivity and subjectivity in qualitative research (Rose, 1982; Stanley and Wise, 1983), and to deconstruct the research relationship, with an eye to issues of power. They have also questioned how to produce an analysis which goes beyond the experience of the researched, while still granting them full subjectivity, and how to create categories which signal new concepts or patterns, while not obscuring the complexities of women's experiences.

3.9 Qualitative Research Methodologies

Mindful of these conceptual dilemmas, I utilise a qualitative research framework because it is consistent with feminist values and research principles and provides a methodology that enables me to uncover the thoughts, perceptions and feelings experienced by the informants. According to Minichiello, Aroni and Alexander (1990), qualitative research permits the study of how people attach meaning to and organise their lives, and how this in turn influences their actions. Its aim is not to reveal causal relationships, but rather to discover the nature of phenomena as humanly experienced.

Qualitative procedures aim to produce full and integrated descriptions of an experience or situation under study. Data are typically produced by noting observations of a situation and its participants or by conducting open-ended interviews. Rather than testing variables chosen in advance, qualitative designs seek to derive explanatory concepts and categories from the data. Qualitative analysis undertakes to identify concepts and relationships that disclose an order in the data and thus make the data more understandable. The analytic process is recursive in that a proposed conceptual order is tested against the data; on the basis of its fit and explanatory power, the proposed conceptual order is continually revised until the data become conceptually coherent (Polkinghorne, 1991).

Qualitative research procedures emerged out of reconstructed views of knowledge which recognised that human knowledge is not a mirrored reflection of reality as previous quantitative research suggested, but rather a collection of cognitive maps and conceptual systems that change over time and vary according to culture, location and history. Both

qualitative and quantitative research procedures further understanding by positing a semblance of order on the complex flow of human experience. However, the use of qualitative research methodology in feminist projects has provoked reactionary claims that it is 'unscientific, politically motivated and overly biased' (Du Bois, 1983). In response feminists have argued that the social nature of qualitative research means that standards by which 'objectivity' of positivist research are judged are not appropriate, that the canons usually used to judge quantitative research, particularly with respect to validity and reliability, need to be redefined to fit the complexities of qualitative research, and that knowledge generated through qualitative research is rigorously tested (Strauss 1987). Strauss and Corbin suggest that qualitative research should be judged on the basis of the 'validity, reliability and credibility of the data', the 'adequacy of the research process through which theory is generated, elaborated or tested', and 'the empirical grounding of the research findings' (1990:252). Moreover, the ways in which research participants are treated and the care with which researchers attempt to represent the lived experience of the research participants are of central concern. Both qualitative and quantitative approaches to research are based on varying epistemological constructions and on logic and rules intrinsic to their own processes. It is a mistake to judge the procedures and results of one by the principles and techniques of the other.

Qualitative research designs mimic the constructive processes that humans ordinarily use to search for patterns of consistency in their experience (Margolis, 1987). Patterns provide the interpretive schemes through which events are understood and actions are taken (Coombs and Syngg, 1959). The principles of qualitative research are based on the operations of gestalt logic of ordinary understanding, which involve a recursive process through hypothetical approximations and revisions. It is the recursive movement between the data and hypotheses that gives qualitative designs a very different character from quantitative designs, which rest on linear, sequential movements through phases of the research.

While qualitative research uses the basic recursive logic of ordinary knowledge, it differs from the ongoing, daily endeavour of pattern construction in that it is deliberative,

methodical, and subject to public scrutiny. The initial pattern descriptions are tested by intentionally searching for instances that would call them into question. On the basis of the analysis of the additional information, initial descriptions are to include the newly produced instances. The movement from formulation of a description to the search for instances that do not fit the description to reformulation of the description is continuously repeated until the description is sufficient to include the variety of instances. The proposed research conclusions are tested against data that is intentionally selected to show its inadequacies. Its conclusions and the analysis used to obtain them are then submitted to the community of scholars for its critique and judgement. Qualitative designs can be seen therefore, to combine the 'context of discovery' (developing hypotheses) with the 'context of justification' (justifying hypotheses) through the processes of creating and refining hypotheses as they interact with the data (Reichenbach, 1938). The recursive movement from partial discovery to partial confirmation continues to occur until a hypothesised pattern configures all the data.

Qualitative research procedures cannot be separated from the context of a particular research project. Their description as discrete parts of qualitative research is an abstraction from their use in practice. The three primary activities involved in doing qualitative research are data producing, data analysis, and communicating results. Data production in qualitative research is a fluid, developmental process. Typically data sources are in the form of observations, interviews, documents and the researcher's own experience. The choice of data sources is guided by the contribution the source might make to answering the research question under investigation, however, the choice of data sources may be ongoing throughout the research process on the basis that new or further sources may contribute to the formation of the emerging descriptive pattern against which hypotheses are formulated and reformulated. After a preliminary descriptive pattern of the phenomenon under study is produced from analysing the data, the researcher selects sources that are somewhat removed from the exemplar or prototypal instances of the category, attempting to enhance and extend the description. As the descriptive pattern evolves from the accumulation of data, specific aspects will lack clarity and definition. The researcher selects further sources of data that address these aspects of the developing

description. The researcher then purposefully searches for unique or unusual instances of a category to be used as a further check on the adequacy of the proposed pattern. When new sources of data continue to reinforce the emerged description rather than adding new dimensions to it, the researcher brings the data collection to an end. The character of data obtained in qualitative designs is 'thick', meaning that it is characterised by vivid, rich and comprehensive descriptions of instances of a category. Less emphasis is placed on formal controls in data production as the obtaining of data rests on a discourse model, in which the data emanate from the interaction of the researcher with their data sources. The aim is to gather connected and related information through a more personal exchange with sources, and for the researcher to be aware of their own biases and presuppositions in the process and the effect on the information being gathered.

The purpose of qualitative data analysis is to develop a statement delineating a structure or pattern of relationships that organises the phenomenon under investigation into a unified whole. The emphasis is on illumination, understanding and extrapolation rather than causal determination, prediction and generalisation. Qualitative analysis requires the search for patterns of connection in experience and proceeds with the identification of larger patterns and then constituent subpatterns, until a level of structural organisation implied by the research question is achieved. Because the process of qualitative research involves fitting mental structural models to the consistencies of data, it is important for the researcher to have some knowledge of the mental operations involved in ordering experience and connecting entities into meaningful wholes. Lakoff and Johnson (1980) list conceptual patterns with which to understand and describe relationships that hold among the aspects of a phenomenon. Their view is that our abstract conceptual structures are extensions of primary structures that organise our bodily encounter with the world. The primary structures are of two kinds - body image schemata (perceptual interactions and bodily movements within our environment), and basic level concepts (the 'humanising' of objects, things and actions into forms of basic categorisation). According to Lakoff and Johnson (1980), our original bodily involvement with the world is organised through the two levels which provide the conceptual repertoire humans use to organise the rest of experience. The bodily repertoire of experiential structures is then

employed to develop cognitive models which we use to organise thought, and they suggest that four types of cognitive models are utilised; image – schematic models, propositional models, metaphoric models and metoymic models. The qualitative analytic process often produces understanding by mapping the more directly understood image schematic and propositional structures onto the more complex and less clear phenomenon that is the object of investigation. The stages in qualitative analysis involve the researcher in the following steps; reading and rereading the data, identifying units of data that represent a single theme or a category, assigning a code to the theme and collecting units with the same theme together and analysing the common elements, noticing relations that may hold among the themes and then searching for contradictory data that could break up the unity of the data that descriptions are beginning to cover. The steps are repeated until the data from new sources continue to fit the emerged structural description.

The results obtained in qualitative research are most often communicated through a research report or as a publication in a discipline's research literature. The research report requires, in addition to a statement of the findings, inclusion of sufficient description of the research process that scholars can make judgements about its value as a contribution to knowledge. In qualitative designs, the writing of the report is an integral part of the research process itself, not merely the reporting of a completely finished process but an extension of the analytic process. In recounting and reviewing the data and their analysis, new insights and patterns emerge, which at times, may lead to further data collecting, re-coding or analysis. The final report consists of clarification of the topic under investigation, recounting the processes involved in data collection, production and analyses, and the elucidation of patterns and themes that make a contribution to knowledge about the topic in question.

3.10 Summary

Recent writing indicates some consensus that there can be no single, prescribed feminist research method. I have chosen to work with qualitative research methods for several reasons. First, they are consistent with ideas about feminist values as a politicised

intellectual endeavour. Second, they uncover the thoughts, feelings and perceptions of participants and the meanings they attribute to their experiences. Third, they encourage a rich, detailed and textured analysis that does not foreclose diversity or complexity. Fourth, they acknowledge the intersubjective nature of the research process which includes the subjectivity of the researcher and the researched. Finally, they give authority and value to the knowledge generated by women themselves. Having established the epistemological and methodological assumptions guiding my work and the research methods I utilise, I now turn to a description of the study.

CHAPTER FOUR
THE RESEARCH FRAME

4. 1 Introduction

As I detailed earlier[45], my research was driven by my desire, and that of the women I interviewed, to tell the stories of women sexually abused in childhood. We wanted to explore and place their stories and their knowledge into a broader public sphere. By so doing, we hoped to make a difference to how the impact of child sexual abuse was understood and, in particular, to acknowledge and change how women experienced and gave meaning to their bodies following this violation. We hoped that the knowledge gained would assist other girls and women who had been sexually abused in childhood and were struggling to live comfortably in their bodies, and also professionals, therapists and academics who make claims to knowledge about the impact of child sexual abuse and the path to recovery. Hence, I trace the trajectory of the research.

I decided to use autobiographical narrative as it described as an essential ingredient in providing understanding about who we are and how we become individuals with separate, yet socially formed, identities (Giddens, 1991). More recently, postmodernists have asked whether there is such a thing as an authentic, unitary self or even an authorial voice claiming that there are only competing discourses. These assertions throw into question the purpose of writing about women's personal stories. However, there are good reasons to use autobiography in sociological and feminist writings as autobiography is one of the strategies developed by human beings to make life matter, to give it form and to create its meaning (Mandel, 1980). The telling of stories and the writing about experiences is a way to make sense of the complexity of life, and of creating meaning out of life events that may seem unbearably painful and incomprehensible (Frankel, 1946). These autobiographies are not simply descriptive, they are frequently the place in which ideas are refined and theory developed. Many of the participants in my study were explaining their ideas in the process of telling me their stories. Further, many influential

writers such as Freud, Sartre and Frankel, have relied on autobiographical material to develop their theories. The development of theories is another strategy to create meaning and to make life matter.

Autobiography can also demonstrate significant links between the individual and society; the heart of any sociological and feminist project. Personal narrative and individual experience can be placed alongside academic discourses and critical theories, and each voice can reflect on the other. Participants in this study often reflected on social theories in the light of their own personal experience and in doing so, participated in their own construction and critique of social theory. The form of personal narrative provides an important source of information about the connection between the individual and their social context. The participants' stories give insights into the experience of female embodiment and the social construction of female bodies in the late twentieth century, which enables comparisons with other periods in history. Their stories reflect the way in which women come to know themselves in relation to the experience of their bodies and how they attempt to change themselves to meet or challenge social ideals and expectations about female bodies.

Kleinman (1988) and Epston and White (1989) argue that narratives have the power to heal. Forming a chronicle, a history, a sequence of events and perceptions, linking the past, present and future and making connections between all narratives, provide a way to make experience coherent. The personal narratives of the women I interviewed contain stories about the past, present and future that provide a sense of self and a continuity to their experience. The ordering and witnessing of the experience of illness or suffering can be of therapeutic value (Kleinman, 1988), and through stories of recovery others have the potential to heal (Garrett, 1998). But there are more than personal narratives in the stories of the women. Each society has prevailing narrative forms, certain 'master narratives' which determine people's perceptions of reality. Narrative links personal experience to the social world we live in, revealing broader cultural stories that shape individual life stories. In the narratives of the women I interviewed there are both personal stories and

[45] See Preface to thesis.

stories that culture has created about sexual abuse, about femaleness and about female bodies. There are also cultural meanings ascribed to trauma and suffering, recovery and healing.

4.2 The Politics Of Writing

Whilst autobiography and narrative has been the focus of my research project for the reasons outlined above, autobiography and narrative also provide a medium of resistance and a counter discourse to the hegemony of psychiatry and psychology. In this sense, the project is also political. The stories in the study are personal, varied, and recounted in the words of the informants, and as such, their accounts are different to the words of professionals and academics whose words have shaped public understanding. Their narratives construct 'the legitimate space for producing that excess which throws doubt on the coherence of power' (Sommer, 1988:111), and as Heilbrun has said of women's autobiographies: 'Power is the ability to takes one's place in whatever discourse is essential to action and the right to have one's part matter' (1988:18). My work is also political because any act of writing is subject to political interpretations, and each story in the study can be written in such a way as to open or foreclose particular readings. To solve this dilemma I have tried to be open to the possibilities and limitations of a variety of readings.

4.3 Issues Of Reliability And Validity

Traditional conceptions of reliability and validity have been reconfigured so as to be meaningful to qualitative research. To ensure the validity and credibility of the data, I listened, analysed the stories of participants, and elicited information through comments, clarifying questions and reflections whilst also sustaining a 'critical inner dialogue' (Minichiello et al, 1990:137). While constantly checking for errors in perception and understanding, I simultaneously checked the empirical observations and emerging data against the social context in which they were embedded. I ensured the adequacy of research by including the voices of my subjects, by applying theoretical reconstructions

that could account for myself as investigator, as well the participants, and by providing descriptions of women's experiences that reveal the underlying social relations that eventuate in their daily lives (Acker, Barry and Esseveld, 1983). The reliability of the research, the adequacy of the research process in generating theories and the empirical grounding of the findings can be only be assessed by providing a detailed documentation of the research process. I have therefore made the research method and the process of theory building transparent, while acknowledging that the findings can provide only a partial representation of participants' experiences.

4.4 Sampling And Recruitment Of Participants

The participants in the research project were drawn from a sample of women who had been sexually abused and who had attended for therapy, or were currently attending for therapy, at a government funded, family therapy centre. I was employed as a social worker/family therapist and part of a specialist clinical team that provided therapeutic services to individuals and families affected by sexual abuse. I decided not to invite women who were my own clients to participate in the study. I felt that combining the role of therapist and researcher may have complicated the research process and the therapy process, and was concerned that my clients may have felt an obligation to consent to participate. Instead I engaged my colleagues in inviting women to participate, knowing they had participants they could refer and knowing they were supportive of and interested in my research project. My own agency and the private practices of my colleagues became the recruitment source.

The details of the study were explained to all therapists at a meeting with the researcher. Therapists were then invited to consider clients or past clients who would be suitable for participating in the study. An important consideration was that the individual participant was in a safe, stable environment personally, interpersonally and socially. Therapists were then asked to post letters to the women outlining the nature of the study and enquiring about their willingness to participate. There was no direct, pre-existing relationship between myself as researcher and the participants. However, I may have

been seen or known of by participants, as a result of my employment in the agency from which part of the sample was collected. An indirect relationship may have existed, as I was known to each participant's current or past primary therapist.

After receipt of the consent form signalling agreement to participate in the study, the researcher contacted women and an interview time was arranged in which the study was fully explained and the research interview conducted. There were three factors that were important to the successful recruiting of participants: one, the therapist was interested in and committed to the research aims; two, the research was presented as something that would be useful to other women who had been sexually abused and to professionals; and three, that the women interviewed were considered to have valuable insights to offer to the research. Several of the women who participated also did so because they believed the project was important in giving recognition to a previously under acknowledged area of sexual abuse impact.

Recruitment of the participants was influenced by 'theoretical sampling' (Glaser and Strauss, 1967), in which theories emerging from the ongoing analysis direct the subsequent collection of data. As I analysed the interviews and began to formulate theories, I continued to recruit women who fitted the selection criteria, and to test if the emerging theories also held for them. Ongoing analysis and theory generation led me to be more selective about the kind of issues I pursued in the research interviews. I then used theoretical sampling on previously collected data (Straus and Corbin, 1990), returning to the old data I had collected and recoding the theoretical themes in the light of emerging theories. Resampling and theory refinement continued until saturation of the data was achieved. At this point no new or relevant data appeared to emerge, the categories of analysis encompassed a full description of issues, and the categories were clearly designated and validated by the data (Straus and Corbin, 1990).

The sample of women was recruited from two clinical contexts: one, a statewide, family therapy agency, where women were attending individually or with other family members to address the impact of sexual abuse on their lives and relationships, and two, private

therapy practices, that women were attending for similar reasons. As such, the women in this research represent a clinical population. Although this research is limited by the nature of the sample, it shares this limitation with much other research on child sexual abuse impact. The similarity however, allows for ease of comparison.

4.5 Interviews

Ten women agreed to be interviewed for the study. The interviews were conducted at a location preferred by participants, meaning that all of the interviews except two were conducted in the participant's homes. One interview was conducted at the centre, another at the private office of the treating therapist. Each woman interviewed had received written information about the research project prior to the interview and the process was explained further just prior to the interview commencing. The opportunity to ask questions and to seek clarification was made available to women at that time. Participants were reassured that their names would be concealed and changed to ensure privacy and confidentiality. The participants were referred to only by their first names during the interview, and the names have been changed on transcripts and in the final research report to further ensure confidentiality. All participants agreed with these provisions and all signed consent forms prior to the research interview commencing. Participants were offered the opportunity to read the transcript of the interview and to comment further. A copy of the interview transcript was sent to participants when completed, and each was offered the opportunity to add to, subtract from, or alter, any information that had been recorded. The interviews were conducted over a twelve-month period. The purpose of the schedule was to allow for the interview to take place, the transcription of the interview to be typed, and a detailed analysis of each interview to take place. The interviews were recorded, transcribed and analysed consecutively to allow themes to emerge that may then suggest ideas for future exploration. While each interview was guided by a set of questions to be explored in the interview, a grounded theory approach was used to allow other questions to emerge and to permit the modifications in response to new participants, new perspectives and new information (Glaser, 1992).

In-depth interviews were conducted with each of the ten women who agreed to participate in the study. The interviews were aimed at producing a conversation between the researcher and the participant in which information about the informant's perception of her self, her life, and her experience of childhood sexual abuse could emerge. In-depth interviews were selected as the most appropriate method for several reasons. First and most importantly, because they suited my interest in each individual woman's experience of social reality and their interpretations of it. I wanted to hear about informants' perspectives on their lives and experiences in their own words, and through the interaction between us, to work towards an understanding of their experience and reality. I believed that by engaging in a meaningful interaction with the woman being interviewed, by listening to her story, by allowing her to communicate in her own words, and then by reflecting together upon her story, that the meanings and interpretations attached to her experiences would be illuminated. Second, I wanted to engage in a research process in which I could spend a greater length of time with each participant. This, I thought, would allow for a fuller description of her experiences and for aspects of specific interest to my study to be more detailed. I wanted to produce more information rather than less, in order to generate a rich and textured description of her experience. In doing so, when I came to analyse the interviews, I hoped to encompass the complexities, contradictions, and intricacies in each woman's story, and likewise, when analysing all the interviews, I wanted to allow for commonalities in experience as well as diversities to emerge. Third, I used in-depth interviews because of the 'fit' they provide with the principles of feminist research. In-depth interviews made it possible to acknowledge and value as 'knowledge' the subjective experience of the informants, to include and admit the subjective experience of the researcher, and, to engage in a research relationship that was reciprocal and non-hierarchical, and which permitted a mutual exploration and reflection on the experiences under discussion. Finally, in-depth interviews allowed for participants to express their views on their experiences, beliefs and behaviours in their own words and in a language natural to them. This provided for a comfortable conversational process while at the same time elucidating very specific linguistic constructions of individual women's perceptions, thoughts and feelings which, in the data analysis stage, could be examined word by word, phrase by phrase, and sentence by

sentence, for particular meanings.

Each interview was guided by a list of questions that were to be explored in the course of the interview (see Appendix 6). The purpose of the interview guide was to make sure that certain topics and subject areas were covered with each participant. Further unplanned questions and areas of exploration emerged in each interview and were freely explored by the researcher in an effort to elucidate and illuminate the subject under investigation. Thus, while each interview was conversational in style, and there was a focus on the predetermined subject under study, the researcher varied the nature and intensity of the exploration, and the wording and sequence of questions and topics under discussion according to the context of each specific interview.

4.6 Data Analysis

In qualitative research, data collection and analysis occur concurrently, with the emerging ideas, understandings and theories tested out in ongoing data collection. Data analysis focuses on the process of systematically arranging and presenting information for the purpose of searching for ideas. As stated above, the research involved conducting interviews, reflecting on and analysing the data, conducting further interviews, and repeated reflection and analysis. The process of analysis involved dissecting each interview sentence by sentence, paragraph by paragraph for words, clusters of words, and issues which arose. These were then 'coded', or put into categories that reflected repeating themes and which then suggested ideas which developed into later theories. As the data was analysed and theories became consolidated, I returned to the literature to attempt to understand where the micro findings from my research 'fitted' with broader theories. In doing so, I could analyse the data in relation to the existing literature and identify aspects of women's exp ices which were absent from or differently defined in the literature. At this stage of the analysis, I did not limit myself to revisiting the clinical literature on childhood sexual abuse. Instead I drew on broader theorisations of women's experience of their bodies. For example, as I was becoming aware of the significance of the cultural domain in constituting women's beliefs about their bodies, I reviewed

literature on anorexia nervosa believing that some of the insights about the connection between the female anorectic body and culture may be useful to my study.[46] I then turned to broader feminist literature and to Bordo's theories on the female body in Western culture as a basis for understanding the intersection between women's personal embodied experience and its social significance. As such the analysis of the data and the analysis of the literature were mutually informed the theoretical ideas that are advanced in this dissertation.

Copies of the interview transcript were returned to participants to allow women an opportunity to add, delete or change any information they had provided in the interview. By ensuring that factual or transcribing errors were corrected and by enabling women to reconsider the nature of the information they had divulged, the 'internal validity' of the data was endorsed (Minichiello et al, 1990). After returning the transcripts, each woman was contacted by phone and asked about any further reflections on the interview and about any changes they wished to make to the record of interview. I was not able to contact two of the women I interviewed, one had changed address and one was away overseas. Of the eight women who reviewed the transcript, only two wished to make changes. One change involved clarifying a point one woman felt was unclearly expressed in the interview. The other involved removing a piece of information which one woman felt may have made her identifiable. Four of the women appeared to have only skimmed over the transcript, each of them making reference to their reticence about or disinterest in going over their painful stories yet again. One woman stated that she had found reading the transcript useful as reading about some of the dilemmas she experienced with embodiment in written form made, on reflection, the competing and contradictory aspects of her struggle clearer for her.

Three issues were highlighted in reflecting on my role as researcher in the research process. The first was the value of implementing processes to monitor my own reflections throughout the developing process of the research, the second was the interaction

[46] Chernin (1982); Celemanjer (1987); Bordo (1988), Mukai (1989); Steiner-Adair (1990); Banks (1992); Garrett (1995b, 1998); Robertson (1992); Lee (1996).

between my role as researcher and my identity as therapist, and the third was the nature of the power relationship between the researcher and the participants.

In the light of feminist and constructivist critiques of research, I was cognisant of the many ways that I would, as researcher, inevitably influence the emerging project. Critical self-reflection was therefore an important part of the research process (Steier, 1991). In an effort to monitor my own developing ideas, beliefs and values, the way I constructed and conducted the research interviews, the way I received, responded to and analysed the responses from women, and the way I finally formulated the written thesis, I kept a journal throughout the research process. The journal assisted me to reflect on my own attitudes, ideas and thoughts, and the way these interacted with the issues emerging from the research.

An important aspect of the research process was the way I perceived my role in the interview and the way in which the women perceived me. Whilst being sensitive and empathic to women's painful stories I was conscious that my role was researcher not therapist. The women, while offering very honest accounts of their thoughts and experiences to me as a researcher trying to accumulate knowledge, also related to me as a therapist with expertise and experience in understanding and helping women who had been sexually abused. My insistence on maintaining a rigid boundary around the roles of researcher and therapist was not possible. The very process of asking the questions I asked, commenting on women's responses, delving further, raising apparent dilemmas, pointing to inconsistencies or to the sense of their responses to abuse, and respecting women's courage and solutions was both research oriented but at the same time therapeutic. Similarly for the women, the process of reflecting on their experience as victims intersected with being experts on the experience of child sexual abuse, and having valuable knowledge to offer to other women, to academics and professionals. The process for them was both therapeutic and generative of knowledge. Clearly, the distinction I had attempted to make between researcher and therapist was a false dichotomy, giving weight to post-positivist critiques that emphasise the interface between the researcher and the researched in the creation of 'knowledge'.

Another important aspect of the research process was the challenge to my prior conceptualisations of power in the research process. Being alert to feminist critiques of research method, and my power as researcher to define and shape the research process, I assumed a hierarchical and static concept of power. However, my interaction with the women participants suggested that the researcher is not always the most powerful. The women made decisions about what they told me, what they wanted included and excluded in the records of the interview, agreed or disagreed with ideas I had on the basis of their own authority of experience, and chose to read and use the transcripts of the interviews according to their own needs. It became clearer to me that these were active and powerful decisions that also inevitably shaped the research process and the research relationship. While still appreciating the consequences of hierarchic power in the research relationship, I realised this was a narrow description of power, limiting women's capacity for agency and influence. Instead I reconceptualised the research relationship as 'intersubjective discourse', a mutual and emerging dialogue reflecting the subjectivity and power of both the researcher and the researched.

4.7 Presentation Of Findings

In presenting the findings of my research, I have intentionally featured the words of the women as the major part of the work. At times therefore, some of the quotes are lengthy, or several quotes are cited or grouped together in a way that may seem repetitive. My intention was twofold. First, I wanted to ensure that the excerpts remain true to women's experience, despite the necessity of editing and decontextualising the quotes, and second, while attempting to faithfully represent women's stories, I wanted to highlight the commonalities as well as the individual nuances of each woman's experience. In doing so, I felt I could hold the existence of similarity and difference together in the presentation of the findings.

In presenting the findings two other strategies have been used to ensure the material is reflective of what was expressed in the interviews. The first is the inclusion of authorial comments designed to indicate particular emotions, feelings or other important non-

language communications that were noticed during the interview. To write a thesis on the bodily experience of victims of sexual abuse, highlighting emotional and embodied experience without attending to these factors in the interview process would seem an inherent contradiction in the research process. The second is the assigning of Participant numbers to the women I interviewed (eg. P1, P2, P3 etc). Wanting to personalise women's stories and also to protect their identities I considered assigning false names to each participant. I decided instead to use participant numbers. Each of the women I interviewed had genuine and painful stories of childhood sexual abuse and inspiring stories of survival and recovery. I wanted the reader to engage with women's voices, their words and feelings and not be distracted by matching names with reported experiences, or by associating characteristics or identities with particular names. While I wanted the reader to engage with each woman as a unique and courageous individual, who had generously agreed to share, with honesty and authenticity, her struggles with embodiment in the aftermath of sexual abuse, I also wanted the reader to focus on the broader themes that emerged from women's stories.

4.8 Limitations Of The Study

There are several limitations to my study. These limitations are outlined here and pertain specifically to the sample, the context of recruitment, the data analysis and the position of the researcher. There were a limited number of subjects in the sample and the subjects were recruited from a clinical population. A larger, general population sample may have produced different findings. All the women recruited had received therapy from therapists who worked in one agency. It is possible that the nature of the therapy context and the perspectives of the therapists impacted on women's conceptualisations of their abuse experiences. Had the women been to a range of treating agencies and seen a diverse groups of therapists, with different theoretical backgrounds and practice styles, the women's constructions of their sexual abuse experiences may have been differently perceived. The data emerging from the interviews was analysed to the point of saturation, that is, until no new categories could be formulated. If a larger sample was recruited it is possible that more categories would have emerged, however it was not possible to keep

recruiting until each and every contingency was accounted for in the findings. Finally, the researcher was significantly involved in every stage of the research process, from the formulation of the research project, through the data collection analysis to the interpretation of findings evident in the completed write-up. This has inevitably shaped and inscribed the research process and emerging findings.

4.9 Introduction To Participants

Each of the women I interviewed had a unique story to tell. Each of the women also shared particular commonalities. The shared aspect of their experience may have related to the nature of the abuse they suffered, the perception of the abuse, the age at the time, their social location, the meaning they attribute to a specific experience, or some other connection myriad of possible associations. Both the individual stories of the women, and the demographic detail are summarised in Appendix 8 and 9.

4.9.1 Group Profile

The women were interviewed between February 1999 and March 2001. Nine of the women were Australian born and one was born in the United Kingdom. They were between 19 and 55 years of age. Four of the women had completed tertiary education and one was engaged in tertiary studies. The other five had not completed secondary education. Four of the women were employed in professional occupations, one was a student, one was employed in a semiskilled position which required training, one in an unskilled position and three were unemployed. Interestingly, at the time of the interview, the three women who were unemployed were not working as a direct result of mental health problems they associated with the childhood sexual abuse. Of the seven women who were employed, one was on sick leave from work, following a work trauma which she reported had triggered unhelpful flashbacks and nightmares relating to her prior childhood abuse. Two were having difficulties at work which they related to problems associated with their childhood sexual abuse; one was having difficulty managing interpersonal relationships and work stress, the other, a teacher in the Catholic school

system, was unable to participate in some of the activities expected of her as aspects of her work context were triggering the re-experiencing of traumatic reminders of her childhood sexual abuse by a priest. One woman who was studying, was also experiencing traumatic flashbacks that were making her feel unsafe and were consequently negatively affecting her study. The remaining three women who were employed reported that while mental health problems associated with their abuse were not currently impacting their employment, that they had disrupted employment in the past. Seven out of the ten women were currently experiencing mental health problems which prevented them from working or disrupted their working lives, and all of the three remaining women in work, reported disrupted employment histories as a result of their abuse.

All of the women in the study had been sexually abused in childhood. Four had been abused by brothers, three by fathers, one by her grandfather, one by a neighbour and a cousin, and one by a priest who was well known to the family. Seven of the women had also experienced abuse by more than one offender. One had been abused by her father, and by several of her fathers friends, one by her father and a stranger who sexually assaulted her, one by her grandfather, then a group of youths who pack raped her and later, by a medical doctor who performed an unnecessary, sexually invasive medical examination. One participant had been abused by her brother and then later raped by a friend's father, one had been abused by her brother and later by her uncle, one had been abused by a neighbour and then later by her cousin, and another had been abused in childhood by her brother and was later raped by a man unknown to her. Three women reported revictimisation experiences that they did not necessarily define as sexual assault or abuse, but these incidents were clearly defined as unwanted sexual contacts with men. Seven of the women in the study had been abused by more than one offender and reported subsequent episodes of revictimisation later in life.

Four of the women in the study were in relationships with partners at the time of the interview. Six were not. Of the four in relationships, two reported being very happy, and two reported current problems in the relationship resulting from their sexual abuse; one reporting sexual difficulties and the other reporting fears about the consequences of

speaking about her needs. Of the six not in relationships, three had recently separated. Each woman attributed the separations in part to the difficulties they had coping with the impact of their prior sexual abuse. One woman reported being unable to have a relationship due to her fears of intimacy and sex, and similarly, another women reported sexual difficulties in relationships that prevented her from forming a partnership. Four of the women in the study had children and six did not.

4.9.2 The Abuse

Half the women in the study were abused at a very young age. Although it is difficult for them to recall the exact age, the abuse began between the ages of 3 to 6. The other half of the women were abused in the latency of their childhood from about age 7 to 14. The length of time that the abuse ranged from was from 1 year to 12 years. The abuse involved a range of behaviours, including fondling of the genitals, oral sex, and vaginal and anal penetration. One woman reported ritual abuse in which the sexual abuse was accompanied by sadistic acts by multiple perpetrators.

4.9.3 The Relationship To The Offender

In eight of the ten cases in this study, the initial abuse experienced by the women interviewed could be considered intrafamilial, in that the women were sexually abused by brothers, fathers or grandfathers. In one case, the abuse was committed by a priest who was a close and trusted family friend. In another, the woman was abused by a trusted family friend and neighbour. For the women who were then sexually abused by another perpetrator, two were intrafamilial (an uncle and a cousin), three by perpetrators known to the women, and one by a stranger (extrafamilial).

4.10 Summary

This thesis is bounded by certain epistemological assumptions that provide a rationale for the feminist qualitative methods used in the research. The ten in-depth interviews

undertaken with women who had been sexually abused in childhood and who had attended for therapy were analysed using grounded theory techniques. By understanding the women's individual experiences and the social context in which these were embedded I work to accurately represent women's experiences via a collaboration that requires my theorised interpretation.

CHAPTER FIVE
INTRODUCTION TO THE FINDINGS

While most academic discourses focus on the psychological effects of child sexual abuse, the accounts of the women in my study highlight the significance of the body to their experience of childhood sexual abuse and its impact. Their stories reveal the profound and lasting effects of child sexual abuse on the body, illustrating myriad ways in which bodily experiences and the meanings attributed to violated bodies shapes how victims perceive themselves, organise their behavior and construct their identities and relationship to embodiment. All of the women in the study described problematic relationships with their bodies in the aftermath of sexual abuse. Whether women abandoned, harmed, endured pain, disciplined or punished their bodies, at the heart of their experiences was profound fear, ambivalence and confusion about the body that was often reflected in critical dilemmas and conflicts with embodiment. So problematic was embodiment after violation that women described the body problems resulting from childhood abuse as the most troubling and enduring consequences of their sexual victimisation.

My study revealed two core dimensions of women's bodily experience after sexual abuse - the body as it is lived and felt as a physical, material presence and the body as it is conceived and constructed as a social entity, inscribed with cultural meanings that shape its nature, form and activities. My study also revealed that the body symptoms and problems of embodiment experienced by women as a consequence of sexual violation also reflected these two key elements. Although womens' subjective experiences of themselves and their bodies after sexual abuse were multifaceted and complex, they converged in feeling and bodily states which I refer to throughout my study as 'individual embodied experience', and in their implicit and explicit understandings of and relationship to social discourses on the female body and femininity. I refer to this as the 'social significance of the body'. I therefore came to understand participants' difficulties with embodiment after the trauma of sexual abuse as reflective of struggles to live comfortably in a body that has been violated, and as reflective of women's negotiations

with powerful (and fraught) social ideologies.

I present the eight major themes that emerged from my analysis of participants' stories in line with these two key conclusions. I first attend to women's individual embodied experience, examining the profound and enduring impact of sexual abuse on the body of victims and illuminating the array of body symptoms that participants described as the most disturbing and longstanding consequences of their victimisation. Hence, in Chapter five I examine the 'Unruly Body'. This theme represented participants' experiences of their bodies being out of control due to traumatic bodily reactions, re-experiencing, body memories and pain, all of which made the body vividly present in womens' lives as an immediate, compelling and unpredictable entity. I also examine the 'Absent Body', a theme which reflected the way in which participants' bodies were also absent from their lived experience as a consequence of dissociation, bodily distortion, fragmentation, disorientation and stringent efforts at bodily denial.

I then turn to my second key conclusion, focusing on women's attributions about their abuse which reveal that it is living through the corporeality of a female body that in and of itself constitutes the singular and primary problem of embodiment for women sexually abused in childhood. I illustrate how the conflicts, dilemmas and contradictions associated with social descriptions of femaleness, femininity and the female body reverberate in women's' numerous problems of embodiment after sexual violation. Accordingly, in Chapter six, I introduce the 'Female Body', a significant theme that embodied two key features. First, it reflected the attributions that all participants made that the sexual abuse had happened to them because they had female bodies. Second, it denoted how body symptoms and problems of embodiment suffered as a consequence of childhood sexual abuse were imbued with beliefs about femaleness and femininity, and with meanings associated with having a female body in Australian culture. The theme of the 'Female Body' is expanded upon in the following chapter (Chapter seven) where I examine two further themes that also demonstrate the significance of the sexed body to womens' body problems following sexual abuse. The 'Dangerous Body' and the 'Used Body' are explored in chapter seven. The 'Dangerous Body' reflected the way in which

participants perceived female embodiment as dangerous, making them both in danger and dangerous. The 'Used Body' represents the self-deprecating attitudes and perceptions participants' ascribed to their female bodies after childhood sexual abuse and repeated episodes of revictimisation.

In Chapter eight I introduce two further themes which I have conceptualised as the 'Punished Body' and the 'Body in Pain'. Each of these themes demonstrate the importance of both individual embodied experience and the personal and social significance of the body, while also highlighting the intersections between the two. The 'Punished Body' reflects participants' stories of self-harm and the complex personal and social meanings of self-harming and punishing the body. The 'Body in Pain' denotes the frequency with which bodily pain was a consequence of childhood sexual trauma and the manner in which participants' accounts of pain embodied particular individual and social dimensions of meaning. Chapter nine examines the final theme, the 'Re(Dis)Covered Body', which represents womens' stories of recovery from the bodily effects of sexual abuse.

In presenting my findings it has been necessary to allocate them to sequential chapters. However, the distinctions between the key conclusions should not be understood to be so neatly delineated. Rather, all the themes intersected and overlapped, revealing connected and distinct threads of experience that cannot be read independently. Of related significance is my key conclusion that women's experience of their bodies after childhood sexual abuse is constituted by two central aspects: by individual embodied experience, which is the body as it is lived and felt as an immediate, physical, material presence in daily life; and by subjective experience, which is the body as it is comprised and invested with significant personal and social meanings. My presentation of the findings has made it necessary to separate and disrupt the connections between the two, but each important aspect of women's experience cannot be understood without reference to the other and without acknowledging their mutually constitutive relationship. Hence, the way I present the findings does not represent a hierarchy of distinct and unconnected findings but rather my creation of a conceptual order that allows the themes to converge

fluently into each other.

In the following chapters I present and theoretically locate the research findings, choosing to explore the findings and theoretical analysis concurrently. The discussion consequently interweaves the women's voices with my own. I have chosen to present the findings in this way because the research process itself was a recursive one. The women's stories guided and directed my investigation of the literature and research and the theoretical ideas embedded in the texts assisted me to conceptualise and understand women's experiences. I also wanted to present the findings in a way which gave value to the academic discourses on child sexual abuse and authority to women's knowledge. Finally, dislocating theoretical arguments from the women's experiences may have foreclosed the richness and complexity of their stories, and the multiplicity of frames available to understand the women's responses.

'THE BODY THINGS AREN'T THAT EASY TO MAKE GO AWAY': THE BODILY IMPACT OF SEXUAL ABUSE TRAUMA

'It's like everything else can sort of be healed. Like the relationships with your family that have been damaged by the abuse, they can be healed. Or dealt with. Or accepted. But like some things just won't be. Like you can heal, but they won't go away...like...the body things aren't that easy to make go away... '(P1)

5.1 Introduction

There were two major dimensions that informed women's experience of their bodies following childhood sexual abuse. These were 1) **the lived, felt, physical experience of their bodies**, and **2) the personal and social meanings attributed to their bodies.** These two threads constitute the dominant part of the findings and are detailed in chapters five to nine. In each of these aspects of women's experience, various 'bodies' are revealed, the physical body, the socially constructed/ imaginary body, the symbolic body, the sexed body and the body politic. Each dimension of embodiment is evident in victims' experiences and perceptions of their bodies and forms part of my analysis of their stories. In this chapter I examine the ways in which the violation of the body inherent in sexual abuse and the biophysiological changes occasioned by the trauma of abuse brought the 'physical' body to the forefront. I elucidate two core themes that emerged from participants' accounts of embodied experience following childhood sexual abuse. The themes, conceptualised as the 'unruly body' and the 'absent body', demonstrate the significance of the body as it is felt and physically experienced. In examining the bodily effects of sexual abuse I interweave my theoretical analysis, which is drawn primarily from trauma theories with the women's voices, then close the chapter by examining the extent to which trauma theories can provide an adequate explanatory framework from which to understand women's experiences of the body following childhood sexual abuse.

5.2 The Significance Of Individual Embodied Experience

All the participants in the study described the trauma of abuse as known and experienced primarily by the body. So central were the responses of the physical body that for many, the body's reactions came to shape and organise the greater part of their lives, their daily activities and their ongoing conceptions of themselves and their bodies. Their stories about embodiment after childhood sexual abuse demonstrate the profound and lasting nature of bodily responses to trauma and reveal the power of the corporeal in shaping subsequent meaning, behaviour and identity.

5.3 Childhood Sexual Abuse As Trauma

The dynamics of childhood sexual abuse and the conglomeration of effects that result for victims have led to the understanding that child sexual abuse represents a trauma. Herman (1992) contends that child sexual abuse is a unique trauma, as far from being 'extraordinary', the sexual assault of children is a common event. Nevertheless, it can be defined as a trauma because the definition includes those events which constitute a 'threat to one's life or physical integrity', 'threats accompanied by real or actual assaults' or 'developmentally inappropriate sexual experiences without threatened or actual violence or injury' (American Psychiatric Association, 1994). The characterisation of child sexual abuse as trauma has been reinforced by the increasing recognition of the impact of child sexual abuse on adult psychopathology. Victims of sexual abuse have been shown to develop a characteristic set of symptoms now identified in the American Psychiatric Associations Diagnostic Statistical Manual (1994) as Post Traumatic Stress Disorder.[47] Persistent re-experiencing of the traumatic event through recurrent and intrusive recollections and the avoidance of stimuli associated with the trauma figure prominently in posttraumatic stress responses. The P.T.S.D. formulation does not however adequately account for the range of symptoms experienced by survivors of childhood sexual abuse.

---

[47] See Chapter one (pp.1-27), where I provide a more detailed discussion of trauma theory and its application to child sexual abuse.

An extended definition of 'complex P.T.S.D.' has subsequently been applied by clinicians to encompass personality changes, problems of relatedness and identity, vulnerability to revictimisation, and the presence of recurring visual, auditory and/or tactile hallucinations in those with a history of child sexual abuse (Herman, 1992).

5.4 Trauma And The Body

Trauma theory is based on the recognition that when exposed to a significantly traumatic event, humans respond in characteristic ways. Symptoms which have been historically misinterpreted as hysteria, personality disorders and psychoses and have led to the pathologising of the victim (van der Kolk, 1996) are reinterpreted as reactions to traumatic events.[48] Trauma theory focuses on the multiple psychobiological changes that occur in response to trauma. Of specific interest are the changes in physiological arousal and the fragmentation of the normally integrated functions of emotion, cognition, memory (Herman, 1992; van der Kolk, 1996). Of particular relevance to my study are the following findings. First, traumatised individuals develop a chronically disordered system of arousal in which heightened physiological arousal produces responses to specific reminders of the trauma and generalised hyperarousal to intense but intrinsically neutral stimuli (van der Kolk, 1996). Second, traumatised individuals exhibit symptoms of hyperarousal and hyperactivity to stimuli that can coexist with psychic numbing and dissociation (van der Kolk, 1996). Third, traumatised individuals are unable to properly integrate memories of the trauma (Herman, 1992; van der Kolk, 1996, Rothschild, 2000). Traumatic events are more often recorded in implicit, nondeclarative memory. Unlike explicit, declarative memory, which consists of facts, concepts and ideas and which is articulated through language and sequential, accurate chronological narrative, implicit memory bypasses language, and is expressed through unconscious or automatic procedures and internal states which are more likely to be experienced as upsetting emotions, disturbing bodily sensations and confused behavioural impulses (Rothschild, 2000). The splitting of traumatic memories from ordinary consciousness means that

[48] See Chapter one (pp.1-27), for a discussion of the history of trauma theory and its subsequent development and application to child sexual assault.

memory traces cannot be translated into personal narrative and instead continue to intrude as terrifying preoccupations and somatic re-experiences (van der Kolk and van der Hart, 1991). The disorder and fragmentation of memory associated with the experiencing of traumatic events, compounded by state dependent triggers and other conditioned associations to their trauma means that traumatised individuals often cannot make sense of their symptoms. Moreover, frightening intrusions, fragmented images, somatic re-experiencing, intense emotion, the absence of coherent narrative and heightened physiological arousal mean that traumatic experiences free float in time without an end or place in history and subsequently cause increasingly greater degrees of restriction, avoidance and debilitation. Fourth, traumatised individuals exhibit this avoidance as dissociation, via the compartmentalisation of experience; a function of traumatic memory (van der Kolk, 1996; van der Kolk, van der Hart and Marmar, 1996), and as emotional numbing which is used as a strategy for reducing the overwhelming effects of trauma (Litz and Keane, 1989). Fifth, in traumatised people, emotions become disconnected from their source and purpose, existing instead as symptoms of chronic physiological arousal that preclude meaning and action (van der Kolk, 1996). Each of these important findings provide a useful starting point from which to understand the experiences described by the women in my study. They also shed light on why the body features so prominently in women's stories of sexual abuse trauma.

5.5 Bodily Presence, Bodily Absence And Bodily Pain

All the women described disturbing and problematic bodily responses that were attributed to the trauma of sexual abuse. Their reported physiological reactions corresponded with current descriptions of posttraumatic stress that exist in the research literature and support recent findings that have increasingly recognised the physiological impact of traumatic events (Schalev and Rogel-Fuchs, 1993; van der Kolk et al, 1996; van der Kolk et al, 1996b, van der Kolk, 1996; van der Kolk, 1998). The physical and embodied consequences of sexual abuse trauma were most starkly revealed in womens' descriptions of living on alert, of reliving traumatic experiences, of cutting off and numbing out, and in their accounts of their inability to find words for deeply felt visceral

sensations and experiences of bodily pain. These experiences, described in the language of trauma theory as hyperarousal (re-experiencing), dissociation (detachment), alexythymia (loss of words), and somatisation (bodily symptoms including pain), constituted major and recurring themes in the accounts of the women I interviewed. I now examine each in more detail.

5.5.1 Bodily Presence: Hyperarousal And Traumatic Re-experiencing

Research has demonstrated that traumatised individuals suffer from heightened physiological arousal to sounds, images and thoughts related to specific reminders of the trauma, and from generalised hyperarousal to intense but intrinsically neutral stimuli (loss of stimulus discrimination), (van der Kolk, 1994:187). Significant increases in heart rate, skin conductance, and blood pressure accompany hyperarousal which is typically manifested in hypervigilance, sleep disturbance, exaggerated startle response, irritability, outbursts of anger and difficulty in concentrating. All the women in the study reported difficulties associated with hyperarousal.

'...your heart beat goes up and you sweat and do all these things and sometimes it is just by seeing a reminder that frightens you, or recalling what frightens you'. (P5).

While sensitisation is adaptive in preparing individuals for quick response to any hint of danger, for my respondents, increased levels of sensitisation became highly problematic, inducing lasting alterations in their behavior and physiological responding that increased over time.[49] Their heightened arousal and sensitisation often progressed to the kindling of triggers for intrusive symptoms (Post et al, 1998), with all the women in the study reporting current and ongoing episodes of traumatic re-experiencing. Symptoms of re-experiencing included distressing memories, images, and dreams, acting or feeling as if the events were recurring, and intense psychological or physical reactivity to internal or external cues that were reminders. Most prominent were intrusive bodily sensations

[49] See Antleman & Yahuda (1994), who document the role of sensitisation in altering behavior and physiology in traumatised individuals.

mirroring those victims felt at the time of the original abuse. These episodes continued to occur years after the initial trauma, revealing the power of hyperarousal and traumatic re-experiencing to severely disrupt the present while also predisposing victims to continually revisit the past.

'I mean sometimes, something might trigger you into a response, if you get a fight or something and every time I see that particular situation again [a memory of an abusive event from the past]. *It might be triggering off to something that is said and it just puts you in bodily mode...I mean the physical feelings get triggered and the physical associations with the abuse...I mean I could still trigger off at any time...my body is still responding all the time. It's still responding to touch, and sometimes that touch reminds me of another touch, and that touch was an unpleasant one'. (P4).*

'My body would react...Just that feeling...feelings about being dirty and shameful ...but funnily enough, weirdly, it's around my vagina. I would start to tighten and stuff like that ...and it would be like when my brother raped me. And I've always had reactions like that'. (P7).

'I had this experience, It was like this is happening now, this is happening now. And so I could just keep reliving it'. (P10).

Intrusive re-experiencing of trauma was often described by clients as 'flashbacks' which were constituted mainly by sensory images and physical sensations.

'I started getting a whole lot of flashbacks. And I could feel them coming in my head, they'd start from the back of my head and they'd go around to the front and then pictures would start coming, like I'd relive it or whatever, like images. But some of the reliving it is really physical. So most of the terrible ones happened just like that...I really felt a lot of pain in my vaginal area and like kind of some pressure there or something, and I'd have pain in other parts of my body as well'. (P4)

The vividness and veracity of physical re-experiencing is demonstrated by the preceding and the following descriptions, in which respondents explain that they believed that sexual abuse was actually happening again when experiencing traumatic flashbacks.

'I'd physically relive it, I'd feel the person start and I'd physically relive it, so I'd think that that had happened too, and it was actually something real, without realising it.' (P3)
'I would get like this scary, numbing, tingling feeling that starts to happen in my body and I still get it... I felt invaded again, the whole thing, like how do I stop this?' (P8).

Victims' distress was associated with both the emotionally and physically intense nature of the experience and by the disorganising impact of the flashbacks.

'...your skin crawls and you feel sick in the stomach...I freak out and stuff like that for no reason, oh not for no reason, but because of memories popping up...and disgusting feelings'. (P1)

'Yeah just like you could feel it again. Like, you know it's not happening again, but you could feel what your body felt like when it was happening and you just wanted it to go away. It's like you could just feel it. I could feel everything that I felt when it happened. To my body. Like how my body felt'.(P1).

For several participants sexual contact was a trigger to episodes of traumatic bodily re-experiencing that were frequently accompanied by with physical pain.

'...my body would react...And then it would happen again. Just that feeling. So like when kissed another boy then those feelings would arise...Yeah. It was kind of like I'd forgotten, like I'd done with everything else and then it would just be there. So present that I couldn't do anything...Yeah, funnily enough, weirdly, it's around my vagina. It's like you know I start to tighten and stuff like that...'(P8).

'...There were times when I would have sex, where I was relaxed but not relaxed. There was not a complete letting go or anything like that, because my body remembers what happened. I'd go along and feel reasonably good about things for a while and then suddenly something wasn't right, and the I was in a quandary, your body is enjoying something for a minute, and then not liking it...'(P8).

For another respondent vaginal pain accompanied somatic flashbacks, effecting her capacity for sexual intimacy and heightened physiological arousal accompanying traumatic re-experiencing resulted in sleep problems.

'Just yeah, it did and also it [the vaginal pain] *affected your capacity to enjoy men for sexual relationships. And it means that a couple of hours in the night, I'd be without sleep'. (P5)*

Similarly, another woman reported that physical re-experiencing disrupted her ability to engage in a sexual relationship and negative feelings about sex, her own body and sexuality associated with the original abuse and subsequent re-experiencing, sullied the experience of sex.

'I think it starts more with the feeling. So I start feeling that sensation, that spidery, yucky feeling. So that's what happens first. So I start feeling it and I start trying to why am I feeling like that. This happens very quickly. Oh God, you know, I feel yuck, I feel gross, I feel guilty. And then there's that guilty thing about if I've had an orgasm, then that's really bad because like to me sex is bad. Because there's a part of my brain that associates all that sort of stuff with the bad thing. So I still can't swap it. Like I know it's not'.(P7)

Just as the women were sensitive to triggers in their environment that produced reminders of their trauma, they were also more likely to be unable to differentiate relevant from irrelevant stimuli. They developed a pattern of continuing to misinterpret innocuous

stimuli as potential threats and began to attend less to affectively neutral but existentially relevant events.[50] The following statement from one young woman I interviewed describes traumatic re-experiencing occurring in response to specific reminders of her abuse (having sex) and to more general and apparently innocuous stimuli (the dark).

'Sometimes my body can feel that disgust all over again...my body sometimes has those feelings still...It normally happens when I am having sex. Sometimes, but it could come on at other times. Sometimes if I don't feel safe, like at night or when it gets dark it can make my body feel like that again'. (P1)

Trauma theorists have suggested that the heightened physiological arousal experienced by trauma victims means that they difficulty neutralising stimuli in their environment in order to attend to relevant tasks. To compensate they have to mobilise excessive levels of physiological arousal to meet ordinary demands (Shulav and Rogel-Fuchs, 1993), or shut down and consequently become increasingly disengaged from everyday life (van der Kolk and Fisler, 1995; van der Kolk, 1996). For respondents in my study, heightened arousal did not only increase sensitivity to their environment, promoting difficulties with stimulus discrimination and kindling traumatic re-experiencing, it also stimulated 'shutting off' which was used as a coping mechanism to manage their heightened levels of arousal. In a characteristic expression of this process, one young participant described traumatic somatic re-experiencing followed by dissociation in response to the distressing effects of hyperarousal.

'The way sickness feels and you just feel sick in the stomach and your head goes numb. That's mostly like if I'd had them all. I don't know for how long, a few minutes of longer, but then my head just feels numb. I don't know, just don't, I'm just not there anymore...I pretty much disappear. Just [become] *not conscious of the feeling that my body is having any more'. (P1)*

For another participant, hyperarousal heightened sensitivity to risk. Dissociation ensued

[50] A finding supported by McFarlane, Weber & Clark, (1993).

as a response to managing what she felt was an unmanageable emotional and physical state.

'...there is still an instant reaction now, especially in situations when I feel threatened. Like I have no idea of how to integrate my body into that situation, so I shut off...it might not be till later on that I'll think Oh God, I wasn't there, so it leaves you paralysed in a way'. (P2)

For the women in the study, highly elevated autonomic responses and sensitivity to reminders of traumatic experiences that happened years (and sometimes decades) ago, alongside the veracity of traumatic re-experiencing demonstrated the intensity and timelessness with which past traumatic events continue to affect current experience (Pitman, Orr and Shalev, 1993).

5.5.2 Bodily Absence: Dissociation And Disconnection

Trauma research has demonstrated that while victims of trauma exhibit hypermnesia, hyperactivity to stimuli, and traumatic re-experiencing, many also experience dissociation, psychic numbing and avoidance, amnesia and the absence of pleasurable bodily feelings, termed anhedonia (American Psychiatric Association, 1994). These concepts are often conflated in the trauma literature but distinguishing between them is important to understanding the complexity of 'cutting off' responses that women in my study experienced. Dissociation refers to the process in which traumatic memories are split from ordinary consciousness and not integrated into explicit memory systems. As long as divided memory traces have not been translated into a personal narrative, they continue to intrude as terrifying perceptions, obsessional preoccupations, and somatic experiences (van der Kolk and van der Hart, 1991). Psychic numbing and avoidance refers to psychophysiological processes that traumatised individuals develop to escape from persistent hyperarousal and distressing bodily responses and feelings. Amnesia refers to the loss of memory often accompanying traumatic events and anhedonia to the absence of pleasurable bodily feelings resulting from detachment and disengagement from the body. The stories of women I interviewed reflect each of these aspects of

disconnection from bodily experience.

(i) Primary Dissociation

All the women reported experiencing periods of dissociation, both at the time of the sexual abuse trauma, and later, in response to reminders of some aspect of the initial trauma. At such times, women would experience a splitting off from ordinary awareness in which their thoughts and emotions became separate from their bodily sensations and feelings. Their experiences confirm findings from the trauma literature which show that survivors of child abuse frequently suffer from dissociation (Herman, 1992; Salter, 1992; van der Kolk and Fisler, 1995; van der Kolk et al 1996b), and which show that during traumatic events sensory and emotional elements of the trauma are not integrated into memory or personal identity and instead become isolated from ordinary consciousness. 'Memories' of the trauma are experienced as fragments of the sensory components of the event - in visual images, olfactory, auditory or kinesthetic sensations, or in intense waves of feeling representative of the elements of the original traumatic event (van der Kolk, 1996). Research findings also confirm participants' experience that dissociation occurs both at the time of the traumatic event (Bremner, Southwick, Brett, Fonatana, Rosenheck and Charney, 1992), and post traumatically as a long-term consequence of traumatic exposure (Bremner, Steinberg, Southwick, Johnson and Charney, 1993).

The young woman below describes how she responded to the first incident of abuse. Being overwhelmed by fear, confusion and powerlessness, she dissociated from her body:

'...when it used to happen to me, [the sexual abuse] *I used to not be there, you know what I mean? It's always been like that from when it was happening to me the first time.... I just didn't know what to do at all. Just really confused. And I knew it wasn't right. Just didn't know what to do. And I think that maybe I might have* [chosen to dissociate, but she's not sure, questioning tone]*...I know the second time, it just happened... Now it's still with me sometimes. He could be doing anything, yelling at you and I won't know...It's not good though really'. (P1)*

When commenting on the meaning she had for dissociating at the time of the abuse, she explained,

'...it was safety and sanity for me. I know I could have kicked and yelled and screamed, but I knew that the response from everybody else would be worse than just putting up with it... Going out of your head was a way of dealing with it, or not dealing with it I guess. Just putting up with it because you'd stop feeling it'. (P1)

Like the participant above, many children and adults, when confronted with overwhelming threat, are unable to integrate the totality of what has happened into consciousness (van der Kolk and Fisler, 1995). For victims repeatedly exposed to extreme stress, elements of the traumatic experience continue to be organised by a separate state of mind, which may only come into play when that particular element of the traumatic experience is activated. This condition, 'primary dissociation' can be characterised by the splitting of experience into its isolated somatosensory elements which are then stored away from consciousness. These elements then recur in intensely upsetting intrusive recollections, nightmares, and flashbacks, which are expressions of dissociated traumatic memories.[51] After dissociating at the moment of the trauma many traumatised individuals continue to use dissociation as a way of dealing with trauma related intrusions. Most of the women in the study also reported dissociating in response to thoughts, sensations or memories of the abuse.

'Sometimes I had thoughts where I'd like think about it, [the abuse*] but I did not want to think about it, so I started to do a list of all the things that had happened to me, and then I'd feel um, a lot of pain there* [indicates pelvic and vaginal area] *and so I'd start a list of people and what they had done in my mind, and that would make me numb...it would just be something that you would automatically do because you feel better, you know'. (P5)*

[51] Many victims of trauma report experiencing dramatic symptoms such as intrusive recollections, nightmares and flashbacks that recur, often in response to some trigger or reminder of the traumatic event. These reactions are in fact, expressions of dissociated traumatic memories that have been split off from

'When there was sort of a memory of it [the abuse] *which would be mostly in my body...I'd have cold feet, I'd feel him coming up, I'd get to a point where it started to be painful and uncomfortable...and I would go into what I called 'my slide'. So that when you go down a slide as a kid...you get fear. So I was taking my slide to a nicer kind of experience than that. It was like I was on that kind of decline. It could happen very quickly. And that happened when I was having that EMDR*[52] *and going back through it. And it has happened at other times where I've been reliving those memories, or sometimes I just feel like doing that, so that it's like I would just go sliding away... I would leave the situation and I'm sliding away...It's sort of dissociation'. (P5)*

The same participant describes the process again,

'Well let's say um, I might have just, um, he'd had a go at me again, and my throat used to close over, with the bruising, and I couldn't breathe, and I'd get in trouble because I was crying and upset. And so then I'd feel really bad, right, and I'd feel very sore and distressed and because of the abuse, after, um, I'd feel small, or humiliated or um, I can remember being, like you are in 'bits' or whatever. So you would get sort of dissociated. ... then you don't know and you feel better. Because you're not in that state any more'. (P5)

Her explanation for dissociating was, *'Well you just have to look after yourself in that sort of situation so you find ways of making it bearable for you'. (P5).* However, while providing some protective detachment from the feelings and sensations associated with the abuse, she also found the process of dissociation disturbing and disorganising.

---

ordinary consciousness and memory (van der Kolk, 1996, Matsakis, 1992).

[52] E.M.D.R. (Eye Movement Desensitisation & Reprocessing) is the use of eye movements to desensitise traumatised individuals to disturbing psychological material. Developed by Francine Shapiro in 1987, E.M.D.R. has had more published case reports and research to support it than any other method used in the treatment of trauma (Parnell, 1999). Positive therapeutic results with E.M.D.R. have been reported with a wide number of populations, including: previously resistant combat veterans, persons with phobias and panic disorders, crime victims, victims of grief and loss, traumatised children and sexual assault victims,. At this point there are more controlled studies on EMDR showing significant treatment effects than on any other method used in the treatment of posttraumatic stress disorder (Parnell, 1999).

'When I had the habit of dissociating, that is something that does make you feel like you are crazy...Also I would think, 'I'm a big girl, there are monsters coming into my bed, I must be crazy'. (P5). Dissociating in response to reminders of the abuse was at times comforting and a relief from overwhelming feelings associated with the abuse, at other times, frightening and upsetting. The feeling of craziness associated with dissociative states was shared by another respondent,

'You're all the time just flipping out. And in a way you sort of feel like you're cracking up. I did. I thought I was cracking up. For years I thought I'm mad, I'm going mad. Sometimes I thought bordering on schizophrenia and I'd tell all my people, in all the relationships, oh I think I've got schizophrenia'. (P6)

Several respondents reported dissociating in response to thoughts, feelings or memories of the abuse. Dissociating however, also became a strategy that women used to deal with other ongoing stressful life experiences. For many traumatised individuals dissociation can be an effective way to continue functioning while the trauma is occurring, and later, the capacity to dissociate can assist individuals to cope with the disturbing feelings and reactions to reminders of the abuse and other stressful experiences. For some women, it allowed them to develop domains of competence making them quite successful in various areas of life. However, when dissociation continued to be utilised after the acute trauma had passed, it also came to interfere with everyday functioning. Women's stories show that while providing a protective detachment from overwhelming affects, dissociation also resulted in a number of other serious and problematic secondary effects.

Participant 3 continued the process of dissociation since the abuse and resorted to it in times when she felt vulnerable and threatened.

'...as a kid because of the abuse my body had shut off, so there is still an instant reaction to that now in situations when I feel threatened. Like I have no idea of how to integrate my body into that situation'. (P3)

She reported a recent and developing sense of awareness of her body and of the triggers to dissociation, recognising how dissociation prevented her from responding appropriately.

'When I was a kid I did not feel my body. Now I do, sometimes. But I mean sometimes if I am in situations where I do feel threatened or vulnerable I do still shut off and it might not be till later on and I'll look and think 'Oh God, yeah okay, I shut it... Yeah, I wasn't there. And so it leaves you paralysed in a way. You know, like you can't respond to the situation'. (P3)

Another respondent reported a similar experience,

'Because in dangerous situations, I go into my survival mode of blocking out'. (P6)

Both these women reported that the tendency to dissociate when feeling threatened or unsafe had led to incidents of revictimisation.

'I think it [dissociation] *would probably lead me to go into dangerous situations. Because I wouldn't (a) know anything else and (b) it's partly because that you're dissociating, there wasn't even a mechanism to indicate that this is a dangerous situation for me, to get out'. (P3)*

Clearly, dissociative responses, while initially protective became destructive, leading women into behaviours that further disrupted and problematised their experience of and relationship to self and others.

(ii) Secondary Dissociation

Trauma research has shown that once an individual is in a traumatic (dissociated) state of mind, further disintegration of elements of the personal experience can occur. A 'dissociation between observing ego and experiencing ego' (Fromm, 1965) has often

been described in traumatised individuals, such as incest survivors, traffic accident victims, and combat soldiers (Gelinas, 1983). They report mentally leaving their bodies at the moment of the trauma and observing what happens from a distance (Gelinas, 1983, van der Hart, Steele, Boon and Brown, 1993). Culbertson (1995) describes how leaving the body can also be accompanied by elements of fantasy and magical thinking. The distancing manoeuvres of 'secondary dissociation' allow individuals to observe their traumatic experience as spectators, and to limit their pain or distress; they are protected from awareness of the full impact of the event. For victimised children and adults, the use of out-of-body responses at the time of the trauma is a way of defending against even more catastrophic states of helplessness or terror, even though dissociated aspects of the self continue to contain the memories related to the trauma. One woman vividly described the experience of leaving her body while dissociating.

'Well I used to fly out window too. Oh I'm sure it was when the abuse was happening but as a kid I know I'd go out and I'd go where I wanted to go...I could do it. I came to know how to do it automatically and I'd just do it. I'd like to try that. I can't remember how I did it...'(P5)

'And when I was flying I would go out the window, I would go back to the blue house and I'd sort of go along the fence, I'd go along the bike track, I'd look down at the trees and shrubs and houses and fly. It was dark, it wasn't too cold. I got scared. I couldn't get back... I would do this at night time. And then I would sometimes shut the window and I couldn't get back in. So I didn't do that any more'. (P5)

'I went to a room too. It didn't have any plaster on it, it was a room in the middle of the house which was my dad's workshop which had a window with like a mirror thing, it's like I was in there and I could go through the wall to it. My memory's like that, that it was um, imagining that there was absolutely nothing left and it existed between my parents' room which was next to mine, my room. So it gave me some distance from what was happening. So at night time I could go into there too. So I used to go into that room sometimes... I'm sure it was for safety'. (P5)

Unable to escape from the actual abuse and thoughts about the abuse, dissociation is used as a way of fleeing from unbearable memories and experiences.

Whereas primary dissociation limits people's cognitions regarding the reality of their traumatic experience, and enables them to continue temporarily as if nothing happened (Christianson and Nilsson, 1984, 1989), secondary dissociation anaesthetises people's feelings and emotions related to the trauma. The experience of secondary dissociation was a common feature in the accounts of the women in the study. They reported distancing strategies such as numbing out, deadening bodily feelings and avoiding both specific and distressing sensations associated with flashbacks and more general stressful life events. The experience of numbing was described in the following ways by different women in the study,

'...my head just feels numb. I don't know, just don't, I'm not there anymore... I pretty much disappear. Just not conscious with the feeling that my body is having any more'. (P1).

One respondent reported not being present in her body for days on end and consequently not having any recollection of the happenings in her life during that time.

'Dissociating. I can't remember when it started. It would have been very young because the abuse started when I was very young...When I first started coming into recognition [of the abuse] *then I'd dissociate. I'd have to work at staying present in my therapy. Most of the time, yeah, I was gone most of the time... Even just days...Yeah, not having a memory of my life. Not to the point of where I was.'(P3).*

One woman had no conscious memories of her abuse. However, she was persistently troubled by intrusive and distressing flashbacks. When the flashbacks occurred she described feeling panicked and terrified and experiencing an increase in heart rate and sweating. She also somatically experienced a heavy weight on her body, to which she would respond by using her hands to try 'push off' or 'brush off' the weight she felt

overpowering her body. She began 'squealing' like a young child and reported feeling like the abuse was immediately re-occurring. Another woman described the experience of dividing from pleasurable feeling, explaining that the absence of feeling allowed her to continue to function in some ways, even though the cost was a deep sense of disconnection from her body.

'It's like if you can deaden off everything else you deaden the body off too, so that you don't feel things and you can go on and keep doing things. I would present as being tough and I went ahead and did things. It was always an effort but I did it...Disconnection, that's probably the right term. Disconnected'. (P4).

And further,

'...there was an awareness that your body was dead...I think more or less the abuse just deadens your body...'(P4).

Another woman reported a deadening of feeling in the body, particularly around the area of the body that was the focus of the abuse, allowing her to survive and cope with a traumatic experience.

'When it was happening I felt nothing...I had that tendency to be numb in the area of the pelvis and I couldn't feel anything... I was just going on automatic'. (P5).

The above accounts illustrate bodily disconnection that was manifested in primary and secondary dissociation, numbing and avoidance, amnesia and anhedonia. However, women's accounts of disconnection from their bodies were not just limited to numbing, deadening of feeling, fragmented or lost memories, or out of body experiences. Many had experiences of bodily fragmentation and distortion which intensified the sense of alienation from the body and further confused and problematised the experience of embodiment. Sometimes the degree of bodily distortion was so great that women reported not being able to see or recognise their own body, seeing only parts of their

body, or seeing the perpetrator's body instead of their own. Other problems of embodiment included experiences of depersonalisation, disorientation, altered pain perception, altered body image and bodily confusion. These experiences were shared by most of the participants. Hence, while bodily disconnection provided a protective detachment from the overwhelming effects of trauma the consequences were devastating. For several of the women the detachment from their bodies was so profound and lasting, it was as if they had never really lived in their bodies. For these women, their own bodies were not just felt to be unfamiliar and unknown, but at times, experienced as unrecognisable, alien and other.

(iii) Bodily Fragmentation

All the women I interviewed reported experiences of bodily fragmentation and distortion.

'I had trouble feeling that I'm not a number of dissociated bits. I found it very hard to think of myself as a whole person'. (P2)

'I haven't really rediscovered my whole body. I mean I really discovered bits of it and I think, 'Jesus, who is that?'. (P2)

'It was quite scary. Scary in the sense to even maybe looking at myself, like really seeing myself in the mirror... Scary in the sense of like seeing myself, starting to see myself for the first time. So it meant coming out of dissociation. So that was probably scary because that had been such a big defence'. (P3)

'Um, so looking at it, I really sort of felt like sort of um, 'bits', because it was so shocking, and I was just like just breasts and vaginas and things, but I didn't even know the name and I felt at the time that I was 'bits' because he was just ravaging me like I was an object and I was just 'bits'. So I sort of crumpled and broke up into bits [voice falters] that was sort of um, the experience that I had then, um, there would be pain or discomfort after a while and so that was just sort of the bits, so it wasn't all of me'. (P5)

'I think it sort of began when my grandfather began abusing me. I was sitting on his knee and I was saying show me what I feel. It was like bits and I broke up at that time. Like into just bits. This was what people thought I was and this was one of my bits. But I didn't want to have that bit [my vagina] *because that seemed to be, that was all men were interested in. And that was what my grandfather said. That was what I was, a hole. That was basically what men were going to do and that was basically what love was, and that was basically it, you know. So I had to remove that in a way from myself'. (P5)*

More than one woman reported the experience of feeling that she was just a head with the rest of the body absent.

'Yeah, I remember when I first starting coming back from dissociating, coming into recognition of myself, I mean all I could see at the time was, if I looked in the mirror all I could see was my head. I couldn't see any other part of my body'. (P3)

'So I had that experience from then but like right through, like when I was twelve I was just a head, I didn't even have a body or worry about my body, because my body had changed before the other girls had in primary school. So that was an easier way to do that. To just be a head'. (P5)

(iv) Distorted Body Image

The degree to which women had distanced themselves from their own physical reality of their bodies is reflected in accounts of distorted body image.

'I go and spend money on things that, on clothes that are actually for another body, for example, that aren't for my body... so therefore some kind of fantasy body for example'.(P3)

'I also spend money I don't have on a fantasy body. So I think that explains um a kind of 'carelessness' that I have with my own [body]. *It's er, it's kind of desperation to provide*

for a body that I don't have. Er, at different ages and stage. So I will go and look for little girl's clothes or um, and I'm a middle aged woman, so I'll go and look at teenagers clothes and I'll think that I can fit into it but you know, even as I am looking at it and thinking I'll buy this, I know that I can't...It's sort of shopping for a person who's gone or something like that'. (P3)

In reflecting upon this poignant story, multiple levels of bodily disconnection are evident. The process of dissociation has disconnected her from her own body, leaving her unfamiliar with her own body image, its' size, shape and proportions. The child's body appears to be the only body that is visible, suggesting that years of dissociation and bodily alienation that has made her growing and maturing body invisible to her. Her account also conveys a sense of grieving for a lost body and perhaps a desire to reclaim and nurture a child's body that failed to be nurtured and cared for.

'I discovered that my estimations were that I was much smaller than I actually am. My understanding was that lots of women think that they're bigger than they are and I thought that, I mean that grabbed my attention'. (P3)

'I guess that I must think in some way that I have a younger body. I still think I am younger than I am or something like that...I don't know...I don't know... It's just not mine. I mean it's, the body I've got isn't mine, or it wasn't, I'm now sort of repossessing it...It's like a science fiction movie. You wake up and you're then transported into somebody else or something like that. Very peculiar'. (P3).

The woman above believed that years of dissociating from her body in an unconscious manner, accompanied by consciously choosing to ignore and deny the reality of her body and its needs and demands, had made her body completely unknown to her. The only body she could relate to was the body she had as a young girl. She later described showering one day and 'seeing' her body, at the age of 52, as if for the first time.[53]

[53] See p.157 where I include the participant's words about this poignant episode.

While dissociation may explain bodily distortion, it may do so only in part. Studies by Oppenheimer, Howells, Palmer and Chaloner (1995), and by Bryam, Wagner and Waller, (1995), suggest that sexual abuse causes women to feel disgust about their own femininity (a finding confirmed by my study), and that this disgust causes abnormal concern with body shape and size, including overestimations of body size.

(v) Bodily Disorientation

Also prevalent in women's stories was the experience of not being aware of bodily movement and action. Physical coordination was reported as problematic for several.

'I didn't feel, like my body looked like everybody else's but I didn't like it I fitted. I didn't feel like part of them, you know. They'd eat, breathe, you know, maybe, it's like, it's weird... and I never noticed until suddenly I realised oh wow, you know, and I'd put my foot down on the ground and the electrical things in my mind to say that's what I'm going to be doing. And my foot's hitting the pavement and I'm registering it all at once, but for years I didn't even know that I didn't even know. In fact I was lopsided'. (P8)

'I was in my body but I wasn't. Like I had a round body and I was a square person trying to fit and it wasn't fitting or it was the opposite. My coordination, it could have always been better. There were times when I couldn't do a simple thing like throw a ball in the air and catch it. For years as a kid all I wanted to do was to play sport and I couldn't do that. I was all the time on the back foot. Hang on a minute, don't put your leg there because the tone of your voice doesn't suit that 'No no, it's not right'. (P5)

'When I walk I don't feel like I'm walking properly. It's not how I want to walk or it doesn't give me a feeling of satisfactory to me... I feel like I'm slopping along and possibly I'm not. It all feels out of place'. (P8)

'I didn't even seem to move around people the way other people were moving. They could sort of zip in and out to avoid people and I'd always crash into them. I could see it

but I couldn't get myself. Like a simple shoulder, flick back. I couldn't get out of the way'. (P6)

'... I have been doing a lot of swimming for example and I used to get into the water and it's been very hard for me to do that. I feel very uncoordinated and you move a little bit and the rest sort of follows about 10 seconds later. It's just a struggle. It's incredibly hard. It's like you do one thing and you forget to breathe. So, you don't live in the whole body. You sort of send your mind to one bit. You know, some far outpost. The rest goes on holiday you know. So it's, um, you lack co-ordination for that reason. It's like my mind goes into one section and the rest, sort of nobody's home. So it's very hard...I get into the pool and I say 'Hello arms'. You know and I start moving my arms and I'd think 'oh oh hello, hello'. (P2)

Participants' accounts reveal that body co-ordination problems are linked to specific dissociative, numbing and avoidance reactions, which result in high levels of bodily dissonance and alienation that manifest many years after the initial traumatisation.

(vi) Identification With The Perpetrator's Body

A further factor implicated in women's accounts of leaving their bodies was their experience of identifying with the perpetrator's body. Several authors have described how in the victimisation process, children come to internalise the distorted beliefs and rationalisations of the perpetrator (Salter, 1992; Ryan, 1999). Victims come to believe they are responsible for the abuse, that they invited, initiated or maintained it, that they were equal participants in the abuse events and at times, empathise and identify with the perpetrator. The internalised offender's voice therefore typically embodies three beliefs: that the child is worthless, enjoyed the abuse, and is responsible for it. Salter describes this process as the way perpetrators 'leave footprints on the hearts and minds of survivors' (1992:250). What is not noted in the literature thus far, and has become evident in the accounts of women I interviewed, is the way in which victims come to identify with the offender's body or indeed to embody him.

'I have had the experience of looking at my body, holding my hands out in front of me and thinking that they are not mine. That they are my father's hands...I looked at him in his coffin and I looked at his hands and thought they're my hands, which was a really weird experience'. (P2)

'Also that thing of feeling, like knowing that I was in a female body but not feeling like a female. Feeling so male. And a lot of times when I first started looking in the mirror I'd just see my dad's face. Didn't see my face. I would see his. And that was really, that was really frightening too. Because it was like well that whole recognition well here I am in a female body but I actually just felt so much like my dad or who I thought my dad was'. (P3)

'I don't look like my father but I'm physically more like him in terms of build. I have had a few things happen which are interesting...he died when I was 51, and he died of a melanoma, and I have got a melanoma and that was diagnosed a few years ago. So I have got something very like similar that way...And then I have this hair problem, which is that my hair is very thin and it's not happening to my sister's or anything, but it's just happening to me. This is why I went to therapy. I'm desperate to get this hair to thicken. I've tried all these different things and it's been like this for ages. There is nothing hormonally wrong because I have had these sorts of things tested out. Yet I have got this male pattern baldness happening. And I want to see if there is something psychological here that is linking me with my father...I wondered if I might be sort of taking on traits that yes, just because of it , because I had the situation of abuse...he had this phobia about his hair, because he had gone bald relatively young. When I started doing this, I wanted to see if there was some way my body was expressing something subconsciously...' (P4)

Contrary to most descriptions in the clinical literature which emphasise victim's psychological identification with the perpetrator, my participants' accounts highlighted the bodily identification with the offender. For some, the physical identification with the perpetrator's body may be explained by biological resemblance or genetic relationship to

the perpetrator, which was vividly apparent to the victim. Less easily explainable is the experience of those others who cannot actually see their own bodies and body parts and who instead recognise only the body of the perpetrator. This may be a consequence of profound dissociative states in which the victim's own body disappears from conscious awareness, it may reflect disturbing flashbacks in which elements of the traumatic memories erupt into consciousness in fragmented visual images of the traumatic event. The experience of having the perpetrator's body may also be explained as an extreme expression of bodily fragmentation, distortion and disconnection that accompanied dissociation and bodily absence. Whilst the experience of victim's identification with the perpetrator's body is a phenomena that embodies multiple processes, women's responses were more singular. All the women in the study reported being frightened or disturbed by these experiences and consequently responding by 'leaving' or 'escaping' their own bodies via dissociation or bodily denial.

5.5.3 Bodily Pain

Bodily pain emerged as a central theme in women's stories. A complex phenomena, the body in pain reflected and encompassed several different experiences of the body.[54] Some participants reported enduring high levels of physical discomfort and pain and being unaware of these sensations due to dissociation from the body. Dissociation not only shaped their awareness of pain but also impacted on pain tolerance, meaning that women would continue to subject themselves to strenuous bodily demands and be unaware of the painful consequences. Participant 2 reported experiencing many physical health problems as a consequence of dissociating from her body. Not living in her body for much of the time, she had a reduced awareness of bodily sensations, including bodily discomfort and pain resulting in physical pain and injury.

'I have a number of injuries that I've sustained as a result of not being able to feel pain properly. Or cold and heat properly. Or hunger properly'.(P2).

---

[54] I examine the theme of the body in pain in more detail in the Chapter eight (pp.231-291), where I elucidate the nature and meaning of victims' bodily pain. I focus here specifically on pain and its

Dissociation was also used in response to physical pain, as a mechanism for controlling pain. Several women reported that when feeling upset or distressed by memories of the abuse, or when their bodies exhibited painful somatic flashbacks, they would 'fall into' dissociation to manage the pain. Of interest is the recursive relationship between pain and dissociation, in which pain was a consequence of dissociation and dissociation a consequence of pain.

For other participants pain was equated directly with their abuse experience and their body's recollection of that abuse (body memories). Many believed that their bodies had stored memories of the abuse that were later expressed as pain by the whole body or by specific parts of the body that were directly injured or wounded by abusive acts.

'Like my Dad was very violent, sexually and physically, and a lot of um, a lot of the sexual abuse was tied into a lot of physical sort of abuse and I would just get beaten a lot...more lately I've been realising how that's still effecting me and I'm still carrying that in my body, and I think more so around my legs. I get pain in my legs and I can remember, you know, that my father would hit me a lot around the legs and kick me and things like that'.(P2).

'I've always for a long time had a lot of lower back trouble. A lot of lower back pain which also effects my legs and I feel like that's directly related to the sexual abuse... Well it's like that area's been invaded and traumatised, so like my body is shutting down'.(P4)

'I always had trouble with my legs and I think that's very much connected with the tension in my pelvis.'(P5).

All the women in the study experienced hyperarousal, dissociation and bodily pain. So prevalent and common were they that traumatic bodily reactions emerged as a major theme in my study, with womens' accounts of hyperarousal and traumatic re-experiencing, (bodily presence) dissociation and bodily disconnection (bodily absence)

---

relationship to dissociation and pain as a manifestation of traumatic body memories.

and pain revealing that it is the body that remembers traumatic events. Their descriptions coincide with those offered by trauma theories which provide explanations for biophysiological alterations and adaptations that arise in response to traumatic events, explaining intense and vivid body memories and sensations, and non-narratable and deeply felt, embodied experiences of women who have been sexually traumatised. The frequency and veracity with which trauma was manifested and revisited in predominantly bodily and physical ways highlights the primacy of individual embodied experience for victims of sexual abuse trauma.

5.6 Traumatised Bodies And Meaning

Trauma theories open up space for thinking about the body of victims. Unlike many theories used to explain human problems and difficulties, they focus their gaze on the body, while also providing reassuring bio-physiological explanations for the bodily responses of traumatised individuals. As such they illuminate important dimensions of victims experiences. However, trauma theories also ignore or obscure other significant dimensions of the bodily experience of women who have been sexually abused. My study revealed that victims' embodied reactions to trauma, while undeniably physically experienced, were also perceived of and constructed in particular ways. It was the potential and potent meanings that bodies had for women who have been sexually abused that constituted a major and vital realm of experience that was not illuminated by trauma theories.

Traumatic body reactions and bodily sensations were attributed with meanings by participants. These meanings converged with other meanings, derived in part from other bodily experiences and in part from women's interactions with their social context. Consequently, experiences of hyperarousal and somatic re-experiencing led to perceptions of the body as unruly and out of control, while dissociative states made women feel and think their bodies to be unfamiliar, unrecognisable or absent and therefore irrelevant to their lives. Further, the absence of words for bodily experiences and the inexplicability of bodily pain made women privately fear an unknowable, 'crazy'

body and conceal it from the public gaze. It was this significant dimension of women's experiences that was least explained by trauma theories but most in need of analysis, as it became clearer that women's subjective experience of their bodies was deeply implicated in many of their bodily struggles and problems of embodiment after sexual abuse.[55] To illustrate this point I now discuss the constructions that participants applied to the major traumatic bodily reactions that I have described above. These constructions were of particular significance, playing an important role in influencing participants' subsequent behavior, sense of identity, relationship to their own bodies, to others, and to the context in which they lived.

5.7 The Body As 'Me' And The Body As 'Not Me'

The severity and chronic nature of symptoms of hyperarousal and somatic re-experiencing, and of dissociation and detachment from the body, was a striking feature of women's accounts. Paradoxically, the experience of child sexual abuse trauma made the victims in my study both more attuned to and more alienated from their bodies. Hyperarousal and re-experiencing made the body a focal point of everyday living and conflated self with the body. Dissociation, on the other hand, diminished the presence of the body making it largely disappear from women's consciousness. Consequently, selfhood became equated with mind in the absence of body. These contrasting conceptions of selfhood – a conception of self as identical to our bodies, and a conception of self as wholly distinct from our bodies continued to be reflected in women's stories.[56] Traumatic flashbacks and dissociation were experiences that frequently co-existed for the majority of women. While both bodily responses to trauma were reportedly problematic and disturbing, the consequences of each were quite different. Past abuse events alongside current episodes of traumatic re-experiencing of somatic flashbacks that often

---

[55] Chapters six to eight (pp.116-265) provide a more detailed examination of this key point.

[56] The two alternatives tend to exist in daily discourse about our bodies. Meyers (1997) suggests that the first physicalist conception is problematic because it fails to explain why some bodies and not others constitute selves and how it is possible for people to be at odds with their bodies. The second Cartesian fails to explain what sort of thing a self is, if not a body and how it is supposed to interact with the body. Moreover, the 'body as me' position implies that I am not more than my body, and therefore am bounded by the arbitrary nature of physical existence, while the 'body as not me' position implies that I am wholly distinct from my body and therefore act upon, use or possess it.

intruded everyday, led women to experience their bodies as being out of control. Both then and now, women perceived (felt and believed) their bodies to be beyond their control, unpredictable, unruly, disruptive and untrustworthy. Their bodily reactions and the subjective meanings attached to these reactions enlarged and intensified the presence of the body in their lives. It was as if the universe was contracted to the immediate vicinity of the body or that the body swelled to fill the entire universe. As Culbertson illustrates, 'the body' is higher in pitch, more cacophonous, more aversive, more existentially confusing than the everyday world. The body, intent on surviving cannot forget the lessons learned in those circumstances' (1995:174). Women responded with fear, anger and at times, concerted, extreme and seemingly bizarre efforts to tame their unruly bodies.

Dissociative responses were also reported by all the women in the study. Each of them described a process of splitting from ordinary consciousness and separating thoughts and emotions from bodily sensation and feelings. For some, dissociation occurred at the time of the original trauma, for others, in response to specific reminders of their abuse. For some, dissociation was a way of dealing with trauma related intrusions, and for others it became a habitual pattern for managing other stressful life events. Events which go on inside the body, which seem to be essentially physical and inescapably tied to embodiment such as sexual, sensuous, affective or proprioceptive experiences, no longer have anything to do with 'me', they became 'not me'. While assisting women to function by providing a protective detachment from overwhelming affect, dissociation resulted in a devastating level of disconnection from the body. For several women, the detachment from their bodies was so profound and enduring, it was as if they had never lived in their bodies. Their bodies were experienced as not just as unfamiliar and unknown but as unrecognisable, alien and other. For many of the women disturbing experiences of bodily fragmentation, distortion and disorientation intensified alienation from the body. While hyperarousal and its consequences increasingly attuned women to the body, amplifying its presence in their lives, dissociation and its effects, effectively 'disappeared' the body from women's lives.

Women's responses to traumatic bodily reactions and the constructions they imposed upon them thus conflated individual embodied experiences into the 'body as me' and the 'body as not me'. Consequently, two sub-themes emerged in the study, which I conceptualised as 'the unruly body' and 'the absent body'. These conceptions of the body were shared by all the participants. In the discussion that follows I reveal the meaning constructions attributed to traumatised bodies that are concealed by a rigid application of trauma theory, show how women arrived at these perceptions, and reveal the consequences for women's embodiment. I provide a more detailed analysis of hyperarousal and its relationship to women's constructions of the body as 'unruly', followed by a discussion of the connections between traumatic dissociation and bodily disconnection and womens' experience of the 'absent body'.

5.8 The Unruly Body

Powerlessness and lack of control at the time of the original abuse coupled with hyperarousal and recurrent, intrusive and unpredictable somatic flashbacks were, for the women in my study, vivid and real experiences of the body being out of control. As a result the bodily sensations created fear, and the absence of control over the unpredictable reactions of the body produced anger - the two most common responses women expressed towards their bodies. For one young participant feeling out of control of bodily responses was the most frightening and chronic of all the problematic consequences of her sexual abuse experience.

'Because it's not, it's not what everybody does. It's not something I can control. Probably it's mainly because I don't have any control over. It's not normal. It might be a normal reaction but it's not, it doesn't happen to everyone'. (P1)

Fear of the unpredictable and disturbing bodily sensations and anger at the intrusive symptoms of an 'uncontrollable body' were recurring foci of women's stories. The body's insistent presence was imbricated in women's perceptions of self. However, equally important was their perception of traumatic re-experiencing and flashbacks as the

body being acted upon by some unknown force outside the owner's control. The bodily sensations did not feel like they were a part of 'me', a property that automatically belonged to 'me'. The body therefore did not feel as if it was identical with the self. A core dilemma ensued in which women's everyday identity was dominated by the body and its troublesome presence in their lives (the body as 'me'), at the same time as a conception of self as something wholly distinct from the body (the body as 'not me').[57]

Whether women felt and experienced their bodies as 'me' or as 'not me', their resolution to the dilemma was the same. It was to 'act upon' themselves and their bodies in pursuit of control. They sought control not just over unwanted physical effects but over a body that was, as a consequence of felt embodied experience, constructed as unruly. 'Acting upon' involved disciplining the body through punishment and control. Punishing the body that was perceived as misbehaving and disruptive and mastering the body that was troublesome and disobedient became the two central and often intertwined ways women attempted to regulate traumatic physical re-experiencing.

'...I want to punish my body for being there...Yeah.. It's like it's not just because of all of that what happened, but because I can just feel it all again, all the sensations. Just that pure disgusting feeling'. (P1)

'...when I am 'schizing' [re-experiencing*], when something triggers it...when it does, it's just shithouse. I hate it. That's the time when I hate it, my body... All the other times I love wearing clothes and that. I don't love my body but I am not afraid of it'. (P1)*

The statement below made by one of the young women I interviewed reveals a construction of the body as either being 'good' or 'bad'. When the body is behaving well, she feels calm and confident, expressing this through the clothes she chooses to wear. When the body is behaving badly, as it did when abuse happened, she feels angry at her

[57] A more detailed examination of this dilemma of embodiment is provided in the following chapter which is concerned primarily with women's constructions of their bodies in the aftermath of sexual abuse. I do not expand upon it here as my focus in this section is on 'felt' embodied experience.

body and insecure about trusting its responses.

'Like I always liked wearing clothes and clothes feel better, do you know what I mean... So my body was doing a good thing...But yeah, other times I'd get angry at my body. Yeah, maybe I got, sometimes I would get angry at my body for not reacting the way I wanted it to react when it happened, you know, for doing a bad thing'. (P1)

Several of the women in the study reported feeling that their bodies could not be trusted because they betrayed them at the time of the sexual abuse. Betrayal implied several meanings for women. For some, betrayal referred to the experience of the body not acting to stop the abuse, so feelings of disobedience and disappointment were attributed to the body. For others, betrayal implied that the body was in collusion with the offender, and because it reacted in ways that the victim did not want it to, namely by responding sexually to the abuse, the body was viewed as traitorous, and as coconspiring with the offender.

One woman described that she felt betrayed by a passive and disobedient body that failed to react and obey her wishes at the time the abuse was occurring.

' Maybe for not doing anything or maybe for not, ah, it's hard to explain...I don't know what I wanted my body to do at the time the abuse was happening. Yeah. I don't know. Something, anything...it betrayed me there... It didn't do what I wanted it to do, yeah, stopping it happening, ...'(P1)

The same young woman also felt betrayed by a disorderly body that responded sexually during the abuse. The body having pleasurable feelings in a context of fear, intrusion, and abuse, represents an uncontrollable, untrustworthy and traitorous body. She described how, experiencing pleasure in the context of abuse and the consequent anger she felt towards her body for responding in this way, was the most difficult and awful of all the problems she associated with the sexual abuse:

'Umm, umm, I remember one time when it happened, when it used to happen to me, I used to not be there, you know what I mean? I know one time my body like, enjoyed it. Do you know what I mean? The worst thing is that. Robyn [her therapist] *just says it's a mechanical thing. I reckon that's the one answer that's sucked the most out of all the answers I have got...It's not a good answer. It's just one of those answers you have to live with. There's no good one...it's just not an answer that makes me feel better still about it, do you know what I mean? ....And I guess that probably the one thing I hate most about it ever, is that...'.(P5)*

Another woman reported a similar experience,

'Yeah out of control in the way that other women say that, in different stages of having sex, you enjoy it. But you don't want to be enjoying it. Mentally you know you don't want to be enjoying this thing. But you physically you are and sexually you are, and your body betrays you because like I don't want to be feeling this, but you can't stop it. It's happening. It's doing its own thing. You know it's like oh. And mentally you don't want to feel that way because hang on a minute, let's just stop, it doesn't feel comfortable. I'm not happy with this. But my body is very happy with this. No I'm not mentally and emotionally happy with this, but my physical body or my sexual parts of me are really happy with this, but you know, it's not making sense'. (P6)

Whether the body was experienced as disobedient, untrustworthy, disruptive, unmanageable, unpredictable or as 'betrayer', in the past when the abuse initially occurred, or in the present when somatic intrusions of the original trauma were re-experienced, all of the women in my study responded with efforts to control and master the unruly body. Three main strategies were used to keep the body under control. Leaving the body through active dissociation was one way women attempted to maintain a sense of bodily control. Being absent from the body meant they could protect themselves from any experiences or feelings of being out of control.[58] Harming the body was a second way women managed overwhelming feelings of the body as beyond their control. Self-

[58] The process of dissociation is discussed in Chapter one (pp.9-12), and previously in this chapter, pp.129-

harming, although embedded with multiple meanings, was often a response to uncontrollable and distressing bodily reactions.[59] The third common strategy used to control the body was self-mastery; setting their bodies all manner of unnatural expectations and tasks. Achieving success in these endeavors was a measure of bodily control.

Attempts at control and mastery involved the use of restraint, management and discipline. Restraint involved keeping the body under control, management was concerned with being in charge of the body, and discipline required regulating and punishing the body. For example, several women referred to the importance of having absolute control when having sex. The need for control in sexual situations appeared to reflect three concerns: (i) to ensure that the present situation did not replicate the dynamics of the original abuse; (ii) as a strategy used to guard against the possible (and likely) triggering of traumatic re-experiencing; and (iii) as also reflective of the desire to correct the body's previous unwanted response to the original sexual abuse. Controlling the body was making it do what it should have done in the past.

The following statements reveal one participant's efforts to control the unruly body through the application of restraint, management and discipline. First, she tries to restrain her body and keep it tightly under her control:

'...Like now, I know I'll only ever have an orgasm or anything like that when I want it now. It's really, that's how it would have affected my body, that thing.' (P1)

Second, she tries to be in charge of her body and have it obey her directions,

'Yeah, like if I am having sex with someone, even someone that I really love, I'd just try to hate it. Trying to make my body do what it should have done back then. Don't know

---

138.

[59] While self-harming was a response to traumatic re-experiencing and to dissociation, functioning to regulate the unwanted physiological affects of trauma, self-harming was also replete with other meanings that women constructed about their bodies. I have chosen to examine self-harming in more detail in chapter

why. Stupid. But my mind would be trying to make it do what I wanted it to do back then. And, I hate it, again'. (P1)

Third, she responds by punishing her body, believing that by regulating and disciplining the body she will feel more in control.

'...when I feel angry at my body , I hurt it...Oh, just by scratching it and hitting it. Just like what I used to do. I punish it maybe. I don't know. But when I do, yeah it just like took away the pain from maybe inside of me, a little bit'. (P1)

The case above is one example of the application of restraint, management and discipline of the body. However, each of these aspects of control is evident in the stories of numerous other participants.

The above discussion illustrates the way in which the traumatic reactions of hyperarousal and re-experiencing are powerful, bodily experiences that implicate the physical body of the victim. Women's felt and embodied experience is constitutive of their everyday reality and of their experience of themselves and their bodies. Furthermore, personal embodied experiences while informing daily lived experience are also the basis for cognitive constructions that women apply to their bodies. I now examine the experience of dissociation and bodily disconnection which was also a prominent feature of women's experiences following the trauma of sexual abuse. My examination of these processes augments my claim that personal embodied experience, made vivid by traumatic bodily reactions, makes the physical body loom large in women's postabuse experiences and subsequently shapes constructions of their bodies and the ways they behave towards them.

---

eight. See pp.231-265.

5.9 The Absent Body

Strongly evident in the accounts of women is the recurring theme of the absent body. The absent body is a body that has, for the most part, no presence for the victim - being experienced as either unknown, unfamiliar, unrecognisable, not belonging to the self or, in extreme cases, as another. For many participants the absent body can be explained as arising due to the process of dissociation and can be appreciated by recognising the profound and disturbing consequences of dissociation. While being an adaptive response at the time of the initial trauma, the continued use of dissociation to cope with the effects of the traumatisation and with other stressful bodily, psychological, emotional and interpersonal consequences, dissociation has devastating effects on everyday functioning, but especially on embodiment. Women's accounts reveal clearly the process of splitting the mind from the body in which the body becomes other and the mind becomes self. Existence is lived at the level of mental processes alone, while the body is out of conscious awareness. At best, it is seen as an 'instrument' to assist one's mobility, an 'object' that is necessary for survival, a 'housing' for the personality, and as a 'troublesome' and 'demanding' reminder of human needs. At worst, the body is 'alien', 'foreign', 'not me', an embodiment of the offender, or is left completely, abandoned in flights of escape from unbearable feelings.[60]

'...It was like that's where the feeling of foreignness came from, like I'd be inside my body but not inside my body. Like my personality was me, not necessarily a physical entity. It was separate from my body, my blood and my insides. I had to eat to keep this thing alive so that it could house my personality'. (P6).

'...it was ...like I had a body but it wasn't mine. My body was mine and I could touch myself, but I didn't feel ... ' (P6).

'I felt like sometimes I really felt like I was alien. I'd sit on a train with a whole bunch of other people and there'd be lots and lots of people and I'd think I'm not like you. You're

doing this with your hair and you probably feel it, you probably feel it's all happening together, whereas when I'm doing that, I'm not conscious of the movement, not conscious of feeling my hair, or even my body at all'. (P6)

'I think other people, I don't know, have a sense of themselves as being recognisable but it was, for me, a bit like you didn't really even have any sense of any part of yourself being familiar to you'. (P3)

While disconnection and detachment from the body can be explained by dissociation and the related biophysiological consequences, this explanation did not entirely account for the absence of body experienced by the women in the study. For some women, bodily awareness did occur, even among those who used dissociation.[61] Their stories indicated that there were times when the body made itself present, making potent physical claims upon them. Womens' awareness of the body's presence was met with vigilant efforts at denial; the desire to make the body disappear, to make it absent from consciousness and to obscure it's reality and demands. Bodily denial was linked with the view of the body as troublesome, desirous or dangerous, and with avoiding bodily reactions and feelings that were frightening and perceived as crazy-making. Bodily denial was also linked with feelings of unworthiness, to which women responded by being careless of and with the body, as if abandoning a contemptible part of the self. Furthermore, for some women, bodily denial extended to silencing the body by punishing it for daring to make its needs and presence known.

Many of the women interviewed had been so absent from and so adept at ignoring their bodies that the body had become completely separate from the sense of self. The resulting split between mind and body created a disembodied experience of 'self' in which selfhood was associated with the mind alone while the body's existence was barely acknowledged. Recognising the split between the mind and the body engendered feelings of alienation from the body that were so profound that the body was an unfamiliar part of

---

[60] Participants' accounts of these processes are detailed previously on pp.129-144.

[61] For example, it is difficult to say how much the body problems I illustrated earlier are the result of

the self. Several of the women discussed an emerging sense of body presence after many years of disconnection and detachment. For most, increased body awareness had been hard fought for through traditional or body oriented therapies, through coming to understand the impact of the sexual abuse, and in particular, the process and debilitating effects of dissociation and denial of the body. Not unsurprisingly, when women began to recover and began to feel present in their bodies, the newfound physicality, while liberating and at times disorienting, was also accompanied by a sense of profound loss.

'You can ignore the body very successfully. You can do it till your almost, you know, until you are an extremist you know...[I have been]*...so successful that I'd wake up in the shower one day and think who is this, you know'. (P2).*

'What it means to me is that I haven't lived in my body and when I'm trying to somehow, er I was saying to my therapist the other day that I feel as though at the point that I'm at now that I've woken up in someone else's body. I actually have had the experience recently off being under the shower and thinking 'Oh my God', you know. It's a really freaky feeling'... 'Oh my God, you know, who is, whose body is this. Kind of looking down and thinking...Yes, yes. It's sort of going to sleep at a particular point in your life and then waking up later and you know something like 50 years has passed...It's sort of missing years and missing bodily experience, you know. I mean whole, I mean decades of experiencing body and I could get pretty upset at this point...Yes, yes...more recently I have had this experience of kind of looking at myself and seeing myself and I don't know that I've been able to see myself for a very long time...um., So there's the enormous loss of life'.(P2).

'It was like if you haven't ever known yourself, it's [your body] *not even recognisable. Like it's not familiar either'. (P3).*

'I now feel as if I'm freeing up and sort of think it's a bit child-like. It's like my body was all frozen from you know those first sort of 40 years of my life or more'. (P4)

---

dissociation and how much a result of women's determined efforts to ignore and not live in their bodies.

It became apparent from participants' accounts that they were all confronted by significant fears and anxieties associated with their bodies. Often, it was uncontrollable and disturbing bodily reactions and experiences that provoked fear. At times it was the claims the body made for food, rest, attention and care that provoked anxiety, while at other times, just the awareness of the body's presence was enough to stimulate immense apprehension. In response to the fears and anxieties associated with embodiment, women distanced themselves by ignoring and denying their bodies. Even greater fears existed in relation to their perceptions about having female bodies.[62] As a consequence bodily denial was frequently employed as a solution to the problems of embodiment and as a strategy for managing other problematic attributions ascribed to the body. For many participants, it was easier to live as if not having a body because being embodied was so problematic.[63]

What is striking in participants' accounts are the profound levels of disembodiment experienced by victims, the extent to which victims functioned as disembodied minds, and the disturbing and serious conflicts associated with having a body and living in the body. Leaving the body, although a problematic resolution, was an attempted solution to feelings of fear, bodily shame, unworthiness, anger, betrayal, the desire to control the body in response to powerlessness, the wish to be empty of pain and distress, silencing needs and overriding or ignoring feelings, engendered by the sexual abuse.

'IT'S THE BODY SYMPTOMS THAT YOU DON'T HAVE WORDS FOR': TRAUMA, PHYSIOLOGY AND NARRATIVE

'I don't know what it was, and it didn't have words. I went through the whole thing physically but it didn't have any words'. (P1)

---

[62] See Chapter six (pp.168-196), where I discuss the problems associated with female embodiment in detail.
[63] Bodily denial was a recurring theme in womens' stories. It encompassed a range of meanings so I have referred to it again in both Chapter six (pp.181ff), where it related to the denial of the feminine and the female body and in Chapter eight (p.261ff), where its meaning was more closely associated with self-neglect and self-harm.

Two further significant, interconnected and possibly recursively related themes emerged in which the physical experience of the body was also deeply implicated. Most of the women reported the experience of not having or utilising words and symbols to describe feelings. Not possessing or using words meant that the body and emotions figured prominently in their lives. The body came to contain the memory of traumatic events while also becoming the medium through which the impact of those events was expressed. Psychiatry has had a long-standing interest in the process through which the body manifests physical symptoms that are reflective of underlying trauma. This process, known as somatisation, has been the primary way through which body symptoms without known medical cause have been understood. Much less attention has been given to the notion of embodied memory and body knowledge, and to the idea that knowledge not only exists in our minds but is also enfolded in people's muscles and skeletons (Fay, 1987). For the women in my study, both understandings are necessary. In the remainder of this chapter, I concentrate on exploring the notion of embodied knowledge as it relates to the accounts of the women I interviewed - my interest here being physical embodied experience.

5.10 Without Words

So disturbing and complicated was embodiment after violation that women reported struggling to find words and explanations for their difficulties, combined with a reticence to articulate the nature of their bodily difficulties, even with supportive others.

'It's the body symptoms you don't have words for...it's easier to talk about head stuff with someone, the body stuff is harder to talk about...I can't just turn around to people and go, someone who doesn't know, 'I scratch myself until I bleed...they are not going to understand why'. (P1)

The participants revealed that the unpredictable and frightening bodily reactions they experienced in the form of traumatic flashbacks, and the persistent struggles they had with their bodies expressed in such activities as self-harming and disordered eating, were

the problems they were least likely to discuss. They reasoned that the bodily feelings and associated emotional responses were indescribable. Words could not contain or describe what they felt. Typical of their responses were the two reflections below,

'...it' s not logic that works because sometimes I can't even think it through. Sometimes I might not even be able to say how it feels. I don't have words, and I don't know why'. (P6).

'I had this experience. I don't know what it was and it didn't have words. I went through this whole thing physically but it didn't have any words. It was like this is happening now and I am reliving it'. (P9).

Recent research has illuminated problems that traumatised people have in finding and utilising words and symbols to identify feelings. Cicchetti and White demonstrated that maltreated toddlers use fewer words to describe how they feel than do secure children of the same age. They concluded that 'the special difficulties that abused toddlers have expressing feelings in words may not simply be a reflection of psychological intimidation but rather a manifestation of neuroanatomical and neurophysiological changes secondary to abusive or neglectful treatment' (1990:369). A subsequent study by van der Kolk et al. (1996) of the brains of people with P.T.S.D. showed that when exposed to stimuli reminiscent of their trauma, there is an increase in perfusion in the right hemisphere associated with emotional states and autonomic arousal, and a simultaneous decrease in oxygen utilisation in Broca's area - the region in the left inferior frontal cortex responsible for generating words to attach to internal experience. These findings may account for the observation that trauma may lead to 'speechless terror', which in some individuals interferes with the ability to put feelings into words, leaving emotions to be expressed as dysfunction by the body.

A neurophysiological explanation may, in part, account for the loss of words that women in my study experienced. However, it captures only one aspect of women's silence. Their stories revealed that the absence of words was also explained by fear. Bodily feelings and

reactions and the activities women engaged in relation to their bodies were seen as too weird or 'crazy', or as just too frightening and distressing to be articulated. Fear of the symptoms and fear of other's reactions if the body reactions and feelings were made overt posed a significant restraint to speaking.

'Its just so different. It's not normal to other people's experiences...' (P4).
'...it's easier to talk about head stuff with someone...The body stuff is harder to talk about'. (P1).

'Because they [the body's responses] *are so weird. It's like what would make you do these things?' (P8).*

Furthermore, women described actively resisting words. In a manner that mirrored their desire for control of the body, some of the women chose not to seek out a narrative for their feelings. It was as if attaching words to deeply felt embodied experiences would somehow make the reality of those experiences and the abuse itself, more true, more distressing and more unmanageable.

'Because it's just that yuck that I don't want to talk about it...definitely'. (P1).

One young participant commented:

' I don't want to have the words, Because that would mean I would have to think it all through, accept it, acknowledge it all happened and I don't even want to have to think about it...' (P1).

Herman contends that the word 'unspeakable' is often applied to our description of atrocities, in which 'certain violations of the social compact are too terrible to utter aloud' (1992:1). She claims that often secrecy and silence prevail and the story of the traumatic events surfaces not as a verbal narrative but as a symptom. Her description, while encompassing the physiological constraints to speaking, also embraces the nuances

expressed in women's experiences of the 'unspeakable'. Women's silence had multiple meanings including the loss of words or symbols to communicate feelings, the inadequacy of words to convey overwhelming experience, and the fear of words. For it is in the speaking that one again becomes vulnerable to others, and vulnerable to the terrible reality of traumatic experiences. Accordingly, it is the body that continues to hold the memories and stories of women's abuse.

5.11 Embodied Knowledge

'...it's mainly through my body that I experienced what happened...' (P3).

As noted above I make a distinction between somatisation and embodied knowledge. In somatisation the body is conceptualised as a medium through which mental and psychological disturbance is conveyed and manifested. In contrast, in notions of body memories (embodied knowledge), the body is not merely a vehicle for mental processes. Nor is its importance secondary to that of psychological significance. Rather, the body, as an entity with all the explanatory power of the mind, has a validity and authority of its own. The body is imbued with knowledge, with memory, with the capacity to meaningfully hold and represent individual experience. Its primacy in victims' accounts related to its perceived capacity to embody vital, felt knowledge of their abuse experiences.

Theories of somatisation in which the body was thought to express experiences that had not been translated into narrative in the form of symptoms were evident in participants' accounts.[64] Also present however, were understandings of bodily pain and symptoms as body memories. Although frequently experienced as problematic, bodily memories were seen as a valued form of embodied knowledge. More often than not, women embraced this bodily knowledge, perceiving it to encompass important information about abuse experiences, their impact, and what the body required for recovery to be possible.

'I think the mind and body go together. I think the mind does play a huge amount. But I also think that that you can lock some things into your body, like memories, that you might do from back then [when the abuse occurred]. *(P4).*

Resisting the tradition to privilege rational and conceptual knowing, women acknowledged and honoured the importance of bodily and emotive knowledge. Embodied knowledge was embraced and valued. It was not excluded, dissected or psychologised to fit supposed mental representations. As such several women were directed towards healing methods that acknowledged, privileged and respected embodied knowledge and towards embodied rather than languaged forms of healing. In these instances, narrative reconstruction was completely irrelevant to the resolution of body problems. Rather, feeling and experiencing the body in safe, positive and new ways led to healing.[65]

The concept of body memories, shared by a number of women in my study, sat in sharp contrast to somatisation theories that are replete in the psychiatric literature. The women's explanations recognised the legitimacy of the body and feeling as realms of knowledge, privileged the body's role in constructing subjectivity and allowed for non–verbal modes of healing.[66] Somatisation theories, however, privilege mental processes, disavow the body and view body symptoms as reflecting mental and psychological states that require verbal expression to permit their resolution. Women's voices spoke of an embodied subjectivity absent in psychiatric and clinical discourses.
The following accounts illustrate the significance given to embodied knowledge, showing how visceral, how 'of the body' women's knowledge was felt to be. Their stories demonstrate their belief that body symptoms are reflective of bodily memories of trauma that are in need of being processed by the body.

'It's like I've got this cell memory in my body. What happens is people lock in, so I mean you're just locking onto something. I think even just coming to awareness of something. It

---

[64] In Chapter nine I attend to the role of narrative in the resolution of body problems. See pp.266-291.
[65] The role of narrative and non-languaged processes in recovery is examined in Chapter nine (pp.256-291).

might just be triggering off to something that is said and it just puts you into that bodily mode'. (P3).

'It's a bit like if someone's in an accident or something and something just happens and they say they hurt their neck. You know things just get locked in there. Like your muscles can suddenly go tighter or the trauma is caught in the muscle area. So it is a bit like the trauma is somewhere in your body'. (P3).

'Because you know I had a lot of trouble with my legs and my knees and I would really tense here and get this sort of tension. And there was not a lot that you could do. This is where body therapy or something, or someone pushing you or doing something takes a bit of that tightness out'. (P2).

A similar belief about body memories of the abuse was shared by the following woman.

'Like I still do have, carry pain in my body sometimes and um, and sort of aches and pains and stiffness which seems to be a bit unexplainable...I think it is tied into the abuse and it's still leaving my body you know, it's still working its way out but I do not have in my mind any idea of what is going on, or what emotional process is occurring'. (P4).

'...the work I am doing now is stressful and I do notice how the stress effects my body, but I still think that it is part of the body memory too. That part of the memory. Abuse is to have stress on the body, so I think it pulls my body back to that memory. It's like something that's not been completely figured out'. (P5).

While the following respondent shared the belief that her bodily pain was associated with the childhood sexual abuse and reflected memories of the abuse held in the body, following a visit to her therapist she revised her explanation. She moved to an alternative explanation about somatisation, that is, that the body pain and symptoms were not so

---

[66] For a discussion of the role of emotion in knowledge see Jaggar (1989).

much reflective of stored body memories of sexual trauma but were about her inability to find words for her pain, which her body then expressed in symptoms.

'Um, What happened was I had that doctor incident, [sexual abuse by a doctor], *after that I went to C.A.S.A. where I went probably for about a year or two. From what Carol* [the therapist] *thought, when I went the first time... I said to her that I was getting a lot of body memories, but she said it's more that I haven't actually got the language to talk about it and so it's just I feel this or that. So it gets, sort of to be more like what you feel in your body'. (P4).*

It is worth noting for most of the women in the study the above understandings of their body symptoms had not occurred immediately following the sexual abuse. Most of them had struggled for many years to make sense of their body responses and their pain, often conceiving less helpful explanations, such as 'I am crazy' or 'my body is out of control'. The outcome of such negative attributions was the reinforcement of an ambivalent or punitive relationship with the body and the perpetuation of ongoing struggles with embodiment.

5.12 Summary

As the examination of women's stories in this chapter illustrates, survivors experience violation in their bodies. They know in their bodies (though they may not consciously know or describe it) that the experience of violation does not end with the violence itself. The neural changes occasioned by violence and fear are permanent (Herman, 1992, van der Kolk et al, 1996). Survival creates an altered physiological and metaphysical reality within which the survivor dwells. As Culbertson writes,

> No experience is more one's own than harm to one's own skin, but none is more locked within that skin, played out within it in actions other than words, in patterns of consciousness below the everyday and the constructions of language. Trapped there, the violation seems to continue in a reverberating present that belies the supposed

linearity of time and the possibility of endings. (1995:170)

The above analyses also demonstrate that the survivor most often becomes silent about her victimisation, though the experience nevertheless remains somehow fundamental to her existence, and to the unfolding and enfolded conception of herself. This silence is an internal one in which the victim attempts to suppress what is recalled (so as not to relive the victimisation countless times), or finds it repressed by some part of herself which functions as a stranger, hiding self from self's experience according to unfathomable criteria and requirements. It is external as well: the victim does not tell what she recalls, in part because others do not seem to hear what is said, partly out of conviction she will not be believed, and more basically because she cannot simply make the leap to words. Despite this silence, the momentous nature of threats and harm to the body dictates that violence and trauma nevertheless leave the survivor preoccupied with the memory of it, which itself is both absent and too entirely present. Most disturbingly, memories and body sensations appear unbidden and in surprising ways, as if possessed of a life independent of will and consciousness. Though presenting themselves as clearly past, real and fully embodied, they appear in nonnarrative forms that seem to meet no standard test for truth or comprehensibility. Victims' bodies hold a known and felt truth that obeys the logic of dreams rather than of speech and so seems unreachable and difficult to communicate and interpret, even to oneself (Culbertson, 1995).

My study demonstrates that privileging the conscious or psychological processes in abuse impact (or even in recovery from sexual abuse) marginalises the critical importance of the body and of physical and embodied experiences that shape victims' everyday realities. The findings detailed in this chapter support results from an extensive range of current research on the effects of trauma and endorse the use of trauma theories to conceptualise trauma victims' bodily experiences. The conceptual map provided by trauma theories conceives of bodily experience in primarily biological and physical terms. However, my participants' stories show that such a map does not cover all the territory, foreclosing as it does another critical dimension of victims' experiences of the body. My study revealed that women's subjective experience of their bodies, in

particular, the personal, social and symbolic meanings they attached to their bodies and bodily experiences were deeply implicated in the problems of embodiment they suffered in the aftermath of sexual violation. Participants ascribed particular meanings to vivid and troubling trauma related body responses, so that the impact of sexual abuse reverberated not only in disturbing bodily experiences and sensations but also in the meanings that were then attributed to these bodily effects and to the body which gave rise to them.

I devote the next four chapters to a detailed examination of women's subjective experience of their bodies following childhood sexual abuse. I focus on the personal and social meanings attributed to their bodies in light of their abuse experiences, highlighting the extent to which body symptoms and problems of embodiment are informed, constituted and perpetuated by these meanings. My discussion extends descriptions of bodily experience beyond biologistic conceptions to examine the ways in which victims' bodies are constructed. To ignore or overlook the significance of compelling personal and social meanings inherent in women's bodily struggles after childhood sexual abuse is to obscure a crucial dimension of female victims' bodily experience and to diminish opportunities for understanding, analysis and intervention.

CHAPTER SIX

'JUST BEING A GIRL': THE PROBLEM OF FEMALE EMBODIMENT

'You know it's a weird thing to say, but it was like my body was the enemy...being a woman was the enemy. Being who I was. Just being a girl.'(P8).

6.1 Introduction

The poignant and troubling statement from one participant is characteristic of the experiences of all the women in my study. It illustrates that having a female body was a deeply problematic aspect of victims' existence. For the young woman above and for each of the participants, female embodiment was a fraught, disturbing and inescapable reality of their lives. There were two fundamental reasons for this, which I examine respectively in this chapter and the next. First, every woman I interviewed strongly believed that the sexual abuse had happened to her primarily because she had a female body. Consequently, 'just being a girl' and 'having a girl's body' was in and of itself highly problematic. Female embodiment predisposed them to sexual violation in the first place and to ongoing risk of harm and revictimisation in the future for as long as they lived in and with a female body.

Second, for each of the women, the experience of female embodiment was informed by their implicit or explicit knowledge of ideologies of the female body and femininity. Giddens (Casell, 1993) argues that people possess a 'knowledgeability' about the social world constituted by 'practical consciousness' which is the level of knowledge available through everyday acting in the world, and 'discursive consciousness' which is knowledge that is verbalised and articulated. Participants' drew on both tacit and explicit awareness of social scripts that reflected historically and culturally determined social representations of what it means to be 'a woman'. Central to the scripts were social constructions about female bodies, power, agency, sexuality and desire, in which woman's essence was linked primarily to sexuality and embodiment.

Innumerable feminist writers have argued that representations of women are of central importance in the construction of female subjectivity and female bodies. Some have illuminated fantasies, warring images and contradictory injunctions at the heart of femininity (Bordo, 1993; Ussher, 1997). Others have highlighted the paradoxical messages implicit in constructions of feminine sexuality by identifying the vivid and conflicting images of women as virgins or whores, goddesses or witches, immensely powerful or quite powerless, capable only of agency or passivity, submission or rebellion, desire or denial, purity or danger. Arguably, for women in general, the equation of femaleness with sexuality and female sexuality with multiple, conflicting and polarised prescriptions creates confusion and conflicts associated with female identity and embodiment. Yet, for women sexually abused as girls, the indivisibility of femaleness and sexuality and the contradictions embedded in social descriptions of femininity were highlighted, creating seemingly irreconcilable dilemmas around embodiment and identity. Implicit in their problems of embodiment were powerful and conflicting scripts that informed, and in part, constituted victims' relationships to their own bodies.

For example, if femaleness is equal to sexuality and sexuality places one at risk of sexual violation, then how does one live safely in a female body? Further, if femaleness is ascribed with immense power, with sex, pleasure and insatiable desire, women have the capacity to unleash uncontrollable male sexuality, inviting and becoming responsible for their own ensuing sexual violation. Alternatively, if female sexuality is associated with passivity and submission, again women are vulnerable to male control and to sexual misuse. The central 'existential dilemma' faced by all the women in my study was therefore: how do I live safely and comfortably in and with a female body? How do I exist when I have learned at a very young age how dangerous and disadvantageous it is to be a girl and to have a girl's body? How do I claim my female body, desire, control, agency, sexuality, pleasure and instrumentality without inviting danger, excess, chaos or sexual violation? Further, how do I live in a body that has been violated, a body whose boundaries have been made to disappear and whose responses are now frightening and unfathomable? All the women I interviewed struggled with how to manage and reconcile these fundamental dilemmas. These dilemmas were reflected in body symptoms and

problems of embodiment that represented 'existential struggles' to live in and with a female body after the trauma of sexual abuse, and at the same time, 'attempted solutions' to the dilemmas inherent in female embodiment.

I now present womens' attributions about their sexual abuse to reveal how and why female embodiment was deeply problematic. I employ several theoretical frames to make sense of women's stories and introduce the descriptions noted above[67] as potentially useful ways of conceptualising their experiences.

6.2 On 'Being A Girl': The Social Construction of Femaleness And Femininity

For several years, feminist critics have been examining the social construction of femaleness and femininity, revealing some of the serious consequences of learning to be female in patriarchal culture. They have argued that women's bodies are objects of sexual exploitation, discrimination, objectification and violation. Feminists have located women's oppression in structural inequities, and in gender socialisation, sex role stereotyping and social and cultural representations of femaleness that provide images and scripts of what it is to *be* and *do* 'woman'. They have argued that the culturally and socially shaped cluster of expectations, attributes, meanings and behaviours assigned to women (and their bodies) have constituted the rationale, basis and process through which womens' subordination to men and oppression in male dominated societies is ensured and perpetuated. Feminist debates have existed around the nature of women's engagement with such social ideologies. Some feminists have suggested women are passive recipients conditioned into embracing their secondary status, some have contended that such oppressive ideologies are 'continually created and recreated by [its] subjects through their participation in its partial representation of reality' (Reiger, 1985), while more recent feminist writings have asserted women's capacity to resist and challenge oppressive social discourses.

---

[67] ie. The notions of 'existential dilemmas' and 'attempted solutions'.

The accounts of the women who participated in my research indicate that social constructions of femaleness and femininity had a pervasive influence on their perceptions of self and were critical in shaping their relationship to female identity and embodiment. Moreover, while none of the descriptions offered above accounted, on its own, for the nature of women's engagement with powerful social ideologies, all were reflected in their stories. In this sense, it may be more accurate to claim that women were engaged in a continual process of negotiation with these ideologies. Before examining the process by which women negotiated powerful social discourses on femaleness and femininity, I illustrate the pervasive influence of such social constructions.

As noted earlier, feminist scholars have revealed the serious consequences of learning to be female in patriarchal culture. The accounts of women who participated in my study validate such feminist assertions, not through their adherence to feminist ideology, but rather through their deeply felt, individual personal experiences of being a girl. All the women in the study believed that they had been sexually abused because they were girls and had girl's bodies. Their attribution related to their experiences and perceptions of power, of the social construction of femaleness, femininity and the female body, of gender roles and expectations, and of the position of women in families and society. Although not always intellectualised in these terms, women expressed how 'being a girl' meant being devalued and disempowered and being socialised to sacrifice one's own needs to satisfy those of others. Being a girl also meant suffering the consequences of patriarchal male socialisation where, in their own families and broader society, male entitlement, dominant sexuality, and lack of accountability produced attitudes and practices that objectified and sexualised girls, and created the conditions in which their own childhood sexual abuse occurred.

'Oh well, I don't think it [the sexual abuse] *would have happened if I was a boy'. (P10)*

'Like if you have a girl's body then it's most probably going to happen to you... If you are a girl it's just common I think...I'm not saying that it doesn't happen to boys, I know it does, but I am saying it is bloody unlucky for it to happen to them. Whereas for a girl,

oh well, its just the way of the world...I know the things that happened to me because, number one, I was a girl and number two, because I wasn't old and I wasn't strong, I didn't have the strength or knowledge maybe to fight that. And also because just because he knew he could...He just knew he could' (P1)

This quote, from a 20 year old woman who was abused from the age of 11 by her brother, illuminates several of the constructions that participants shared, in one form or another, about society's view of girls and girls' bodies. I now examine what 'being a girl' meant to the women I interviewed.

6.2.1 'I Am Not Of Value'

First, participants told me that to be a girl was to not be valued. Their belief was principally constituted through their observations of the interaction between their mothers and fathers. The way in which fathers treated mothers and mothers related to fathers gave powerful messages to girls about women's role and what was expected. The perception that to be a girl was to not be valued stemmed from the way in which females were treated by the males in their families or by other men in their lives. Hence, the majority of women believed they were abused because they were not valued in their families, with the abuse experience then reinforcing their feelings of worthlessness and unimportance.

'Well, I grew up in a family where men were revered, because in an Italian culture the boys are it. I mean the example or story that I tell people is my brother John dropped something on the floor and my mother asked who dropped it and I said 'John did'. She said, 'Well John dropped it, you clean it'. So that was essentially the view ...girls were less important. I always got served last at dinner. Well not last. Mum served herself last We would get served last...It's like being taught that you get last and you get least...'(P10)

'Women are there to serve men's needs, to make sure you are there for their pleasure'. (P5)

'I just really believe that if I was a boy it wouldn't have happened. Like the whole thing...I suppose for me it was a lot to do with how we were viewed as women, in that family especially. Women weren't really put in the highest regard...Since I was 5 I noticed, all of the women, we'd cook, clean, wash, do everything...I would be encouraged to do that, and I would get really frustrated and stamp my feet and say; 'Why can't the boys, why can't they help?'...Something inside me would go, 'Well, that's not fair, then I'd want to be a boy. So then if you were a boy, then straight away, like you were better, more important, and life was much better anyway being a guy. Because you got to be served and pampered and treated in a different way...'(P8)

'You know, women don't have as many rights as men, they don't have a say and they shouldn't have a voice and they shouldn't be powerful. Yeah choosing what they want'. (P1)

'I wasn't valued growing up by my father or by other men around him...It gave me the belief that I'm not valued and definitely I had the belief that my body's not valuable...I'm still carrying a belief somewhere in my body that I'm not of value, that I don't deserve to be seen for who I am...I'm not worthy, I'm not of value and I don't have any rights'. (P2)

'I was just nothing, I was told my babies would be born deformed, I was just, I'd lost the one thing that makes a girl of value, which was her chastity and I didn't have that'. (P5)

Women who were sexually abused by siblings perceived differences in the position and treatment of boys and girls by parents. When parents were seen to have either disbelieved or ignored their daughter's disclosure, not acted to stop the abuse, minimised the offences, or failed to apply consequences to their son's behaviour, then girls saw this as both a symptom and consequence of their devalued position in the family.

'I know the second time it happened because he knew he just could. Because he knew it happened to me the first time around. He knew that the response I received from my family was nothing and he knew that, and they first thought I was crazy and he knew, just

knew that he could'. (P1)

For this young woman, being disbelieved by her family and being seen as 'crazy' for making an abuse disclosure coupled with her brother (the offender) 'getting away with it', left her feeling less valued by her family than her brother. Having her reality invalidated reinforced her sense of powerlessness, teaching her that she just had to find a way to endure the abuse and that her own action would have no useful consequences.

Women also arrived at a belief about their lack of value as a consequence of how the disclosure of the abuse was managed. If there was no action to stop the abuse, if they were disbelieved, if the abuse was minimised, or if the offender was not held responsible, women felt that this reflected their inherent lack of value. A sense of powerlessness, resignation and inevitability about their lot ensued and was internalised by some of the women, fostering already well developed feelings of low self worth.

'I told my Mum and Dad what my grandfather was doing to me. My dad did not do anything. My Mum said nothing and went out. She came back later and gave me all this shit about good and evil, saying that I was a wicked child... well it was the same with Nan. Like they knew about my grandfather but they had this fear, still going to serve him tea, I must get his lunch. I must make sure'. (P5)

For another woman, her family's response to her disclosure about being raped by her brother prompted a deeply felt conviction that to be a girl was not to be valued. Their response led to longstanding confusion, ambivalence and conflict about femaleness and femininity that was principally expressed what she termed 'a battle' with her body.

'When that big thing happened [the rape by her brother] *and I went and told my parents, it was kind of like, that was the start of me not getting it at all. Me not understanding, not having respect for myself...I didn't get it. My mum was saying you don't have sex with someone until you get married and ra ra ra...But in the same breath, my brother had been doing this stuff to me. He had raped me. But that was OK. And the same with my Dad. He*

might not have been verbalising it like that, but he often commented on somebody else if they did something saying 'that's disgusting, that's rude', but again allowing my brother and my uncle to do that. But it wasn't OK for me to voluntarily do it...' (P8)

6.2.2 Being For Others

The second pervasive articulation about being a girl or woman inherent in all the women's stories was that it entailed being there for others to meet their needs, demands and wishes. 'Being for others' embraced the expectation that as a girl, one would meet or satisfy the needs, expectations or demands of others and have no power to choose otherwise. 'Being for others' also implied not having or acknowledging one's personal needs and therefore denying or silencing them. If needs were recognised, women felt they were unable to express them, as the communication of personal needs and desires meant either being ignored or exposed to further denigration, anger or abuse.

'I guess the fact that I was sexually abused just reinforced that that was my purpose in life, to be there for a man's pleasure basically. Later on my life this idea was really a problem because I would do sexual things with men just to please them, not because I wanted to. It's just what I had to do, and I felt such incredible shame'. (P10)

'You get the message as a girl that you have to do things for others, good or not, whether you want to or not... It's just disempowerment, you doing things because you feel you have to, or because that's what you are expected to do, as a girl'. (P4)

'I had to be there for my father [the perpetrator] *in the way that he wanted me to be there for him and how he saw me, how he wanted to see me'. (P2)*

'As a woman you are not allowed to desire anything. You're trained not to need anything, because your needs are secondary or supposedly non-existent, and because there is anger when you have had needs...As a woman I didn't feel entitled to privilege or education. I felt I didn't deserve it...that I was there under false pretences. Women settle

for less'. (P3)

'If you don't have expectations as a woman it would be okay, yeah like don't have needs. An' if you do have needs well we won't call it needs, we'll call it pressuring men, being demanding and having expectations... I have seen how the person I am with will almost get into shaming me for being powerful or speaking my mind. You know I can say so much just as long as it's what they are comfortable with'. (P2)

6.2.3. The Sexualisation And Objectification Of Girls And Women's Bodies

A further key theme in women's narratives about being a girl involved their perception that the sexualisation of the female body was a factor in their abuse experience. The women told me that the construction of women as sex objects permeated their family and social context as they were growing up in the form of accepted attitudes and practices towards girls and women. Female identity was defined in terms of sexuality and desirability to men as sexual objects. Most of the women believed that these attitudes and practices were central reasons explaining why the sexual abuse occurred. The abuse occurred because their bodies were sexualised at a young age, their identities were solely defined in terms of their sexuality and gender, and because males' sense of sexual and social entitlement promoted disrespectful and objectifying opinions and habits in relation to women and their bodies.

'It [the sexual abuse] *happened because I had a girl's body and because men and boys have these attitudes. Like women, on the whole don't go and do these things to men because we know, number one, we can't, I mean physically, and number two because we just don't, we know it is not right... Like I won't go and see a male stripper because I don't want to see men used as sex objects. I'm not going to use them. It's just respect you know, I think it's just their lack of respect, they just don't give a shit enough'. (P1)*

'I felt like an object. Like an unimportant object. I was there for the use of others. You were only valuable for what you were doing. Not valuable as you are. Not valuable as you are but what you did for others'. (P10)

'Women are portrayed as sex objects, not as whole beings, and unfortunately women buy that, so it keeps feeding it, keeping it alive. So the focus is more on the external rather than on who they are'. (P3)

'Maybe it is just a habit for them. Not a habit but a taught habit.... passed on from generation to generation that they can do it...like being taught that that's our place and that's their place...It is just an attitude that has been around forever that women can be used as sex objects'. (P1)

Interestingly, while all the women agreed that the objectification of girls and women was a factor in female sexual abuse, one woman pointed out that she classified this as child sexual abuse in and of itself. For her, being exposed to such images and attitudes as a young child deeply affected her developing sense of her own body. From the age of 5 or 6 she came to believe that her body was a desirable and therefore dangerous object, capable of inciting men and provoking unpredictable and unwanted events.

'I remember when I was a really little kid, and I mean about 5 or something like that, 5 or 6. I can remember I had a cubby house down in the chook house. I had, there used to be a men's magazine called 'Esquire' in those days, sort of the equivalent of 'Playboy', and they'd have women in lingerie and centre-folds and I um had those pinned up in my cubby house...It was weird...It gave me a highly developed sense of the power of women's bodies or something like that...I think it is part of the abuse'. (P3)

6.2.4 'On Being A Boy': Over-Entitled And Under-Responsible

There was a shared perception among several women that males were more privileged, powerful and entitled than females. The social privileging of males meant that the abuse could occur in the first place, and that men could get away with it.

'...it seemed to me that they [boys] *had something, they had this something over women that they did not have to earn, something about them, an air about them, something that*

they had and you didn't. But they got adulation about it, whereas women didn't get that adulation. It wasn't, you did not see it on them, but they were, the way in which they were being greeted and treated was totally different'. (P7)

'Because physically we're just weaker than them. So they can just do it and get away with it'. (P1)

'Because men don't take enough accountability. Men will still go to strippers. Men will go see the strippers down at the bar. They do not have enough respect or understanding of what is actually going on. Like they fucking can sit there and I can tell someone that one in three women are sexually abused, and they will hear it but they don't feel it. Or they will ignore it... Like in Year 10 maybe or something at school we were talking about how girls have to be responsible because it's not a safe world for them. This male teacher is telling us that it's not a safe world for us and we have to be responsible and asking what initiatives we have to take to make ourselves safe. I think he must have been saying something like we shouldn't walk the streets, and I stood up and said 'how dare you say that, that it is up to us to take the initiative, don't stand here and teach that in front of boys, because it is their initiative...don't teach us, teach them ...So things like that make me really angry'. (P1)

'If it came down to it, if it happened in our family that someone had to be accountable or responsible for the offence or the repercussions of the incest, they made a choice of who it was going to be given to, you know. Well give it to the girl, you know'. (P5)

'The response I received from my family was nothing and he knew that...he knew, he just knew he could do it'. (P1)

And for another woman:

'I think for my brother his opinion of me was 'less than' and in a way who blames him? I mean why should he think different of me? Because if your mum, or your aunties or

everybody else, even your uncles treat their boys as better, and their girls basically like a slave, then why shouldn't he think like that? God, why should he have respect, why should he have respect for somebody when he has been seeing that? It might not be the obvious things like he's bashing someone or doing all that, but you're feeding somebody this sort of stuff, why shouldn't he do it?'(P8).

For all the women in the study, the experience of 'being a girl' was inextricably linked to their attributions about why they were sexually abused. At times, this belief was expressed as succinctly as 'I don't think it would have happened had I not had a female body' (P7). The sexual abuse happened to them because they were girls, where being a girl was constituted by a set of beliefs and practices that invited abuse. Not being valued, having to meet other's needs and disavow one's own, being objectified and sexualised, and not expecting that male offenders would take responsibility or undergo appropriate consequences for their behaviour, were all seen to constitute both the experience of being a girl and the experience of being abused. One was synonymous with the other.

'Being a girl' became a recurrent component of all the women's stories and led to two important understandings that became clear to me as I listened to and synthesised the meanings they offered. First and importantly, the experience of being a girl and having a female body mirrored or replicated all the women's experience of sexual abuse. Both experiences involved unequal access to power, the domination of one person's needs over another's, the sexualisation of the female body and the experience of being silenced or powerless. Second, when women's abuse experiences are understood to be so entwined with one's identity and embodiment as a female, then just having a female body becomes problematic and troublesome. This finding was most definitively validated by my study. Women's stories revealed a stunning array of complex and problematic meanings for and responses to their own bodies. All shared deeply ambiguous feelings about having a female body. And while there were differences in the expression of their feelings, they ranged from at best, ambivalent or confused feelings about being a woman to, at worst, a denial and rejection of femaleness and female embodiment. Even when women reported developing more positive relationships with their bodies as their healing and recovery

occurred, there remained ongoing, profound challenges and struggles with female embodiment.

6.3 Having A Girl's Body: 'It was this body that I had that was all wrong'

My participants articulated how 'being a girl' predisposed them to being sexually abused. The experience of being a girl was not one in which they felt valued, entitled, whole, or equal to others in terms of their sense of power and worth. 'Being a girl' and 'having a girl's body' was therefore in and of itself an experience about which they felt ambivalent, negative or angry. Being sexually abused compounded their feelings, and further and more deeply problematised having a girl's body, especially when female identity was so implicated in the experience of sexual abuse. To elucidate more clearly women's responses to female embodiment, I have classified them to reflect the key aspects that emerged from my analysis of their accounts: ambivalence and confusion, denial and rejection, vulnerability, and powerlessness and resignation.

6.3.1 Ambivalence And Confusion

'It's like two people maybe. Sometimes it's OK and other times it really comes up for me. It [the abuse] *could have made me angrier, it could make me sad and make me confused but at times I try to assert my femaleness rather than deny it... Yeah, or just things will never change. But like I said, it's like two people because sometimes I can feel ashamed of it* [my body]. *But if it's out with people and at school, things like that, or even in the pub, then it's the opposite'. (P1)*

For the young woman above having a female body is an ambiguous experience. At times she feels comfortable with her body, *'I want to have a female body, to not hide my female body'*, at other times she asserts her femaleness as if in an act of rebellion; *'Like I know it's happened to me* [sexual abuse] *but I'm not going to be ashamed of anything. I'm not going to walk down the street not in a short skirt and I'm not going to let someone tell me what to do with my body. It made me the opposite. Like I fight these things' (P1)*. Yet at

other times, (P1) struggles with an intensely problematic relationship with her body, self-harming because of intense feelings of anger, betrayal and discomfort she feels towards her body. Not only does she live an ambiguous relationship with her body but she creates a distinction between her private experience of her female body and her public expression of femaleness. Despite how problematic it is for her to live in a female body, she is adamant that this is the body she wants, not necessarily because she is comfortable with female embodiment, but as a rejection of the alternative. For her, male embodiment represented attributes associated with the male offender. 'No, I want it [a female body] because I don't want a male's'. (P1)

6.3.2 Denial And Rejection

A number of participants coped with the problem of female embodiment by developing beliefs and behaviours that invoked a denial or rejection of having a girl's body. They did so in response to feelings of anger, fear, conflict and powerlessness that were intrinsic to their experience of being embodied as a girl. The following quote is one of the most poignant examples in my study of the profound sense of despair associated with being a girl.

'I used to pray, when I was young I used to pray. Not pray, wish upon a star. Wish upon a star, the first star I used to see I used to wish that I was going to be a boy. Every night...I wished I was going to be a boy...and every morning I'd get up and my body had not changed. Oh no. So the next night I did the same. I did that for a long time'. (P7)

Cosentino, Heino, Meyer-Bahlburg, Alpert and Gaines's study (1993) uncovered a similar theme, finding that sexually abused girls experienced extreme unhappiness about being female and a strong desire to become a boy. Many of these girls rejected their female genitalia. In my study several participants who attempted to deny or reject their female embodiment also did so in response to anger at their bodies for having distressing, unexplainable and unpredictable sensations such as those felt when re-experiencing trauma symptoms, or in response to anger directed towards the body for betraying them,

for not acting to stop the abuse, or for experiencing sexually pleasurable feelings during the abuse.

Having girls' body meant being smaller and weaker and therefore subject to being overpowered by others. For all the women in this study, perpetrators were male and were typically fathers, stepfathers, grandfathers or older siblings, and therefore older and bigger, with the physical capacity to overpower. Yet, while women experienced themselves as smaller, weaker and not able to counter-act when the sexual abuse occurred, reporting that the abuse had occurred because 'I was physically weaker', 'I was a lot smaller than he was', and because 'he was bigger', they later report anger at themselves for 'not acting', 'for not stopping the abuse', 'for not screaming or shouting', 'for letting him do it', for not saying 'No', or for responding sexually 'when I did not want to'. Their statements imply that they had the power to resist or rebel in the context of the abuse, but did not enact it.

'But Yeah, other times I'd get angry at my body. Yeah, maybe I got, sometimes I would get angry at my body for not reacting the way I wanted it to react when it happened... Sometimes just anger. I'm angry with it'. (P1)

Other women felt anger at their bodies for just having needs:

'I've used food as a way of trying to shut up all sorts of needs, so um, and I've eaten and hurt myself eating, and I could feel it hurting...Overeating was kind of like trying to shut myself up or something. It was um, it was savage. It was a kind of er you know 'oh for God's sake, 'have that' you know and 'be quiet'...Um, oh I'd just say that I'm afraid of needing anything, because needing anything's such a dangerous thing. It's so, because you are trained to, because your needs are secondary or supposedly nonexistent, and because there's been anger when you've had needs, you get angry with yourself for having them'. (P3)

Women also sought to deny or reject their bodies out of fear, believing that their bodies were dangerous or ugly, and articulating that to be embodied as a female was incitement to attack or intrusion.

'...you're being told all the time one way or another that female bodies have meaning that is independent of the intent that you have, then you learn that you're helpless and you learn to vacate your body. And you must do that to live. I mean you must do that because if your body can bring a whole world undone and the most powerful people in the world, if it can undermine them as the most powerful people in the world, regardless of what you intended, then you have to kind of separate yourself from it [your body] *in order to keep breathing at all'. (P3)*

'...out of my sexual abuse...I would say that um my father's fear of me, my father's horror of my body, my father's sense of the power of my body was the um overwhelming experience, and was experienced as the most pervasive and abusive. As a child, I was told I was so powerful, and that my power had such a capacity to bring everything undone, including my family or anything...it's like I could occupy anything and I could disrupt any thing and I was in control of the world sort of thing, because of my girl's body...Um, so for me, I've been so frightened of my body and my power'. (P3)

'Yeah, not feeling safe to feel female. I'm still learning to be safe as a female'. (P2)

For other women in the study the rejection of female embodiment was associated with their perception that to be a male was preferable, not because they wanted male bodies, but because women wanted to have the power they associated with maleness. Power, status and value were all absent from participants' experiences of femaleness.

'Well not wanting to be a girl was not just about that, but you as a female had to take the bottom position'. (P7)

Although women desired power men were perceived to hold, they were simultaneously repulsed by its association with male bodies. For these women, to have male power and a subsequent increase in status and value and to have one's needs attended to was desirable, but to have a male's body was frightening and repulsive, as it represented the body of the perpetrator.

' I want to be a female rather than a male. I don't want a male's body, that's for sure. I'd really like to have the power that a male has'. (P1)

Other women were angered by the apparent power differentials between women and men and by what they saw to be the consequences of male entitlement and irresponsibility, namely disrespectful and objectifying attitudes and abusive behaviours towards women. They rejected the idea that it was preferable to be a male, for 'being a boy' implied replicating objectifying and disrespectful beliefs and behaviours, and involved offending against others.

'What happened at high school was that the teacher asked a question, we were studying a book by D. H. Lawrence, she asked if we had a choice of sex, if we wanted to be a boy or wanted to be a girl. All the girls put up their hands and said they wanted to be a boy except for me. I wanted to be a girl...I didn't want to be aggressive. I did not want to be the aggressor'. (P1)

For this woman, being a girl was not satisfactory either, so she attempted a solution that provided a kind of comforting intellectual if not practical resolution. If she could just be 'human' then she could be degendered and resolve the complex and contradictory claims that her sexuality or an alternative sexuality made upon her.

'But it was hard because being a girl meant be a nothing, being less than anybody else, so I evolved this kind of philosophy, I guess, with a girlfriend of mine ...that there weren't any genders in Heaven, so why should there be any here and you know we are all just human beings and that's the important thing and let's just be the best human being we

can... It was just something I would say'. (P5))

6.3.3 Vulnerability And Disempowerment

Sadly but understandably, many women believed that having a female body automatically conferred vulnerability and disempowerment.

'Obviously I'm conscious of having a female body. I know it makes me a target maybe. Do you know what I mean? I always think it is going to happen again, right. I don't know. And I know it's because I am a girl'. (P1)

'It happens because we are just physically weaker than them'. (P1)

'And I wish myself that I had brothers to defend me and stick up for me. Like I can't do it myself. But I never had them'. (P5)

'All I remember is that I didn't want to be a female because it was just abuse. If it wasn't sexual abuse it was verbal abuse. If it wasn't verbal abuse it was physical abuse. Some sort of abuse. Nowhere that I could see any body or anybody's family that didn't seem to be any different'. (P7)

For others having a girl's body and having a vagina made one more vulnerable to physical intrusion, and to the disempowerment and inequality conferred by childbirth and motherhood.

'...having a vagina, it's like, ... some other human being inserting a piece of them into you is like oh, no, this is just no, ...To me when I saw my brother do that to my sister, I was traumatised I thought 'well my God'...it's impossible to let somebody else put a piece of themselves inside of you and not go away and not be traumatised in some way...and then we have to have the babies. Not fair. All this and then you know to be abused for that you know. This is who you are; you know the nurturer and the mother and

the baby, the sex that has the baby, all of these things. Then on top of that there's all of this abuse that goes with it'. (P7)

6.3.4 Resignation Or Resistance?

All the women interviewed held the unshakeable belief that having a female body was inevitably associated with experiences of victimisation and abuse. Their powerful perception of the inescapability of abuse when embodied as a girl left several women with attitudes of resignation and acceptance.

'Like if you've got a girl's body it's most probably going to happen to you...If you are a girl it is just common I think'. (P1)

'For a girl just, oh well, that's the way of the world, it's like you just accept it...like I don't accept it but other people do'. (P1)

'Women's bodies are just sex objects'. (P5)

'Just not in control you know, nothing you could do. I probably could have done something, like I probably could have yelled. But I knew the consequences of it. Like I know the second time I knew the consequences of yelling out would be worse than having to put up with it...I know I could have kicked and yelled and screamed, but I knew that the response from everyone else would be worse than putting up with it'. (P1)

Participants used various strategies to resist the fear and disempowerment associated with having a girl's body. Their attempted solutions included challenging female stereotypes and acting more like a boy, enjoying clothes, make up and the trappings of femininity, and challenging impulses to hide the body, by trying to feel safe and comfortable embracing female embodiment. However, despite occasions of resistance and rebellion, women's stories were dominated by extreme, complicated, problematic and long-standing struggles with their bodies, that stemmed from the difficulties of having a female body

and continuing to live in a body that had been violated.

The absence of positive beliefs and attitudes towards having a female body is stark, with only one women (P1) articulating that she liked her body, enjoyed wearing clothes and was able mostly, to feel comfortable with her femaleness. Interestingly, however, she perceived this behaviour as a form of rebelliousness against the confines of femaleness, and as a reaction against feelings of discomfort and powerlessness. She says, *'It* [the abuse] *could have made me angrier, it could make me sad and make me confused but at times I try to assert my femaleness rather than deny it. ...Yeah, or just things will never change... But like I said, it's like two people'.* (P1). She also reported continuing to experience periods of time in which she had an intensely problematic relationship with her body, being troubled by vivid re-experiencing of bodily sensations reminiscent of the abuse and consequent self-harming.

While recovery stories illustrate women experiencing a more positive sense of self, this was more likely to be tied to a sense of bodily integration than to an increased level of comfort with being a woman and having a female body. For most, being a woman and having a female body remained problematic, and a source of discomfort even though they may have significantly progressed towards recovery from their childhood sexual abuse.

6.4 'Gender Related Conflicts'

Some of the difficulties I describe above have been revealed in previous research studies where they are conceptualised as problems of 'gender identity' in child victims (Herman 1981; Zucker and Kukis, 1990; Aoisa-Karpes, Karpas, Pelcovitz, and Kaplan, 1991; Green, 1991; Cosentino, 1993). Cosentino (1993), in particular, found that sexually abused girls manifest relatively intense feelings of conflict and ambivalence regarding their gender identity and expected social role as girls. In comparison, intense unhappiness about being girls was rarely noted in comparison groups of nonabused girls. He suggests that gender related conflicts might be related to sexually abused girls' experiences of abuse and their association of femininity with a vulnerability to victimisation. The above

studies have also shown an increased likelihood of female victims identifying with more masculine role behavior, and engaging in age inappropriate sexual behavior and heightened sexual aggressiveness. Herman (1981) concluded that women and women's roles were often devalued among incest survivors, whereas men and male roles were idealised. The above authors have speculated that some female's identification with the aggressor or male roles may allow for the denial of traumatic victim roles to help defend against the feelings of vulnerability and helplessness associated with abuse. Masculine gender identification also may be related to feelings of maternal abandonment and ambivalence regarding relationships with mothers, who may have been viewed as weak, powerless and unable to be protective.[68] Gender identity problems have had a tendency to be missed or overlooked in evaluation and treatment despite findings indicating their particular relevance for children. Research and clinical observations suggest that these problems may persist into adolescence and adulthood and impede interpersonal and psychosocial functioning (Eisnitz, 1984-85). While the issue of gender identity has been under acknowledged in clinical research, studies that do exist are limited by their failure to analyse the relationship between gender identity and embodiment, or the possible relationship between victims' problems of embodiment and the sexed nature of their bodies. Instead they attend to the behavioural consequences of apparently problematic psychological constructions of gender. My study indicates however, that female adults who have been victimised as children exhibit serious and chronic problems of embodiment that, in part, relate to the negative associations attributed to being female.

6.5 Female Embodiment As An Existential Dilemma

In the context of personal experiences participants associated with being a girl and the social meanings perceived to be ascribed to girls and women, having a female body constituted the primary problem of embodiment for all the women in the study. Not surprisingly, the inescapable nature of female embodiment when contrasted with

[68] The role of the mother in child sexual abuse has been a contested issue in the clinical literature. Excellent reviews of the way in which mothers have been portrayed in the literature (commonly as 'dysfunctional', 'collusive', 'unprotective', or as 'helpless victims of patriarchy') have been undertaken by Wattenberg (1985); Humphreys (1990); Elbow & Mayfield (1991). A recent study by Dwyer (1999) examines the

women's need to escape from their bodies posed an irreconcilable existential dilemma. Two fundamental quandaries feature in their stories. First, when femaleness and female bodies are principally associated with sexuality, it is very risky for women who have already been sexually abused to claim any semblance of a female body or female sexuality. At the same time, how can they escape the material reality of their female embodiment? Second, a female body is, according to the dominant social scripts that inform women's reality in Australia, desirable but not desirable, powerful yet powerless, innocent and pure yet dangerous and seductive; it can be controlled by others but also overrides men who are bigger and stronger and older. Such contradictions and conflicting prescriptions embedded in social discourses on the female body and femininity are understood as 'real' descriptions of female nature rather than as dominant social constructions. Moreover, they powerfully construct female sexuality so it is perceived primarily in dualistic terms, as either passive and submissive or active and all-powerful. Both are dangerous positions for women who have been sexually abused. For how does one embrace female embodiment when the dominant social constructions of femaleness, female bodies and femininity lead to psychic, social and corporeal danger?

6.6 Negotiating With 'Ideology': Practical And Discursive Consciousness

It was abundantly clear that participants' perceptions of themselves and their bodies, and their understandings of their past sexual abuse and the current conditions of their lives, were inextricably tied to sociocultural discourses on the female body and femininity. It was also clear from their stories that such social discourses are particularly pervasive, informing, shaping and creating not only the meanings ascribed to femaleness and female bodies, but also structuring and constituting women's behaviour, practices and actions. It seems reasonable therefore to ask how it is that women engage with these discourses and why it is that they are so pervasive in their influence? [69]

---

connection between mothers' abuse history and the sexual abuse of their children.

[69] Earlier in my thesis, I outlined my epistemological preference for the term 'discourse' (SeeChapter three). However, I use the word 'ideology' in this section to be consistent with the terms that Giddens applies in articulating his 'theory of structuration', a theory which I argue, provides some useful concepts for understanding women's relationships and negotiaions with social discourses.

Giddens (in Cassell, 1993) 'theory of structuration' is potentially useful in responding to these questions.[70] Giddens posits that people are competent actors in their world and that their actions are based on 'knowledgeability'. 'Knowledgeability' refers to 'all those things that members of society know about that society and the conditions of their activity within it' (Giddens, 1982:9). 'Knowledgeability' refers not only to conscious knowledge, but also to 'tacit' knowledge; the knowledge that people possess that makes it possible for them to engage in and with society. As such, 'knowledgeability' can be seen to be constituted by 'discursive consciousness' and 'practical consciousness'. 'Discursive consciousness' is the level of knowledge that can be verbalised and articulated, while 'practical consciousness' is 'on the fringe of consciousness' more implicit than explicit, and including thoughts and activities constituted by context rather than language. Giddens contends that knowledge incorporated into social practices is both practical and discursive and that there is a 'fluctuating and permeable' relationship between the two (Giddens, 1993:91).

These ideas hold potential for explaining participants' engagement with social ideologies on the female body and femininity. Conceptualising women's knowledge as comprised in discursive and practical consciousness also sheds light on why such ideologies exert such a powerful and pervasiveness influence in women's lives. Their 'knowledge' is constituted by the discursive scripts of femaleness and femininity and by life long experiences of unspoken rules, values, beliefs and practices associated with being a girl and having a female body. As such 'being a girl' is both an embedded and embodied experience, embedded in social scripts of femininity and embodied in specific practices and enactments. The stories detailed above show that women were indeed influenced by both articulated and unarticulated practices that informed their knowledge of what it was to be a girl in Australian society. I argue that participants drew on their knowledge about femaleness, femininity, female bodies and female sexuality as it was inextricably linked to their sexual abuse and that their implicit (embodied) and explicit (embedded) knowledge of what it was to be a girl/woman and to be sexually abused then guided their actions, behaviour and practices in relation to their own bodies.

---

[70] I am indebted to my colleague, Dr Jennny Dwyer for drawing my attention to Gidden's theory.

6.7 Problems Of Embodiment As 'Attempted Solutions'

It is not surprising that the key existential question faced by victims in my study; how is one to live in and with a female body after sexual abuse? - led the women to the site of the body. That this existential dilemma *of* the body is enacted in profound struggles *with* the body is a poignant demonstration of the significance of victims' bodies to sexual abuse and its consequences. It is also testament to the absolute centrality of the sexed body to women's experience of childhood sexual abuse and to the ongoing struggles with embodiment they subsequently experience. In the light of women's accounts I have come to conceptualise their problems of embodiment after sexual abuse as 'attempted solutions' to the existential dilemmas raised by female embodiment, and such dilemmas as being constituted by women's ongoing interactions and negotiations with social discourses on the female body and femininity which they united with sexual abuse.

Many of their problems of embodiment represented 'attempted solutions' to the seemingly irreconcilable dilemmas inherent in female embodiment after violation. A pertinent example is offered by one of the participants,

'I always thought I wanted to look good. So it's quite confusing for me. Because there is one aspect where I just adore clothes and looking good. I love that side of it. I love when people do it. I think it is really fun. It's great expression. So I don't really understand myself why there was one part of me that was all into that stuff, but then I had this need to be ugly...After having my first kiss I distinctively remember taking off my nail polish and cutting my nails...I felt disgusting and dirty and I just didn't like myself'. (P2)

The young woman cited above developed anorexia then bulimia, and following long periods of extreme fluctuations in her weight, agoraphobia and crippling depression. She described her symptoms as a 'battle'. One part of her wanted to be thin and therefore attractive and desirable because that is how women are supposed to be. She believed she would then feel good enough, valued, loved, desirable and happy. In response to her perceptions she became dangerously thin. Another part of her felt extremely fearful and

vulnerable about the 'requirements' of being female because having that kind of body was dangerous, making her vulnerable to further sexual victimisation. Her perceptions about being a female and what it meant to have a female body were in constant and irresolvable conflict over many years and were reflected in serious and chronic symptoms of the body.

Numerous participants reported similar struggles with female embodiment and utilised a range of bodily strategies in their attempts to resolve the 'problem of embodiment'.[71] Their accounts demonstrate that 'the experience of trauma calls into question our relation to 'having a body' and 'living in a body' and makes profoundly troubling the centrality of the body in human existence and the body's claims upon us' (Young, 1992: 92). Nonetheless, the serious and lasting body symptoms and problems of embodiment suffered as a consequence of childhood sexual abuse have not been thoroughly examined in the clinical literature.

6.8 Absent Bodies or Human Bodies

Instead the models that have been applied to child sexual abuse impact (and which continue to proliferate) have been etiological models (including trauma models) that have emphasised psychological issues, physiological dysfunction, perceptual and cognitive disturbance. Recent literature from the trauma field has redirected, to some extent, attention from the psychological impact of child sexual abuse to the bodily impact of abuse. It has done so by showing the numerous and significant biophysiological changes occasioned by exposure to trauma. Such studies have expanded our understanding of the experience of trauma victims by attending to the body, by drawing attention to the powerful ways in which the bodily reactions to trauma affect behaviour and functioning, and by identifying body symptoms associated with trauma. However, they have arguably reduced the body to its physiological operations, foreclosing a broader analysis. Young (1992) in contrast, acknowledges the physiological and psychological symptoms

[71] I elaborate the relationship between victim's problems of embodiment and their intersection with social discourses on the female body in Chapter seven (pp.197-230).

associated with trauma and examines the meanings attached to bodily disorders and problems of embodiment. In her analysis, the body is more than mere biological object. Its' reactions and responses inform and shape survivors' sense of self. Problems of embodiment therefore reflect struggles with personal identity resulting from the trauma of sexual abuse. Attending to the personal meanings ascribed to the body adds the dimension of subjectivity to the analysis, giving a phenomenological coherence to problems of embodiment that is unexplained by purely biologistic conceptions of the body. I have employed this distinction in my work, believing that trauma theories usefully acknowledge and explain what may be referred to as 'body symptoms', but do not adequately admit or theorise 'problems of embodiment'. To do justice to the experience of women in my study both conceptual frames were necessary.

Young (1992) is one of the few writers to focus specifically on the body of victims and to theorise about the personal meanings attached to the body violated by sexual abuse. However, while her analysis of the links between embodiment and identity is central to how I came to understand the experiences of the women I interviewed, two limitations to her analysis emerged from the stories of the women in my study. First, Young (1992) refers to and analyses the symptoms and disorders of embodiment as difficulties with living comfortably in the 'human body'. The body is discussed as if it were a neutral or non-sexed body, as if the sexed nature of the body, its' maleness or femaleness, were seemingly irrelevant to personal identity. In my study, women's attributions about the sexual abuse, the consequent problems of embodiment they suffered as a result of the abuse, and the ongoing struggles with their sense of themselves in the aftermath of their abuse, were fundamentally connected to the sexed (female) nature of the body. Second, while the individual and personal meanings attributed to the body and to embodied experience following the violation of sexual abuse were central in women's experiences, so too were the social and cultural meanings about female embodiment. For the women in my study, social beliefs and perceptions about the female body were deeply implicated in their problems of embodiment and dilemmas around identity. So intrinsic were social beliefs and perceptions they were inseparable from the personal meanings women constructed from their particular individual experiences of trauma. Women's experience

of embodiment and identity in the aftermath of childhood sexual abuse was inextricably tied to 'having' and 'living in' a female body.

Despite this finding, analyses of the construction of sex and gender and other social factors in current child abuse discourses are, at best, shallow and unsystematic. I assert that even feminist discourses on sexual violence against women and children that apply a gender analysis have been largely aimed at explaining causes and there has been an absence of any theoretical focus on the sexed body applied to the consequences of abuse. As a result, not only has the body of victims been mostly overlooked in discussions of sexual abuse impact, but also any conceptualisations or interpretations of problems of embodiment for survivors of sexual abuse have ignored a consideration of the sexed nature of victims' bodies. Victims' accounts, in contrast, show that individual embodied experience could not be separated from the personal and social context in which it is constructed.

6.9 Recognising The Sexed Body

I challenge descriptions of body symptoms and problems of embodiment currently held by theorists in the field on the basis that they consistently lack one crucial element: recognition of the significance of the sexed nature of victims' bodies. Recent feminist theorising has called attention to the sexed body, arguing that different kinds of bodies give rise to different perceptions and actions (Young, 1989), to different kinds of metaphors and different understandings of the body. Race and ethnicity, youth and age, masculinity and femininity mark the body and its modalities, and shape how others perceive it. In turn, they determine our subjectivity: the ways we come to know the world. In her essay, '*Throwing like a girl*', Young (1989) writes about differences in feminine bodily comportment, motility and spatiality, while Moira Gatens (1983) stresses that the body is never neutral, contending,

> There are at least two kinds of bodies; the male body and the female body...The very same behaviours (whether they be masculine or feminine) have quite different personal and social significances when acted out by the male subject on the one hand, and the female subject on the other. (1983: 148)

My findings support her contention. My participants' stories vividly illustrate that having a female body and negotiating how to live in and with a female body in Australian culture was inextricably tied to their problems of embodiment. Their body problems were not just struggles with embodiment but struggles with female embodiment. They revealed attempts to resist, disown, deny, ignore, manage, punish, escape or accommodate the female body. They also revealed the contradictions inherent in social scripts of femininity. Their problems of embodiment could also be conceptualised as constituting symbolic enactments of these compulsions and contradictions. Women's bodies and body problems were unmistakably replete with deeply inscribed social significance and meaning.

Young (1992), in the only article I located in the clinical literature that addressed problems of embodiment for sexual abuse survivors asserts,

> It is the problematic area of embodiment which is so often minimised and overlooked in discussions of sexual abuse and trauma. And yet it is undeniable that severe trauma is inscribed in and often on the bodies of survivors, leaving a mark that can perhaps be explained but never effaced. (1992: 91)

Unlike many trauma theorists who limit their analysis of body problems to a biophysiological examination, Young (1992) extends the analysis, attending to the subjective meanings that can be attached to the body that has been traumatised by sexual abuse. She thoughtfully explores multiple meanings that are embedded in a range of problems of embodiment suffered by victims. While exploring the phenomenological coherence of symptoms of the body, Young's analysis, like that of other trauma theorists, rests on a notion of the body as neutral. A distinction is not made between the body of

male victims and that of female victims. The traumatised body is therefore not a sexed body, and by implication, the traumatic consequences of sexual violation are felt, experienced, expressed, enacted and rendered meaningful in the same way by male and female bodies. In contrast, my conceptualisation of victims' problems of embodiment as inextricably linked to social discourses on the female body and femininity, and as reflective of 'existential dilemmas' constituted by their ongoing interactions and negotiations with these discourses, positions the sexed body at the forefront of analysis.

6.10 Summary

For all the women in my study, conceptions about 'being a girl' and 'having a girl's body' were central to their attributions about the sexual abuse, making female embodiment itself the core problem of embodiment. Beliefs about their own bodies could not be separated from their sexual abuse experiences, which were enactments of these social meanings, or from the implicit and explicit knowledge of broader social discourses which shaped, defined and constructed their bodies as immediately as did their own individual experiences. In this chapter I have examined 'the female body' and its meanings for victims, as it was a prominent theme in their stories. In the next chapter I demonstrate the ways in which society is inscribed on the body of victims and in their problems of embodiment.

CHAPTER SEVEN

'JUST FEARFUL AND ASHAMED': THE DANGEROUS AND USED BODY

'I've never had the feeling of being safe to feel female, I'm still learning to be safe as a female, instead of just fearful and ashamed of my body'. (P2)

7.1 Introduction

In this chapter I present two key themes that further illustrate the significance of the sexed body to sexual abuse and which constitute striking examples of two dominant social discourses on femininity encapsulated in women's problems of embodiment. I have described the themes as 'the dangerous body' and 'the used body'. While they are examined here as separate themes, they both converge in and extend the broader theme of the 'female body' discussed in the previous chapter. In presenting these themes I show that the sexually violated body is not, as implied by much child sexual abuse discourse, a neutral or unsexed, ungendered body. Nor are the body symptoms experienced by women solely reflective of an object body, responding to the immediate and longer-term biophysiological changes occasioned by trauma. Rather, victims' bodies and the nature of their symptoms are unmistakably sexed and gendered, inextricably tied to social meanings about sexed identity. Hence, I argue that the body needs to be appreciated as a social entity, inscribed with and constituted by a myriad of cultural meanings, and that problems of embodiment suffered as a consequence of sexual abuse cannot be understood in isolation from the context which confers meaning upon them.

In this chapter I also examine the process through which social discourses on the female body become enacted in victim's problems of embodiment. Before doing so, I present the two themes that emerged from women's stories to illustrate women internalisations of socially dominant discourses on female bodies.[72] Interestingly, and appearing purely by chance, they reflect each side of dualist representations of female sexuality. The

[72] See p.168 where I mention the scripts of femininity evidenced in women's accounts. A more detailed analysis of this issue is provided on pp.189-190 and on pp.223-229.

'dangerous body' speaks of female sexuality in terms of power, seduction and desire, while the 'used body' characterises women's sexuality in terms of passivity, docility and submission.

7.2 The Dangerous Body

In all the women's accounts there was a common perception of their bodies as dangerous. Having a 'dangerous body' arose from and encapsulated two central experiences. Danger stemmed from personal embodied experience, in which the feelings and activities of the body were accompanied by suspicion, fear and loathing. Traumatic and unpredictable bodily reactions that included anxiety, re-experiencing, pain, intrusive thoughts and images, numbing, and bodily distortion or fragmentation were at best disquieting and, at worst, terrifying. These sensations, feelings and activities of the body all contributed to women's perception and consequent construction of their bodies as dangerous. In response, women employed a range of strategies to assist them to live a body that was dangerous, using dissociation, numbing, somatisation and self-harming as strategies to negotiate disturbing bodily symptoms.[73]

While the experiences and meanings participants associated with traumatic bodily reactions were significant to attributions of danger ascribed to their bodies, my interest in this chapter is in another critical dimension of women's experience of their bodies as dangerous.[74] Danger also stemmed from the social meanings attached to female embodiment. For victims, it was dangerous to have a female body because of how that body was constructed, positioned, imbued with meaning and acted upon in the social context. To have a female body in Australian culture was, for the victims in my study, to be both in danger and dangerous.

---

[73] Several trauma theorists have described the way in which traumatic bodily reactions are unnerving for victims and have identified strategies traumatised individuals use to regulate unwanted sensation and affect (Calof, 1995, Part 1, 1995, Part 2, 1997; van der Kolk et al. 1996). See Chapter five (pp.116-167).

[74] I have examined traumatic bodily reactions and their meanings for victims in detail in Chapter five. In this chapter, I focus on the social meanings of female bodies in order to explore the way in which such discourses inform the problems of embodiment exhibited by female victims.

7.2.2 Social Meanings of Female Embodiment: In Danger And Dangerous

To have and live in a female body was dangerous because participants perceived that in Australian culture, female embodiment conferred powerlessness and vulnerability to sexual objectification and sexual attack. The social position of women, their unequal status and value, and the meanings ascribed to femininity contributed to the danger associated with female embodiment. Several participants believed that being a 'female' was to be physically weaker, less powerful, undervalued and consequently, at risk of harm at the hands of others. Having unequal power as a female meant increased vulnerability to attack, abuse or harm from others; it meant being in danger.

'...being a girl meant you were vulnerable to that sort of physical intrusion. That was going to happen. That's what was going to be happening to me. I think oh my God, you know'. (P7)

'Yeah, not ever feeling safe to feel female. I'm still learning to be safe as a female'. (P2)

While being embodied as a female in the Australian cultural context meant, in victims' eyes, being vulnerable and powerless, female embodiment as it was constructed in the Australian cultural context also involved possessing physical characteristics of femaleness and feminine sexuality that bestowed power. Female bodies and female sexuality were also endowed with an immense power. This alternative construction of female bodies was evident in women's practical and discursive consciousness of historical scripts of femininity and reinforced by contemporary images and representations of women that abound in Australian society. Yet, paradoxically for participants, power, like powerlessness, also invited the possibility of danger, violence and abuse because female power could incite, seduce, control and overpower men.

'I was terrified about having a female body. It terrified me because there was times when there was power. Huge amounts of power. I didn't know what to do with that...Oh no. I didn't know what to do and I didn't want that power'. (P3)

'Being female was having a dangerous body that could wreak havoc on all the men around and God knows what... '(P2)

'Oh yes, on yeah. Very ugly and very dangerous...every little bit of me was a kind of inducement to some kind of [sexual] *attack'. As a child I learned that women's bodies are enormously powerful, enormously dangerous. Female flesh. Not just women's bodies but female flesh. That they torment men. That anything happens, anything that men are provoked into doing, it's because we've desired it...I mean, even little children can bring powerful men undone'. (P3)*

Women's accounts of the 'dangerous body' reveal a stark polarisation in regard to power. Either all the power was located in male bodies, in which case women needed to be constantly alert to risk and to engage in activities to hide or conceal the female body. Their bodies were powerless in the face of the threat of danger from others. Or, all the power existed in female bodies, which had the capacity to disarm and disempower those even stronger than themselves. So while most of the participants reported feeling in danger and at risk from men, most of them also came to believe, with even greater vehemence, that it was their bodies that were dangerous. Rather than identifying and focusing on the male body as the dangerous body, and thus locating the danger outside the self, women believed that it was the female body itself that was dangerous. Overlooking the danger that could be enacted by male bodies and locating all the danger in their own bodies, more often than not, women saw their bodies as dangerous, as somehow inviting attack or abuse, as inciting powerful and uncontrollable feelings in men. As such, female bodies came to embody both the sources of the danger and the responsibility for the danger.

7.3 The Relationship Between Experience And Meaning

The perception of their bodies as powerful or powerless (and in either case, dangerous), emanated from two main sources. First, women internalised beliefs derived from the dynamics of the sexual abuse and from the words and actions of the perpetrator. The

attribution of meaning to their body in the context of the abuse events was a complex process. While the abuse events could lead women to a view of their body as powerless, which later translated to the pervasive sense of female embodiment making one 'in danger', several women also believed that their body's had initiated, failed to stop, invited or encouraged the abuse. This view led women to construct their female body as 'dangerous', as having a will and influence independent of them. In either case, responsibility for the abuse was attached to female embodiment, to their body's actions or lack of them.[75]

Second, perceptions of their body as dangerous resulted from participants' practical and discursive consciousness of social ideologies relating to the female body. Women's knowledge of historical scripts of femininity were reinforced by contemporary images and representations of women which objectified and sexualised women's bodies while coupling female sexuality with both purity and danger. Women engaged in constant negotiations with these social scripts, and when paired with early (and frequently ongoing) sexualisation and objectification, meant they often constructed their own body's as powerful enough to undermine or overwhelm men, (whose own sexuality was not subject to their control). Representations of femaleness, femininity and sexuality in broader society served to intensify their perceptions about the danger of women's bodies.[76] Informants therefore struggled, not with the powerlessness of their bodies, but instead, with their powerfulness. Interestingly, while women's stories reveal constructions of their body as powerful or powerless, their perceptions were not fixed. Rather, their attributions shifted, moving from one to the other or existing both at the same time.[77]

---

[75] I examine the process by which women internalised communications from the perpetrator on pp.224-225.

[76] I have attended to the process by which women are receptive to societal constructions of the female body in my earlier discussion of 'practical' and 'discursive consciousness'. See Chapter six (pp.189-190), I refer to the process again in the latter part of this chapter. See pp.223-224.

[77] Although it is beyond the scope of this thesis to expound in detail upon the factors were influential in this process, my preliminary analysis reveals that time, the presence or absence of trauma symptoms, relationships with significant others and engagement in therapy were of importance. See Chapter nine for a fuller examination of these themes.

7.4 The Relationship Between Experience, Meaning And Embodiment

It was clear from women's stories that attributing meaning to their body was a complex process, incorporating aspects of embodied experience, feeling and sensation, the interpretations of such bodily activities, and knowledge based on practical and discursive consciousness relating to social ideologies on the female body and femininity. Meaning was therefore derived from both the embodied (implicit, 'practical', interpersonal, unspoken, enacted), and embedded (explicit, 'discursive', contextual, social, spoken), nature of experience. Each of these aspects constituted women's knowledge of the body. For participants, this knowledge converged in a pervasive sense of their body as dangerous. Their accounts demonstrated a personal experience of the body as dangerous, (their personal reality), and a social experience of the body as dangerous (the social significance of female bodies). Not surprisingly, women were confronted by the compelling and inescapable problem of female embodiment.

'I blamed the fact that I was female on all of these instances happening. Now I figured that because I was a female and because we had the internal organs and outside parts of a female, well, that's what was going to happen and it was because of that. Because I was a female. And it was because my body was the way it was, that that happened. Not because of me the person. No, it was this body that I had that was all wrong'. (P7)

7.5 Problems of Embodiment as 'Attempted Solutions'

Women's accounts revealed that *multiple* problems of embodiment arose in response to the *singular* problem of female embodiment. These problems of embodiment reflected participants' efforts to resolve the dilemmas occasioned by female embodiment. When women perceived and constructed their female body as dangerous, they employed a range of strategies that were undeniably attempts at creating safety. The solutions to being 'in danger' involved attempts to conceal, hide or leave their body. When they constructed their body as 'dangerous', in addition to efforts to disguise their bodies, they sought to control, harm and punish their body. Self-mutilation, self-abuse and neglectful self-care

made participants feel sexually unattractive and thus safer from sexual assault, but also functioned to control and punish bodies that would wreak danger and mayhem. Eating disorders, self-injurious behaviours, bodily denial and rigorous strivings for bodily mastery reflected and symbolised psychological dilemmas about how to live safely and comfortably in a dangerous female body. Embodiment after violation was so deeply problematic that it mostly involved survivors inflicting harm on their body with their own hands, and ironically, constituting a body that was more dangerous to themselves.[78]

7.5.1 Solutions To Being 'In Danger'

To protect themselves from danger and to establish some vestiges of control, various women went to great lengths to hide, disguise, distort or disfigure their female body. Strategies for self-protection included overeating and/or undereating to disguise the body and diminish female attributes, wearing layers of clothing or excessively large clothes to conceal the body, and rejecting rituals and practices associated with femininity so as to reduce sexual attractiveness and desirability.[79]

'Oh, it was a way to protect myself I think well, overeating, you know being really quite overweight. It was a way for me to, where I felt ugly anyway. So it was a manifestation of that, but it also carried the belief that if I make myself ugly it will protect me. Yeah, I'd be safe because then I'm not part of the cultural picture of what a women should look like'. (P3)

'I have always worn layers of clothing to protect myself. I would dread the heat of summer and always cover up my body, even if I was at the point of dying in the heat'.

---

[78] While I attend to some of these problems of embodiment in this chapter, those associated with self-harm are discussed in more detail in the following chapter. Also, having previously made an artificial distinction between body symptoms (trauma-related and biophysiological) and problems of embodiment, (sociocultural struggles with embodiment), I limit my discussion of body symptoms in this chapter and refer the reader back to Chapter five, and focus here on the social dimensions of participants' body problems.

[79] Negotiations with social discourses and practices of femininity had taught participants that desirability, attractiveness and value as a female was associated principally with the female body and sexuality, and that complying with the regimes of femininity would confer such desirabilty. To not do so was to be sexually

(P10)

'One part of me wanted to be constantly hiding because any bumps coming out anywhere, no I didn't want anybody to notice that. Bumps, breasts, hips. Anything like that. Any feminine sort of bumps happening. Straight down tent you know. Using a jumper as a tent. It was always hiding. Yeah always everything was a thousand miles from here' [indicates body]. *(P7)*

One woman succinctly described the conflicts inherent in female embodiment, articulating her need to conceal her femaleness to protect herself from physical attack and intrusion and her profound discomfort with the cultural expectations of women's bodies. The requirements of feminine posture, movement, dress and practice were all problematic, reflecting ideas about female identity and associated behaviours that she needed to resist to feel safe. Her resistance to 'doing woman' had made female identity and embodiment confusing and dubious.

'I was disguising my femaleness. Yeah that so that I wasn't noticed, because I was too awkward. I disguised my femaleness for so long I didn't know how to be a female. How to put a dress on. And I'd think oh my God but I can't sit with my legs open because it's not what you're supposed to do. But it feels so squashed when they're together. Then I'd have to have this particular way about me and I'd have to copy something that I remembered how women used to be. I didn't have a clue. I'd think oh my God, this is rotten you know'. (P7)

7.5.2 Solutions to Being 'Dangerous'

Just as women developed a range of bodily solutions to deal with being 'in danger', which often involved harm, neglect, damage and danger to their own body, women coped with the perceived 'dangerousness' of their own female body in similar ways. Having a powerful female body, as both a child and a woman was experienced as extremely

---

unattractive, undesirable, and therefore safe.

dangerous and frightening. One solution involved separating mind from body and denying the body's reality. Pretending the body did not exist enabled this woman to continue in safety.

'...you get separated, your mind gets separated from your body too, in that sense, because you have, if you hang on to a sense of yourself at all, I guess, just to live, you have to in some respect, um, you sort of separate it out from your body and you think well, and because you're being told all the time one way or another that female bodies have meaning that is independent of the intent that you have, then you learn that you're helpless and you learn to vacate your body'. (P3)

Anorexia and bulimia represented further examples of conflicts around femaleness and femininity and patterns of disordered eating demonstrated attempts for control over the dangerous female body. Eight out of the ten women in the study struggled with disordered eating. While embedded with multiple meanings that at times were unique for each individual participant, more often than not anorexia and bulimia reflected meanings that were shared. Disordered eating was inextricably linked with participants' beliefs about being a female and having a female body and with their attributions about their sexual abuse in which the 'rules' associated with femininity and the attributes ascribed to femaleness and female bodies created the context for their original abuse while also predisposing them to further harm.

Anorexia and bulimia were 'problems of embodiment' that reflected participants' attempts to manage female embodiment in the context of social, sexual and political meanings attached to women's bodies.

Seven informants reported that they were or had been overweight. Being overweight was associated with a lack of sexual attractiveness and desirability, so was used as a form of protection from unwanted attention or from further abuse.

'You don't ever become a sex object if you are overweight...'(P6)

'It was like a protection. Overweightness meant that I was ugly...so it kind of kept me safe'. (P2)

'I don't know why I needed to be ugly but I did. It was fitting to the way I felt about myself, but it was also like then no one would want me...and I couldn't deal with that'. (P7)

Being overweight, while a symbol of protection, also invited self-denigration, because being overweight meant that women did not look like they were 'supposed to look'. The struggles between wanting to be desired, valued, perfect and attractive while also wanting to be undesirable, unattractive, and less than perfect were often patterned in anorexia and bulimia. Overeating was an example of attempts to control the dangerous body.

'Yeah. Protect me from having to protect myself in case I was attacked and I was in a situation then, my femaleness would have been at fault for that. I would blame my femaleness for that. It would make me feel even worse'. (P6)

So too was anorexia.

'...it's a bit like too the anorexia was like a battle...It was like on one hand the anorexia was like I want to be desirable and attractive and sexually appealing to myself and to men. That was one side of the battle. And the other side was but I actually don't want to be sexual and attractive and desirable because that's a dangerous position to be in'. (P8)

Two women reported having suffered from anorexia. Anorexia was at times seen as a protection from femaleness and therefore further sexual harm, at times it constituted proof of self-worth, desirability and value, at times, it expressed a desire for purity, while at other times, it was an attempt to master and control an unruly, dangerous female body. The struggles between wanting to be desired, valued, perfect and attractive while also wanting to be undesirable, unattractive, and less than perfect were often patterned in anorexia and bulimia. Interestingly, for one woman, the perfection she associated with

the anorexic body meant that had a pure, innocent and perfect body, that embodied her goodness, making her, importantly, not responsible for the sexual abuse.

'If I looked like well perfect on the outside then well maybe I could be perfect inside too...Yeah and I was absolutely determined I would be, after having been told how imperfect I was. I was determined that no one would be able to say that what I did was imperfect'. (P9)

Women coped with the precarious nature of embodiment by using a range of responses, most of which were dangerous and harmful to themselves. The struggle to live safely and comfortably in their bodies and to resolve dilemmas about personal and social power were ongoing and difficult to resolve. The issues were intensely problematic because they not only involved struggling with the everyday realities of traumatic bodily experiences, but also with broader questions of female identity, subjectivity, sexuality and power. The complexity of female embodiment after violation and its embeddedness in a larger web of social meanings was encapsulated in the following woman's words.

'I mean someone, someone avoiding touching you can be as awful as someone touching you'. (P3)

In exploring the next theme of the 'used body' I again highlight the interconnection between the experience of sexual abuse and having a female body, demonstrating the links between individual meanings and social constructions. Women perceived their body to be 'used bodies' on the basis of their personal experiences of sexual violation. But they also considered their body to be 'used' because they were situated in a culture that equated female worth with purity, while also adhering to contradictory beliefs and practices that reified women's value as primarily sexual objects.

'I was told I was just nothing, I was just, I'd lost the one thing that makes a girl of value, which was her chastity and I didn't have that'. (P5)

'Oh because in some ways I felt my body was useless. I thought well gees if this is a big hole to fuck and that's all it is, that's pretty useless. What else is there...It's all a big mess. Messy'. (P7)

Although presented with opposing gender prescriptions, the message received by sexual abuse victims was the same; that they were used and to be used. In the context of social meanings ascribed to female sexuality, the childhood abuse conferred upon them bodies that they saw as impure, tarnished and spoilt, while continuing to live in a violated female body conferred upon them ongoing experiences of sexual objectification, revictimisation and denigration. Hence, the devaluing of the body was associated with the sexual abuse, but importantly, also with perceptions that once sexually active a female loses her worth. Paradoxically the continued objectification and sexualisation that many of the women experienced following the original abuse confirmed the opposite belief; namely that women are only of value if sexually available. This contradiction and many similar paradoxes inherent in constructions of femininity were embedded in women's struggles with embodiment following the violation of sexual abuse.

7.6 The Used Body

'Every once in a while I feel like a used body, do you know what I mean?'(P1)

While the previous discussion of 'dangerous bodies' reflects one side of essentially dualistic social descriptions of female desire, that is the extreme power of women's bodies, my examination of the theme of 'used bodies' reveals the other polarity, where female sexuality is inscribed with passivity and docility. Just as powerful social constructions of female sexuality as 'dangerous' led to problematic embodied consequences for women who had been sexually abused, so did descriptions of female sexuality as passive and submissive.

In this theme as in the previous one, the experience of the 'used body' encapsulated significant social meanings. Women's individual experiences of sexual victimisation

were enactments of 'the body for others.'[80] These enactments occurred in a social context that inscribed femaleness with self-sacrifice and compliance and female sexuality with docility and passivity.

'I was just an object. And so men are going to do this to you and boys are just going to do this to you'. (P5)

'Somewhere along the line I got this message that I took on board that, you know, that as a girl, you have to do it for others, good or not'. (P9)

While the extent to which these social beliefs could be said to be constitutive of the sexual abuse in the first place may be debated, that these powerful descriptions of female sexuality reinforced and perpetuated the message that 'the body was for others' is less disputable. Participants' stories show that both their victimisation experience and their implicit and explicit knowledge of the prescriptions of femininity were so powerful that most developed templates for relating that involved silencing their own voices, devaluing their own bodies, overcoming their body's protests and enduring the imperative to satisfy other's desires before their own. In addition, women developed a deeply entrenched belief that 'I am not of value and my body is not of value'. The meanings women attributed to their body were central to their subsequent responses and by extension central to the solutions they drew on. That their solutions led to problematic and damaging behaviours that compounded and reinforced the precedent of 'the body for others' is testament to the power of both embodied experience and practical and discursive consciousness based in social discourses of the female body.

[80] At the core of childhood sexual victimization is the (mis)use of one person's body by another. The abuser typically uses the child's body to satisfy his own desires, having a complete absence of consideration for, or awareness of, the needs or wishes of the victim.

7.7 The Relationship Between Experience, Meaning And Action

As I described earlier, victims engaged in a complex process of attributing meaning to their body. Once experienced and rendered meaningful as a 'used body', women then embarked on courses of action that reflected this construction of their body.

'Well, I didn't care about my body... Well, obviously I was nothing. I was basically a hole to fuck then. What would be the point of caring for me, for my body... because they obviously weren't going to care for me? There was nothing to respect because I hadn't been given respect. Therefore I had no respect for myself, no care'. (P8)

Interpersonal and sexual relating were two main areas that became particularly problematic for participants once they had embodied descriptions of themselves and their bodies as 'used'. Not only did the belief that they had a 'used' body lead to difficulties with interpersonal and sexual relating, it also reflected in and influenced women's subsequent revictimisation.

7.7.1 Interpersonal Relating

All the women in the study, except one, reported re-enacting the abuse dynamics in interpersonal relating.

'I wasn't valued growing up by my father or by other men around him. So I think you know it gave me that indication why I am not of value and definitely my body, you know, the belief that my body's not valuable. Because of how it was used and abused. I carried that belief into adolescence and I think ... because my father didn't protect me and was a perpetrator, it's like I didn't know how to protect or value myself...I think I took on those beliefs that I was not a valuable person and that in some way I was proving that I was worthless'. (P2)

Already feeling like a 'used body', women reported falling into unwanted encounters with men, or relationships with men in which some of the original abuse dynamics and feelings associated with victimisation became replicated. The 'body for others' was therefore reinforced, as was the prevailing sense of the 'used body' that was not of value.

7.7.2 Sexual Relating

Several women reported being unable to say 'no' to sexual advances from men and reported having sex with them. Unwanted sex often occurred in response to a kind of automatic submission to the other's wishes, to the inability to articulate and declare needs and wishes, to fearfulness about the consequences of stating these desires and in response to deeply felt beliefs of unworthiness and powerlessness. Women's prior experience of victimisation intersected with accepted societal beliefs prescribing female passivity and compliance with the unfortunate consequence that victims responded with an absence of agency in relation to their own bodies.

'...you know, I would just do things because I did. It was just like if someone would pick out who you were or what your were or something...It's sort of like you are a magnet, you draw in someone like that. It was like you went into victim's role again. I don't think I had the ability to say 'No' in a sexual sense...I mean I was not promiscuous, it's just that I would not know how to say 'No'. (P4)

Women's apparent consent to unwanted sex can be understood in terms of their own victimisation histories, their responses mirroring those from prior victimisation experiences. As adolescents or adult women some reacted to situations of unwanted sex in the same way they responded as children to their earlier sexual abuse. The process of victimisation was then re-enacted with its accompanying dynamics of powerlessness and domination. Other women had been so well socialised by offenders into a pattern of submission that they either had no skills or were too fearful to do other than go along with what was happening. Women's responses below demonstrate the relationship of prior victimisation to later problematic sexual relating and to episodes of revictimisation

as adults. However, also significant to victims consent to unwanted sex were their beliefs about female bodies and sexuality. As women in Australian culture they had also been well socialised into accepting that passivity and compliance were essential aspects of women's sexuality. Each of these factors converged in participants accounts of 'falling into' the victim position almost automatically and in their repeated experiences of themselves as 'used', yet bereft of alternative responses.

7.7.3 Silence and Stillness As Attempted Solutions To The Problems of Interpersonal And Sexual Relating

All of the participants reported using the embodied responses of silence and stillness as solutions to problems of relating. In these solutions, victims' experiences of violation are again entangled with their constructions of female embodiment. Both silence and stillness were employed as strategies to avoid harm. At worst, harm represented further episodes of assault or abuse, at best, the censure and disapproval of others. As child victims, participants had learnt compliance. As adult women, participants had relearnt that female compliance and submission were required. To act otherwise was, as a woman, to invite some form of harm.

'I probably pick people who are unreliable. But in the last 3 years I've probably connected with 3 or 4 people and I've noticed a real power thing. You know they will be wanting to have the power and the real male-female thing too, women seen as inferior and not giving them equal power. I have seen how the person I am with will almost get into shaming me for being powerful or for speaking my mind. You know, a lot of it too is like I can say so much just as long as it is what they are comfortable with'. (P2)

The dynamics of intimate represented a replication of the position she was in when abused as a child, namely 'if I speak up, I will be hurt, therefore I need to protect myself by privileging the other and silencing myself'. The fear of revealing one's needs and desires and in so doing becoming visible and therefore vulnerable also showed itself in many informants' experiences of relating. One woman described being assaulted at work in response to asking for acceptable behaviour from the adolescents in her care. The

attack prompted parallel feelings to those she experienced as a result of her victimisation by her father. In the attack, as with her father, when she acknowledged her needs, said what she wanted, and in doing so revealed herself, she provoked anger and in provoking anger was hurt and victimised.

'... I notice that like with the kids and with the attack, it was basically around setting limits, setting guidelines and it was for them. It was like well I wasn't who they were wanting me to be. So they lashed out'. (P3)

The imperative of the 'body for others', involved privileging others needs and demands, sacrificing one's own needs or wishes, and seemingly 'agreeing' to avoid harm. The solution inadvertedly reinforced women's perception of themselves and their bodies as 'used' and worthless.

'Lots of times I had sex with men. A lot of it I'd have to say was not wanted, but I sort of consented. So far as I was concerned because I consented it was OK. But I really wanted to say 'No, I don't want to be having sex with you', said, 'I just don't want to...but I just said 'Yes'- against my better judgment.' (P8)

Several other women also reported being unable to say 'no' in circumstances where they felt uncomfortable. The desire to speak up was extremely strong for many but the constraints to speaking up were even more overpowering. For many, fear of the consequences of revealing their own needs; especially in sexual situations was a significant restraint to saying 'No'.

'No, I couldn't deal with situations like that... 'No' was what I was screaming out on the inside but I couldn't get it to come into my mouth...It never comes out on the outside. It's like it's trapped on the inside, it's underneath a very light veil and it can easily come out, but for some reason its trapped there because of the fear of what will happen, the consequences of what will happen'. (P8)

'I was constrained by fear and not knowing, not be able to find the 'no' that I needed. The ' no' is inside but I couldn't verbalise it. The word 'no' was an impossible verbalisation. I could do 'no' in other situations but not when it came to sex. Because that was a mess, a real mess'. (P6)

Upon reflection, the above woman realised that 'No' was problematic for her in other areas of her life and not just in regard to sexual relating. As in her original victimisation, the imperative to please others and satisfy others' needs rather than her own dominated many of her life choices.

'Like joining the Army. Same thing. I didn't really want to join the Army but...I wondered how many other areas in my life were the 'no' thing. Because of the 'no' setup. 'No' on the inside and not being able to verbalise it in the situation that I've walked into. 'No' I couldn't verbalise as well. Even in different situations. Not necessarily to do with sex. As well. And doing things that I really didn't want to be doing because I thought that maybe somebody else might like that. That they might think this is good for me, so I'd do that. For them... All the time satisfying everybody else and not myself. But then, it didn't really matter because I didn't care about myself, so it didn't really matter what the hell was going to happen to me in the long run'. (P7)

'I mean in a lot of cases, the situations would get to the point where the person could become violent. They want to have sex and you don't want to have it. You're in the middle of nowhere. You're in a car with some bloke who's stronger than you and you don't say 'no' to them or they're going to start smacking you around. You yell out something and you're dead'. (P7)

The above accounts show that women arrived at bodily solutions that were attempts to keep themselves safe. Possessing a body that was most often silent and inert was undoubtedly, for participants, a significant problem of embodiment. Yet, silence and stillness were embodied solutions that made eminent sense in the context of their abuse experiences and ongoing negotiations with social discourses on the female body. These

two inextricably related aspects of their experience, victimisation and female embodiment posed a dilemma; don't speak up or move and be harmed, or do speak up and move and be harmed. The dilemma was enacted in victims' problems of embodiment where silence and immobility became common attempts at resolution.

7.7.4 The 'Used Body' And Experiences of Revictimisation

All but one of the women in my study reported episodes of revictimisation. Whilst revictimisation occurred for several reasons, it was in part, related to victims' constructions that female embodiment was in essence, constituted by the 'body for others' and consequently, by 'the used body'.

'I didn't care about my body...there was nothing to respect...you have a body that you don't feel anything about and that you don't really care about...No-one else respected my body, so why should I? I could do anything I bloody well wish with it. I could put it in the most dangerous or awkward situation.' (P8)

Another woman explained that she found herself in dangerous situations or abusive relationships because she did not value her body, rather, she saw herself as unattractive and undesirable and this led her into situations where she was revictimised.

'I relate this back to my body and my image of my body, and that was basically to do with low self-esteem. I didn't think I was attractive and so if they [men] *asked me out it was well, you know, I should be thankful, sort of. There were these feelings there but sometimes I wouldn't even be aware of that'. (P5)*

An underlying theme in women's stories of the 'used body' was the way in which the female body was primarily a sexual object. Again, the original sexual victimisation, experiences of revictimisation and cultural representations, images and constructions of woman as sex objects reinforced women's objectification and led to shame and self-loathing. The culmination of these experiences confirmed victims' enduring belief that

the female body has no value or worth except as an object for others.

'I don't know, I guess it didn't really matter to me. I mean what was the point? It didn't matter, I didn't matter, you know, probably brought on by the fact that my grandfather said that basically was what I was anyway. You know that was going to happen. It wasn't in a sense that it shouldn't be happening, you know...So I just sort of thought oh yeah, whatever, you know'. (P5)

Not surprisingly, several women reported feeling that they were unable to exert any agency or control over the events of their lives. The 'body for others' continued to be enacted over and over again, so that along with recurring episodes of unwanted sex were other experiences of revictimisation. These experiences intensified feelings of powerlessness, and led, for several of the women in the study, to feelings of worthlessness and despair that were so profound that they that eliminated the capacity for self-care.

'I'd also do something I didn't mean to, putting myself into situations which were extremely dangerous and not caring. The end result of that was possibly serious injury and I didn't care. I knew the possible result but I just did not want to do anything about it'. (P6)

'I could walk out in front of a train and not give a stuff. I used to do shit like that. I'd stand on the train platform and watch the train coming and I'd think, 'I'll just jump out there'. (P7).

'I don't know if I hated my body. I was past that I think...I was just not a human being any more. Nothing sort of mattered...Just like, 'Who cares?' (P8)

7.8 Shame And Self-Loathing

The accounts of participants revealed that bodily shame and self-loathing emerged in response to having a 'dangerous' body and/or a 'used' body. The initial abuse experiences, revictimisation, feelings of being used and abused at the hands of others and themselves and fear and distaste for their powerless yet powerful body led to intense feelings of bodily shame.[81] Interestingly and importantly, like other body problems, bodily shame and self-loathing were directly connected to the sexed body, to having a female body. It was more than a simple body self-consciousness that emanated from women's stories. Instead, it was a profound discomfort with femaleness that could inspire the deepest feelings of embarrassment, ambivalence or hatred for the body. Such feelings often led women to inflict harm on their own bodies, as expressions of discomfort, confusion, frustration and rage.[82]

'Well as I say, I sat in the bath right curled up, like a ball, so I did not have to see myself. So I did not have to see all those parts of my body that made it all happen to me.' (P5)

'But like I said, sometimes it is OK to have a girl's body, but sometimes I can feel ashamed of it [my body]'. *(P1)*

'It was harder when boys looked at me and stuff like that. I'd feel shame and whatever'. (P5)

Interestingly, like several of the other dilemmas faced by women, shame was a two-sided phenomenon. Shame and self-loathing were associated with being a female and having a female body, but when female embodiment had become so problematic as a result of victimisation experienc[illegible]d social imperatives of femininity, shame was also associated with *not* being able to live in and with a female body.

---

[81] See Andrew's study (1995) which links bodily shame with depression in women who with sexual and physical abuse histories.

[82] Self-harming behaviours emerged as a significant theme in participants' accounts. They are examined in detail in Chapter eight. See pp.231-265.

'Just shame...Yeah. Shame about my body, shame about who I was and shame about feeling so masculine, knowing that I was in a female body and not being able to embrace that. And that is something I still struggle with today...Um so judgmental, and you know the media, magazines and TV and the images that you get. Yeah you should look this way and this is what is feminine is. So there is all that influence too...So just feeding into that shame and the myth of how I think I should look you know'. (P3)

Another participant expressed a similar experience of feeling discomfort with the female body.

'I didn't know how to be a female. I didn't have a clue. I'd think oh my God, this is rotten, this is shameful, you know. And I couldn't get up with it.'(P6)

Self-loathing was however, the most common and most intensely felt response women had to their bodies. The experience of self-loathing was complex, embedded with a range of meanings and accounted for by varying experiences. Self-loathing related to experiences of somatic and visual flashbacks, to a deep sense of alienation from others, to guilt about their body's responses to sexual victimisation, to feelings of bodily objectification, to shame and self-blame and to self-hatred emanating from profound conflicts at the heart of female embodiment.[83]

'Well it was fitting to the way I felt about my body. Well I hated it. I hated it. I despised it. I distrusted it. Never did what I wanted to do. Even emotionally, all over the place'. (P8)

Several informants believed that having a female body or some other unidentifiable flaw caused their abuse. Alternatively, some act or omission caused the abuse to happen. In either case longstanding and powerful feelings of self-blame and self-loathing were inspired.

---

[83] I examine self-loathing and its relationship to traumatic re-experiencing, bodily alienation and unwanted body responses at the time of the abuse in Chapter eight (pp.231-265), where I link self-loathing with self-harming behaviours. Of interest here are the associations between self-loathing and female embodiment.

'Because it's not what I wanted. It's not the way I wanted things to go. It's not how I felt that I wanted to go.... I just couldn't figure it out. And I just kept feeling like somehow I'd gotten the wrong body or I'd done the wrong thing or something. And also way back down deep somewhere there's obviously this feeling that it's me. Like the heart of the matter is it comes right back to like me at the bottom. I must have done something wrong for all this to have happened'. (P7)

'I must have done something really bad to be treated like that. What's wrong with me. I must have done something really bad'. (P5)

'It was my belief that I had to have done something to have made it happen...I did something, I felt ashamed. Originally I didn't think it was something awful and I don't know... but then I was told not to tell'. (P6)

Having a body that had been used by others and that continued to be for others in a society that represented female bodies primarily as sexual objects led victims to believe that female embodiment would inevitably lead to a 'used body'. In addition, having a female body that was endowed with a powerlessness that limited personal agency and/or a female body that was powerful enough to create undesirable events would inevitably lead to danger. Accompanied by feelings of shame, self-loathing and self-blame, devaluing and fearing the body led, for many the women in the study to ongoing struggles with embodiment. By denying the body, leaving the body, disciplining the body and harming the body women attempted to resolve some of the profound and seemingly irresolvable difficulties associated with female embodiment. While their problems of embodiment can be seen as attempted solutions to dilemmas inherent in female embodiment after violation, these solutions often led to an intensification of existing difficulties.

7.9 The Corporeal Effects of Sexual Abuse: Psychopathology or Crystallisation of Culture?

The 'dangerous' body and the 'used' body emerged as prominent and central themes in women's accounts. Both themes highlight the importance of the sexed body to victim's experience of sexual abuse and its impact. My discussion has shown that the subjective meanings individual women attached to their body in the context of sexual abuse are interwoven with and informed by broader social discourses on the female body and femininity, and that victim's problems of embodiment reflect their negotiations with these ideologies. This finding has not, to my knowledge, been addressed elsewhere in the sexual abuse literature despite its significance to my informants.

The notion that body symptoms are characteristic expressions of culture has however, been examined in feminist explorations of anorexia nervosa. Bordo argues that 'psychopathologies that develop within a culture, far from being abnormalities or aberrations' reflect culture and are a 'crystallisation of much that is wrong with it' (1993:41). Anorexia is therefore regarded as a 'symptom of some of the multifaceted and heterogeneous distresses of our age' (1993:141), in which a variety of cultural currents or streams converge. Female child sexual abuse and its bodily consequences may usefully be conceptualised in the same way. Given the alarming frequency with which sexual abuse happens to girls in Australian culture (32% having experienced some form of unwanted sexual experience by the age of 16, see Mullen et al, 1996), female child sexual abuse cannot be called an aberration or abnormality. Moreover, as my thesis suggests, the profound and disturbing problems of embodiment suffered by my participants as a consequence of abuse, at least in part, can be seen to reflect the precise expression of significant cultural themes.

Resting her examination on the premise that the body is constantly in the grip of cultural practices, Bordo identifies and analyses the cultural components of the anorexic body, revealing three dominant cultural streams of thought that converge in the practice of anorexia. She describes dualism, control and gender/power as the three central themes

evident in the anorexic body. These social themes were also notable in the problems of embodiment suffered by the women in my study. Their body problems showed the bifurcation of the body and mind, a dualism in which the body was experienced as alien, as not self, as not me, as fastened to me or attached to me but not really me. The body was also experienced as confinement and limitation from which the will or mind struggled to escape. Or, the body was the enemy, liable to the distractions of food, lust, desire, fear and fantasy.

For most participants, the body represented the locus of all that threatened their control, feared for its capacity to 'overtake, erupt or disrupt' (Bordo, 1993:145). Such a dualist relationship to the body incited a battle with the unruly forces of the body, yet attempts to subdue the spontaneities of the body only succeed in making the body more alien and more powerful, and thus more in need of control. Bordo (1993) argues that for the anorexic, the only way to succeed is to cease to experience the body's spontaneities, hungers and desires. The women in my study, in a similar way to their anorexic counterparts, also experienced their bodies as not self, as onerous, as burdensome and as the enemy. They therefore worked against an active recognition of their body and their body's association with femaleness and sexuality. For many, their body became disconnected from their sense of self and consequently they became deeply alienated from their body. For others, the traditional philosophical association of women with the body or 'female as body' was mirrored in their acute attunement to their body.[84]

Control is another central feature of Bordo associates with anorexic women's bodily practices, asserting that the individual suffering anorexia experiences her life as out of control and is torn by conflicting and contradictory expectations and demands in a modern society which is obsessed with control of the body. The decision to become thin and succeeding in this goal signals control and accomplishment. Similarly, many women in my study experienced their body (and their lives) as out of control. Their stories also reflected conflicting and contradictory social expectations in relation to female identity (what it means to be a girl/woman), sexuality (the nature of the female body and desire),

[84] See Chapter six (pp.168-196), for a discussion of this theme.

and behavior (what should female bodies look like and how should they behave?). The solution or focus became (as it does with anorexic women), an identification with the mind (or will) and with fantasies of absolute control. The emphasis on control when feeling out of control and feeling a sense of accomplishment derived from self-mastery is reflected in my participants' practices around embodiment. Living in a society in which women both perceived and experienced it to be dangerous to have a female body and dangerous to conform to the ideals of femininity intensified the need for mastery and control of their body. Taking little pleasure in embodiment their mental energies were devoted to mastering their body.

The third cultural current Bordo (1993) describes as inherent in anorexia and which also has resonances with the stories of the women in my study is the gender/power stream. First, anorexia, like child sexual abuse is a phenomenon that is not gender neutral. Girls and women are overrepresented in the statistics of each. Second, for the anorexic woman and for the woman suffering body problems as a consequence of sexual abuse, the body self and the female self are perceived to be at constant war. Third, the gender associations attributed to the body self and the female self involve respectively, a fear, disdain or ambivalence towards 'femininity' and a deep fear of 'the female' with its associations with unruly desire and sexual insatiability. For victims of sexual abuse, an additional fear is associated with having a female body and cooperating with traditional expectations (passivity and being for others), or contemporary prescriptions of femininity (slimness, attractiveness, the desirable body), as both demands were perceived to be implicated in sexual violation. The gender/power currents inherent in femaleness are intimately connected with a profound fear of harm and misuse by others (sexual violation or revictimisation).

Bordo (1993) and other feminist authors have characterised anorexia as a 'protest' against the limitations and contradictions inherent in contemporary femininity and as fear of a certain archetypical images of the female as uncontrollable, devouring and insatiable. The body problems of women who had been sexually violated also reveal the contradictions and paradoxical injunctions at the heart of contemporary femininity, and a

profound fear of classic representations of 'the female'. Their problems of embodiment may have an element of protest, but more closely resemble intensely problematic 'existential struggles' which 'symbolise' these two central dilemmas while also constituting attempted solutions to the problems inherent in living safely and comfortably with a female body.

7.10 The Process of Meaning Making: From Individual Experience To Social Significance

Throughout this chapter, my analysis has challenged commonly held conceptualisations that reduce victims' bodies to their physical status and that subsequently limit understandings of their body symptoms to predictable biophysiological reactions to trauma. I propose that for sexual abuse victims, their body and the difficulties they have with their body need to be thought through in more complex ways. The accounts of my participants revealed that the subjective meanings attached to the body were highly significant to body symptoms and problems of embodiment. I have argued that the complex process of attributing meaning incorporated individual embodied experience and aspects of practical and discursive consciousness; that is, knowledge which participants derived from their engagement with social discourses on the female body. Both levels of experience converged, making female embodiment especially problematic.

Before closing this chapter I briefly examine the process through which social discourses on the female body come to be expressed in participants' problems of embodiment. I have found three specific theories useful in this regard. The first, Gidden's structuration theory which I detailed earlier, posits that people draw from both implicit and explicit knowledge of social ideologies to participate in social practices. Because social ideologies are both embedded in language and embodied in enactments, processes and contexts, they are both consciously and unconsciously absorbed by peoples' minds and their bodies. Thus all people come to embody knowledge of the social context and, in either acknowledged or unacknowledged ways, this knowledge influences their actions. Implicated in the problems of embodiment enacted by victims in my study, and in the

explanations participants offered for them, was evidence of women's practical and discursive knowledge of dominant social discourses on the female body.

A second theory that may usefully illuminate the way in which social discourses became embodied in the problems of embodiment suffered by women in my study derives from Watzlawick, Beavin and Jackson's work on human communication patterns (1967). While also distinguishing between implicit and explicit knowledge, they focus on interpersonal rather than individual-societal interactions. Their theory is therefore applicable to the dynamics that occur between perpetrator and victim, shedding light on the way perpetrator's' words and actions are so powerful in their impact on victims, while also explaining how it is that victims may be thought to 'embody' such communications. Watzlawick, Beavin and Jackson (1967) suggest that there are two types of human communication – digital and analogic. Digital communication refers to language and analogic communication refers to all non-verbal communication. Content is central to the first, relationship to the next, but both aspects are present in every communication (Watzlawick, Beavin and Jackson, 1967: 64). However, while digital communications can be amended, altered or changed, analogic communications cannot be. The meanings in analogic communications, because they are implied and enacted, cannot be qualified. Hence, while the words the perpetrator used may be challenged or reconstructed by victims, the actions cannot be, remaining felt and embodied and reverberating in lasting problems of embodiment. For the participants in my study, who all coupled their abuse with the fact of their female body, their problems of embodiment may be understood as reflective of both digital and, particularly, analogical communications conveyed by the perpetrator. A poignant example of an analogic communication about female embodiment is reflected in the following participant's words.

'...out of my sexual abuse, er, there wasn't prolonged touching, for example. But, I, there was some, and I would say that um my father's fear of me, my father's horror of my body, my father's sense of the power of my body, my femaleness, was the overwhelming experience, and was experienced as the most pervasive and abusive'. (P3)

If powerful messages about what it means to be a girl and have a girl's body are communicated by the abuse itself, they were for the victims I interviewed, confirmed and reinforced by the familial and social context which surrounded the abuse. Communications at both an interpersonal and social level can therefore be understood to severely problematise female embodiment for female victims.

Alternatively, Bordo (1992) uses a Foucauldian theory of power to explain how prevailing forms of female selfhood and subjectivity are maintained.[85] While acknowledging that female submission to such norms is often the result of 'power exerted over' them, power that sexualises and objectifies female bodies, she argues that individual self-surveillance and self-correction to norms is a form of 'power from below' in which women themselves seek to normalise their body to fit prevailing social and historical ideas and forms. The sexual violation of child victims clearly represents a form of *power over* women that enforces their submission. The problems of embodiment suffered by women as a consequence of sexual violation can be seen as a reflection of *'power from below'*. Their struggles with female embodiment after violation may be understood to represent both the desire to normalise their body to fit prevailing social and historical ideas and forms, while also seeking to resist, undo or deviate from these norms, which they perceived to predispose them to further risk of harm.

Utilising any or all of the above conceptual frames, it is possible to theorise the ways in which social discourses become absorbed by women's bodies and embedded in the problems of embodiment women suffer as a consequence of sexual violation. They also make possible a fuller appreciation of the power of these beliefs and the influence they exert in individual's behaviour and action, often serving to maintain profoundly problematic activities and practices. Yet, in conceptualising victims' problems of embodiment as, at least in part, negotiations or struggles with discourses on the female body, or 'attempted solutions' to the dilemmas inherent in female embodiment after violation, there are both possibilities for reproducing dominant social discourses and

[85] See Foucault (1977) and Foucault, 'The Eye of Power' (1980). Also see Chapter two (pp.62-660, for a discussion of Foucault's ideas on power.

opportunities for changing them. An appraisal of participants' accounts showed that at times, their behaviour and practices recursively shaped and constituted constructions of femaleness in ways that maintained and reinforced dominant (and unhelpful) constructions of femininity and female bodies, creating fixed and enduring problems of embodiment. At other times, women reconstructed discursive and practical consciousness and in so doing transformed their relationship to female embodiment.[86]

7.11 Summary

In this and the previous chapter, I have shown that victims' constructions of childhood sexual abuse, its causes and consequences, and their understanding of the context surrounding the abuse (before, during and after the event/s), is inextricably linked to the sexed (female) nature of their body and to their knowledge and experience of social discourses of the female body and femininity. Having a body that participants believed was violated precisely because of the sociocultural meanings ascribed to femaleness, made female embodiment the primary problem of embodiment.

I have also argued that powerful historical and contemporary cultural constructions of the body and in particular, the female body, are evident in many of the body problems of sexually abused women. As it is for women suffering from anorexia, themes related to dualism, control, gender and female power and sexuality characterise victims' bodily struggles. For sexual abuse victims, however, the critical dilemma of how to live safely and comfortably in a female body that coincides with a further critical dilemma around embodiment which is how to live safely and comfortably in a violated body. When the meanings, activities and responses associated with the body also provoke fear, disdain, disempowerment, complexity and confusion, bodily solutions are demanded. Thus female embodiment itself may be thought of as a 'primary' problem of embodiment for female victims, and the solutions they then apply in their attempts to resolve the difficulties associated with female embodiment may be considered as constituting a range of

[86] I examine reconstructed ideas as 'resistance' and 'recovery' in Chapter nine (pp.266-291), which is devoted to exploring women's accounts of healing from the bodily impact of childhood sexual abuse.

'secondary' problems of embodiment.

I have argued that the problems/solutions associated with living in a violated body should not be reduced to characterisations of illness or psychopathology. Rather, the violated body, like all bodies, is engaged in a process of meaning making, a 'labor of the body' (Bordo, 1993). The bodily activities and practices of victims are thus attempts to create a body that will speak for the self in a meaningful and powerful way. In the following chapter I explore three further core themes that emerged from my study, which demonstrate the personal and social significance of victims' bodily struggles.

CHAPTER EIGHT

PAIN, BODILY DENIAL AND SELF-HARMING: THE WOUNDED BODY

8.1 Introduction

In the previous two chapters I examined three core themes that emerged from my analysis of women's stories. In presenting the themes that I described as 'the female body', 'the dangerous body' and 'the used body' I highlighted the social and sexual significance of victims' bodies, which I argued could not be understood without reference to the cultural context and to the social discourses which inform and constitute female bodies. In this chapter I examine another set of core themes that also embody social dimensions. Participants' accounts of bodily pain, bodily harming and bodily denial converged in the theme I have characterised as 'the wounded body'. My discussion of each of these body problems reveals that they, like the themes discussed earlier, are also imbued with social and sexual significance. My purpose in this chapter is however, to highlight the symbolic dimensions of embodiment after violation. I therefore focus on the compelling personal meanings created by the enactment of abuse upon victims' bodies, and argue that the problems of embodiment experienced by women as a consequence of sexual violation can be read as rituals that represent complex but essentially meaningful configurations of sexual abuse and its impact.

In discussing the body as a symbolic site and focusing on the unique symbolic meanings of the body for victims, I make an arbitrary and false distinction between women's individual interpretations and their links with broader social meanings.[87] My study shows that such a distinction is not so clear. Women's subjective experience of their bodies was inextricably interwoven with broader cultural discourses (in particular their interactions with ideologies of the female body and femininity), and all their symptoms could be said to reflect historically situated sociocultural meanings. My decision to introduce an artificial separation between personal and social meanings was based on my desire to

[87] In my attempt to make independent the personal significance of women's stories from their social significance, I have had to deliberately foreclose some of the social ramifications of themes explicated in this chapter for the sake of conceptual clarity and theoretical analysis.

illustrate the layered nature of women's subjective experience and in so doing to emphasise the importance of 'reading' victims' bodies in multiple ways. Moreover, having already highlighted the common and shared social and sexual dimensions of their bodied experience, I wanted to reveal the uniqueness and specificity of individual experiences. For my participants, childhood sexual abuse and the consequent symptoms also held deeply personal and private significance that had become embodied in their particular life trajectories. This intimate type of meaning transferred vital significance from the person's life to their experience of bodily symptoms (Kleinman, 1988).

Before turning to an exploration of the three core themes and to my premise that these problems of embodiment reflect symbolic meanings arising from women's bodily experience and from their perceptions of the sexual abuse and its impact, I examine the notion of body symptoms as symbolic.

8.2 Symptom as Meaning

Early psychoanalysis interpreted symptoms as symbols indexing deeply personal significations: sexual conflicts, issues in dependency and passivity, drives to control and dominate, fantasies and hidden desires. Frequently, these significations were held to cause the symptoms with which they were associated through a process of psychosomatic transduction that materialised psychic conflicts as somatic complaints. Such complaints were thought to be a symbolic expression of core unconscious themes in the repressed neurotic conflict of the patient's psychic life. Although the model addresses the special and private meanings of symptoms or illness, it does so in a way that narrows the scope for understanding symptoms. Psychoanalytic conceptions have, at worst, relegated sexual abuse and associated physical symptoms to the realm of fantasy and, at best, have decontextualised sexual abuse, reducing it to its psychological variables. The legacy of Freudian psychoanalysis remains influential in psychiatric theories of somatisation and conversion disorder. Somatisation is understood as the communication of personal and interpersonal problems in a physical idiom of distress and a pattern of behaviour that emphasises the seeking of medical help (Kleinman, 1988). Conversion symptoms can be

described as the literal embodiment of conflicted meanings, somatic symbols and social uses, for example, when a paralysis of muscles in a patient reflects a paralysis of will (Kleinman, 1988). At first glance, these conceptions appear potentially useful to my study in their capacity to theorise women's bodily experience and to provide a notion of embodied subjectivity. However, several limitations inherent in these ideas made me cautious about their application. Such conceptions relegate body problems to the realm of intrapsychic conflict. Social practices are always referred back to unconscious representations of self, largely separating symptoms from their context and minimising the connections that exist between body, self, and society. Moreover, psychoanalytic interpretations privilege rationality over bodily knowing, replicating the traditional mind/body dualism - a tradition my study works to subvert.

My participants' accounts also challenged psychoanalytic assumptions. They suggested instead that bodies are more than their psychological representations, that social practices are inscribed on and enacted by women's bodies, that context powerfully shapes women's experience of, beliefs about and relationship to their body, and that 'all the effects of subjectivity, all the complexities of subjects', as Grosz asserts, 'can be as adequately explained using the subject's corporeality as a framework as it would be using consciousness or unconsciousness' (1994: vii). While not wanting to engage with Grosz's argument that bodies 'have all the explanatory power of minds' or to reinforce the existing polarisation between minds and bodies, women's stories imply at least, that broader conceptualisations of their bodily problems are needed.

Importantly, the symptoms and problems of embodiment experienced by the women are not 'illnesses', as psychoanalytic explanations for behaviour would suggest. They are more like experiments with ways of living in a body that has been violated. I have suggested instead that they are existential choices women make or solutions women apply in response to the dilemmas inherent in female embodiment after sexual violation.[88] Further, women's bodily solutions make more sense when they are not simply reduced to individual psychological significance that is interpreted by others, but when

[88] See Chapter six (pp.168-196), for a more detailed explication of this idea.

enfolded in the webs of social and sexual significance that women themselves articulate, and which link them to the social world. Clearly, medical, biological, physicalist and psychological explanations do reveal some dimensions of women's embodied experience as do phenomenological approaches that focus on the intrinsic qualities of the body, on how the body is felt and experienced and how it is rendered meaningful by the individual. Yet, they conceal other significant dimensions of women' s embodied experience.[89] In moving beyond medical explanations for bodily symptoms and problems of embodiment experienced by the women in my study, I utilise the concept of body as symbol and metaphor for society.

8.3 The Social Body

Numerous theorists have been interested in the representational uses of the body, in particular, the relationship of the physical body and society (Mauss, 1943; Douglas, 1970; Bourdieu, 1977; Freund, 1988; Kleinman, 1988). Challenging phenomenological explanations in which the body is seen as nongendered, prediscursive, natural and acultural, such theorists have claimed that the body cannot be understood outside culture and society. Emphasising that it is the body that mediates the social situation as a channel of communication between the individual and society, they have conceptualised the body as a metaphor for society, asserting that all modes of bodily action are social, imbued with imitation, tradition, and ritual.[90]

8.4 The Body As Symbol

The notion of the body as a symbol of social relations can, Douglas (1966) suggests, be applied to any experience of margins or boundaries. The more personal and intimate the source of the ritual symbolism, the more telling its message, and the more the symbol is drawn from the common fund of human experience, the more wide and certain is its

---

[89] As I noted in Chapter five, even the more contemporary trauma/dissociation model, useful in theorising the traumatic bodily consequences of abuse and highlighting physical bodily experience, is limited by its narrow biomedical focus and inability to account for women's subjective experience of their bodies.
[90] See Chapter two (pp. 48-58) where I present these theories in more detail.

reception (Douglas, 1966:114). The bodies of women who have been sexually abused in childhood may, I argue, be usefully conceptualised as symbols of social relations. Moreover, their bodily symptoms and problems of embodiment may be seen as constituting what Douglas describes as deeply 'personal and intimate rituals' that convey compelling meanings.

I consider the body to be a symbolic site for victims for several other reasons. First, because the experience of abuse itself takes the victim to the intensely physical ground of the body and to the immediate experience of pain, wounding, suffering or violation. As several authors writing on the Holocaust and on war trauma and torture have noted, in extreme circumstances, 'symbols actualise' (Des Pres, 1976; Delbo quoted in Langer, 1995:69), the body becomes emblematic. Second, victims frequently become silent about their victimisation, though the experience remains fundamental to their life and to their conceptions of self. Despite the silence, the victim knows and feels in, and often recounts through her body, the 'truth' of her experience. Third, human experiences are not 'simply created by given narrative forms, or born only of the relationship in which they are presented, of a reality completely socially and culturally mediated' (Culbertson, 1995:67). Life stories are also about feeling, about unspoken and bodily knowing, or as Culbertson states 'about a sloppy negotiation between felt and said, said and heard and heard and felt' (1995:68). This bodily dimension of experience is often unacknowledged and undervalued.

8.5 Symptoms As Symbols

While the body may be conceived of as a symbol, body symptoms may also be seen as symbolic, as imbued with layers of social meanings. Kleinman (1988) asserts that body symptoms are informed by standardised truths in local cultural systems, implicit in which are accepted forms of knowledge about the body, the self and their relationship to each other. Symptoms are also understood to be marked with powerful cultural significance determined by gender, age, class, ethnicity and race and by different epochs and

societies.[91] Of special interest to my work is Kleinman's insistence that symptoms and illness carry meanings of personal and social significance. From a clinical perspective, he describes the personal and interpersonal meanings as 'the most important' (1988:32). While still grounded in an illness model which fails to adequately describe or conceptualise the existential dilemmas I have suggested are embodied in women's body problems,[92] Kleinman's ideas hold potential for theorising the experience of women whose bodies have been violated. The revisioning of bodily symptoms and problems of embodiment as embedded with meanings that are both immediate, personal, historical, and social is a useful frame from which to analyse women's descriptions of the body problems they suffered as a consequence of child sexual abuse. Moreover, reconceptualising symptoms as meaningful and bodies as symbolic of material, personal and social experience suggests a move away from the oppressive preoccupation with painful bodily process and narrow, dualistic and reductionist illness categories. Instead, the importance of the sensitive solicitation of the individual stories of the body problems, the assembling of an ethnography of the changing contexts in which they are situated, and the empathic witnessing of the existential experience of suffering is required.

In this vein, I explicate the personal meanings women attributed to their symptoms and illuminate the context which gave shape to them. My analysis reflects my application of the notion of the 'symbolic body' and my 'reading' of women's body symptoms as metaphorical representations of important personal meanings.[93] Acknowledging that violation of abuse is a primary, existential experience in which a person's physical boundaries are challenged or compromised and which reverberates in ongoing traumatic

---

[91] See Chapter two (pp.50-51) where I have previously discussed Kleinman's ideas.

[92] See Chapter six (pp.188) for a detailed examination of this issue.

[93] While I utilise the concept of metaphor, I am conscious of Sontag's caution in her useful essay, 'Illness as Metaphor' (1988). She writes that 'of course, one cannot live without metaphors' and suggests that there are some metaphors we might helpfully 'abstain from or retire' (p.5). Certainly some of the metaphors that have constructed women's ways of living in their bodies after sexual abuse are not helpful or useful. Garrett (1998), in her thoughtful analysis of recovery from anorexia, asserts that it is not enough to offer models or metaphors for the body which elucidate only 'social illness'. She works therefore to uncover the metaphors implicit in the bodies of recovered 'anorectics'. While the violated bodies of women in my study revealed symbolic meanings of the body that could be said to reflect personal and social 'ills', women's recovery from the body problems associated with sexual violation also revealed previously hidden or undiscovered metaphors about the body. In Chapter nine I show how their bodies become endowed with resistance, rebellion, desire, strength, power, agency and pleasure.

bodily responses, the act of sexual abuse and its consequences also confers compelling meanings upon the body. As the themes below demonstrate, women derived deeply significant personal meanings from their abuse and its bodily ramifications that, in many ways, were mirrored in their bodily symptoms. Their bodies became symbolic sites where bodily symptoms and suffering would 'speak' of the meanings that the abuse held for them.

8.6 The Body In Pain

The connection between chronic pain and a history of childhood sexual abuse has been well-documented (Haber and Roos, 1985; Wurtle, Kaplan and Keairnes, 1990; Linton, Larden and Gillow, 1996). All the participants reported experiencing some form of bodily pain that they associated with their prior childhood sexual abuse. Bodily pain was not the same for all participants. Rather, the body in pain was a complex phenomenon, reflecting and encompassing different experiences of the body. Some of the women reported generalised pain, often in the form of muscular tension that was associated with heightened arousal. For others, bodily pain related to the physical sensation of pain in parts of the body associated with the abuse (body memories). Others reported bodily pain to be linked with traumatic re-experiencing of bodily sensations that were felt at the time of the original abuse. And for more than half of the women, bodily pain was a consequence of dissociation, where not living in the body precluded an awareness of bodily discomfort and increased vulnerability to an array of bodily symptoms and disorders of embodiment. Symptoms included muscular tension, headaches, high blood pressure, eczema, sore throats, gynaecological problems, anorexia and bulimia. The body symptoms were described as severe. troubling and persisting over many years. The insight that symptoms embodied meaningful responses to the abuse was an understanding that for most of the women had taken many years to unfold. Interestingly, however, the gradual process of understanding the impact of the abuse and coming to understand the symbolic meaning of their body symptoms and pain was, for several women, tied to a resolution of the body symptoms. For others, recognising the significance of their body problems and giving them meaning led them into therapy. Verbal and especially body-

oriented therapies were helpful in symptom resolution.[94]

The major bodily problems women described as being associated with pain are outlined below. The abuse and its impact are central to their accounts of pain.[95] Of particular interest are the subjective meanings attributed to their painful symptoms. Three informants complained of muscular pain and heaviness, eight reported pain associated with disordered eating, three woman complained of throat problems, one of cold sores, one of chest pain, two of excema and four complained of pelvic pain. All of these symptoms were, in participants' perceptions, linked with their sexual abuse, and importantly, all of the symptoms were invested with unique meanings that were for each woman tied directly tied to a particular aspect of their abuse experience.

'I went through a lot of like physical symptoms. You know like muscular cramping, involuntary kicking out in my sleep...I think it was about always being tense. It happened a lot when the abuse memories came out for me'. (P4)

'I've probably always had a heaviness in the body...it's been the heaviness, yeah, just a sort of deadening, its like if you can deaden off everything else you deaden off the body too...but I went ahead and did things...it was always an effort to drag my body around but I did it'. (P4)

One woman had suffered from cold sores that persisted until the abuse stopped. She understands the cold sores to have manifested because of the unwanted kissing which was part of her abuse.

'I definitely relate my cold sores to the abuse that was in my system and I'd constantly have cold sores, but these weren't little. We're talking about the whole top of my lip would be covered. I mean to me that was bizarre with a kid... It was constant all the time.

---

[94] See Chapter eight for a detailed discussion of women's recovery from body symptoms attributed to sexual abuse.

[95] For a review of the medical consequences of child sexual abuse see Lechner, Vogel, Garcia-Shelton,

I always had them and nobody seemed to be able to blame that [the sexual abuse]. *But I think it is because he was kissing me, my brother and none of this was supposed to be happening. And then it's interesting, because once I got away from the abuse they stopped happening...Every week I'd have one. I'd just finish the scab on one and another one would come off on the other side down ... Unbelievable. Constantly. It was horrible. I'd also have stomach cramps. Headaches.'(P6)*[96]

Eight out of the ten women in the study struggled with disordered eating patterns that included patterns of binge eating, anorexia and bulimia.[97] So significant was this theme and so obviously embedded with multiple meanings, that it is discussed in previous chapters and mentioned again here.[98] While my earlier focus was on the social, sexual and political dimensions of women's disordered eating, of interest here are the links between disordered eating and body pain. Patterns of starving, binge eating and vomiting were all associated with pain.

'I was doing it by starving. Then by binge and then by taking laxatives and that sort of stuff...Oh God, like I could see why I'd be paralysed and be so full. I can remember myself sitting in a corner not being able to move. Because I was so full. You know.....Yeah. It would be just so painful. It started off as a way of trying to silence or numb out the physiological feelings.' (P7)

Three women in the study suffered from throat problems. Both believed that throat problems were symbolic of the their inability to speak up about their sexual victimisation and the need to suppress their words. One of the women developed throat problems including vocal polyps that she attributed to the ongoing suppression of her painful feelings. She describes being unable to find a voice to express a range of overwhelming feelings associated with the sexual abuse.

Leichter & Steibel (1993).

[96] Domino, J.V. & Haber, J. D. (1987) found physical and sexual abuse histories were relevant to women with chronic headache.

[97] See Root (1991); Connors & Morse (1993); Miller (1993); van der Linden (1993) and Schwatrz & Cohen (1996) for accounts of the relationship between sexual abuse and eating disorders.

[98] See Chapter seven, pp.197-230.

'Well you know the fact that I've had a lot of throat problems and stuff like that, and that happened. I know that's a pretty obvious thing. Well I don't know whether it is. But to me it really is, it's that I couldn't express it. I held a lot of my pain there and then it developed into having polyps. If I want to, if I'm really upset about that issue, other things, my voice will go...' (P7)

'... When I first started going to therapy and wanted to speak about my abuse, I couldn't speak. My throat would tighten to the point where I felt like I wouldn't breathe and speak, and amazingly enough I developed polyps on my vocal chords through strain... I remember it took me ages and ages. I just couldn't and even sometimes now my neck or my throat close up'. (P7)

'Until I actually starting speaking about my abuse I suffered from sore throats almost constantly. I used to go to the doctor all the time. It used to feel sore and tight, even sometimes on my chest. Since I have spoken about the abuse and how it has effected me I have not had any throat soreness. I know my throat was always sore because I was pushing back many words I needed to speak out' (P10)

'I'd have bad nightmares and stuff like that...Yeah I'd have a repeated nightmare where I was yelling, yelling...but no one could hear me, then it would happen in real life, I couldn't speak about it...But like in real life it'd be like say if I was here talking to you and I started, I couldn't say it. So just saying maybe a sentence would be such a struggle. So the strain I put on my throat and the stress'. (P8)

In a similar way to the throat problems reported above, chest pain was tied to the effort to suppress thoughts and feelings related to the abuse. For the following woman, chest pain was indicative of pain in her heart and, for her, the pain was the knowledge of her sexual abuse and her fear of disclosure. Again, in a symbolic way, she sees chest pain as 'heart ache' - where the soreness and hurt is about intensely painful emotions.

'There was always something that I couldn't tell. Always, always. I used to suffer from chest pain which I think was about the pain in my heart that I could not speak about. We went to a priest in Lakes Entrance who was a faith healer, ... he came to me and he said, 'oh I need to talk to you.' He said, 'there is something there'. He said, 'you need to talk, there is something...And he said, 'there's something there.' He said, ' if I push there it will hurt', [indicates chest] *and he just went like that and I felt like hell. He said, 'there's something inside of you that you've got to let go'. (P7)*

'I figure there's something with my chest. So I don't know whether that was an area that I was particularly sensitive about, I don't know. I've had lumps removed from my breast and things. So my breasts, I get a lot of things. Chest, breast area...I don't know if it is pain from keeping it all down or if it is because my breasts are a sexual part of my body and so are always experienced with some discomfort?'. (P7)

Two women reported suffering from excema. For one, the excema was understood as a symbolic form of protection. Although making her very uncomfortable, she believed that it afforded her some protection against sexual activity, against feeling unsafe in public and from having to dress in ways that may not disguise her body.

'I didn't ever understand or believe that my body was having symptoms because of the abuse, even though I've had high blood pressure since I was 20 and been on medication for it. I've had eczema all over my body since I was a teenager. I haven't at the moment. And I've had, I get a lot of nasty illnesses. Like pneumonia and things that go beyond the normal... They effected my life majorly. The eczema in particular. I'd scratch all night and bleed. It means you couldn't do things or go places, wear certain clothes...Like it stopped me from being sexually desirable, from going out of the house and I'd have to dress in loose clothes and stay at home...a kind of protection I guess, even though I hated it too'. (P5)

Interestingly the eczema made her feel safe not only from being sexually desired and therefore at risk of abuse by others, but also safe from herself and her construction of

herself as someone whose body was responsible for the seduction of the offender. *'Just, I suppose it's still that it was a way the body was made less of. I couldn't use my body to seduce anyone or to do anything wrong while it had that eczema. Because nobody would want to touch it. It was cracked and bleeding.' (P5).* But the excema was also a reminder of the abuse at the same time it was a protection from further harm.

'I get eczema across here [indicates the chest area]. *The eczema used to worry me the most because it was so disfiguring and you have absolutely no control over the itch. And it was a complete loss of control again...the kind of scratching and not being able to do anything about it made me feel really powerless...It was the powerlessness more than and it was the disfigurement I think... every time there is a news report about a priest or a brother sexually offending, I get eczema. Every time. Our school is having a retreat and it's to the Celesians' farm in Lysterfield. The minute they said that I broke out in eczema across here. And I scratched and itched for days'. (P5)*

Four participants experienced pelvic pain.[99] For one, pelvic pain occurred when she felt frightened or vulnerable; *'pain and tension go straight to my pelvic area'* (P2). Another explained that, *'I really feel a lot of pain in my vaginal area and like some kind of pressure there or something' (P10).* For another, pelvic pain was associated with traumatic bodily re-experiencing. Another young women in my study suffered from frequent pelvic pain that had manifested during her teens. Her explanation for the pain was that it was symbolic of her fear. Suffering from constant nightmares, night terrors, disturbed sleep and re-experiencing reminders of her abuse on a daily basis meant that she felt in a state of constant fear. She believed her pelvic pain to be a result of her body's efforts to suppress her fear. The young woman also suffered from an unusual gynaecological problem involving a twisted fallopian tube that caused extreme pain and had to be surgically removed. The understanding she attributed these problems was that her body was 'always in a knot of fear'. She was subsequently diagnosed with endometriosis, the pain of which she described as akin to the pain she felt when being

[99] The association between pelvic pain and sexual abuse has been documented in studies by Duncan & Taylor (1952); Beard, Belsey & Leiberman (1977); harrop-Griffiths, Katon & Walker (1987).

subject to unwanted vaginal penetration. Further problems with fertility were to her, symbolic of a damaged and spoiled body, no longer wholesome enough to carry babies. Just as bodily pain was attributed with personal symbolic meanings that were constructed in the context of women's abuse experiences, symbolic meanings were also attached to self-harming, which was another significant theme emerging from women's accounts of the bodily consequences of sexual abuse.

8.7 The Punished Body

Punishing the body was a major and recurring theme in women's accounts of bodily experience following childhood sexual abuse. All of the women I interviewed engaged in active self-injurious behaviours that involved directly and overtly harming the body, or in passive self-injurious behaviours, involving neglect and denial of bodily needs and collusion in their own revictimisation. The kind of behaviours women engaged in when actively harming their bodies included scratching, hitting, cutting, nail and cuticle mutilation, injurious masturbation, starving, substance abuse, the self induction of pain through overeating, excessive physical exertion and handling the body roughly. More passive forms of self-injury included ignoring bodily pain to the point of physical injury and the failure to ensure personal safety, often resulting in revictimisation.

All the women attributed self-harming behaviours to their earlier experiences of childhood sexual abuse, even though it was difficult for many to articulate the particular meanings and motivations behind the self-harming behaviours. What emerged from my analysis of women's stories were multiple, complex and multi-faceted meanings for harming and punishing the body, many of which were concurrent with the existing literature on self-injury in survivors of childhood abuse. Their self-harming behavior was associated with traumatic re-experiencing, self-loathing, mental anguish, rage, frustration, the need for control, dissociation and trance states, escaping the body, internalisation of the perpetrator, revictimisation and suicide. Moreover, each individual act of self-harm, as well as the more chronic self-injurious behaviours served important physiological,

psychological interpersonal or symbolic functions.[100]

Self-injury is predominantly conceptualised in the most recent clinical and research literature as a response to chronic psychophysiological trauma reactions. The accounts of at least two women in my study support the use of the trauma framework in explaining self-injury. However, women's accounts also revealed two further significant dimensions to self-harming that are not usually addressed by the trauma paradigm, demonstrating that acts of self-harm have several important subjective meanings. First, crucial metaphorical and symbolic meanings were attached to harming the body. Second, conflicts, fears and anxieties around the meanings and experience of female embodiment were also deeply implicated in self-harming behaviours. Hence, both symbolic and sociocultural currents could be understood to form a part of participants' bodily harming. While self-harming was the act, the meanings it was ascribed by women related to their desire to deny, discipline and punish the body. Although I understand each individual act of self-harm, as well as the more chronic self-injurious behaviours as serving important physiological, psychological, interpersonal and symbolic functions, and as being embedded with individual and sociocultural meanings, it is the use of the body as a symbol that remains the focus of this chapter. I therefore seek to illuminate the connections between self–harming and the meanings given to the body.

Numerous intentions and purposes were attached to punishing the body. For the women in my study self-harming behaviour was prompted by: the re-experiencing of the bodily sensations that occurred at the time of the abuse, self hatred or self loathing driven by feeling 'dirty' or 'disgusting', the wish to replace physical pain with mental pain, anger at the body, frustration, fear of the body being out of control, the desire to feel something other than numbness, the wish to escape from the body, or to die, the internalisation of the perpetrator's thinking or re-enactment of aspects of original abuse, the induction of trance states, and by the need to possess control over the body. I examine each of these sources attending primarily to the meanings that women give to these acts.

---

[2] For a more detailed explication of the variety of functions and meanings attached to the self-harming behaviour of the women in this study see Chapter eight (pp.241-265)

8.7.1 Self-injury And Traumatic Re-experiencing

Two of the women in the study engaged in self-injury in response to the traumatic re-experiencing of bodily sensations related to earlier sexual abuse. Not only did they respond to the unwanted and intrusive bodily sensations that were frightening and painful and to the intense emotions such bodily responses aroused for them, but what re-experiencing meant to the way they felt about their bodies. The traumatic re-experiencing of bodily flashbacks was described by one of the participants as an experience that made her skin crawl. The skin crawling may be considered a physiological reaction to somatic re-experiencing, but it was also interpreted as the skin being dirty and contaminated by the hands of the offender.

'Well when I could just feel it happening again...it would feel like that person touching it [my body] *again, do you know what I mean? Like all the feelings that I got from when they touched me...It was like I was in that situation again...Its like you could just feel it. I could feel everything that I felt when it happened to my body. Like how my body felt...your skin crawls and you just feel sick in the stomach...Yeah just like you could feel it again. Like you know it's not happening again, but you could feel what your body felt like when it was happening and you just wanted it to go away. Wanted to like take your skin off and get new skin maybe...I was just scratching all my gross skin that was dirty, and number two, it hurt' (P1).*

In response to the intrusive recollections of body sensations associated with the earlier abuse, the young woman described scratching her skin until it was bleeding. Her purpose of the scratching was to distract from the disturbing physical sensations being experienced by her body and to erase the feelings of disgust and self-loathing toward her body that she felt had been 'dirtied' by the sexual abuse.

'Just disgusting, Just, I was scratching myself. Just really like disgusting. Your body would. I don't know...It was like I want new skin again, not dirty skin. I'd only feel that way when that was happening [the re-experiencing]. *All the other time it was fine until that would happen, then, like as soon as it did I'd feel yukky about it, I'd want clean skin,*

that's all'. (P1)

Self-harming is, in this instance, an attempt to regulate sensation, affect and knowledge. It assists her to keep oriented to the present and distracted from difficult, intrusive material. In this way, self-injury is a management tool, a counter irritant to unwanted affects, sensations and knowledge. Self-injury is also a way to relieve pain by inflicting pain. Orne (1959) coined the term 'trance logic' to describe such thinking in which subjects have the ability to tolerate, without apparent disturbance, the coexistence of multiple incongruous perceptions or logically inconsistent ideas. Subjective logic has been shown to be characteristic of the trauma survivor (Calof, 1995). Self-injury, for this young woman, also has other purposes apparently unrelated to the management of traumatic effects. Self-injury has some symbolic meaning reflective of the desire for purification. Scratching the skin is a way of removing from the body surface all the 'dirtiness' of the deeds done to her. Scratching until she bleeds allows the dirtiness from the interior of the body to be bled out. Self-injury resembles a ritual of purification, reflecting the desire to be clean and renewed.

The next woman describes the process of re-experiencing to which she responds by developing self-abusive, disordered eating patterns. Starving then binge eating to the point of extreme physical pain function to control her body, and to ward off and erase unwanted body sensations associated with the traumatic flashbacks.

'Well just always, and I still get it. It's like this scary numbing, tingling feeling that starts to come in. Yeah I feel invaded. The whole thing, like how do I stop this. Then I was doing it by starving. Then by binge and then by taking laxatives and that sort of stuff...Oh God, like I could see why I'd be paralysed and be so full. I can remember myself sitting in a corner not being able to move. Because I was so full. You know...Yeah. It would be just so painful. It started off as a way of trying to silence or numb out the physiological feelings. And I was doing it...'(P7)

Self-injurious behavior here is another attempt to regulate unwanted affect, sensation and knowledge grounded in the belief that hurting will relieve pain or prevent worse pain. But

being in charge of what enters the body, how and when, is also a symbolic communication about control, despite the fact that starving, bingeing and purging are inherently self-injurious.

8.7.2 Self-injury And Self-loathing

Self-loathing was a common feeling among the women in the study. Harming the body was a main response to feelings of self-loathing and self-blame. Three women I interviewed described engaging in self-harming behaviours and punishing their bodies in response to intense feelings of self-loathing. One woman described a history of cutting, overeating, and drinking excessive fluids then refusing to urinate. Self-injury was reflective of the desire for control and pain, invoked due to feelings of self-blame and hatred of the body.

'I wanted that degree of pain and control over my body because it was fitting to the way I felt about my body. Well I hated it. I hated it. I despised it. I distrusted it. Never did what I wanted to do'. (P7)

For these respondents, the belief that they were responsible for the abuse, that they caused it to happen, or at least could have done something to stop it, or to stop the body from responding, was a rationalisation that brought the illusion of control, that is, if you caused the abuse, or your if your body responded, you could also do something to control it. Further, you could also punish your body for being bad and make sure it behaved as you wanted it to in the future. Conversely, if the bad things that happened were not perceived as fundamentally about me, if I have not done anything to deserve these bad things, then there is nothing I can change to control it, so I am powerless and without hope. Therefore, I will self-harm because,

'Oh because in some ways I felt my body was useless. I thought well gees if I am just this is big hole to fuck and that's all it is, that's pretty useless. What else is there?'. (P7)

The third woman also self-harmed in response to feelings of loathing and disgust at her body.

'Sometimes I just feel disgust at my body, but yeah, other times I'd get angry at my body. Yeah, maybe I got, sometimes I would get angry at my body for not reacting the way I wanted it to react when it happened, you know, for doing a bad thing'. (P1)

The resulting scratching and hitting of her body was a way of punishing her body, a body she hated and by which she felt betrayed, as if in some way this treatment might teach the body to behave well, doing 'good' rather than 'bad' things.

8.7.3 Self-injury: Physical Pain vs. Mental Pain

Four women in the study reported that self-harming was a way to reduce mental pain and anguish. Physical pain could successfully divert attention from disturbing emotions that felt far more agonising than self-inflicted physical injury or abuse. Punishing the body was a way of inflicting pain to relieve pain.

'It was a relief in some ways...something else to feel rather than what you were feeling'. (P1)

'I just wanted to take away the mental pain of it'. (P2)

'...not having control over my body made me feel...feel angry all the time...and I'd react probably by just hurting it...by scratching it and hitting it...I punish it maybe. I don't know, but it took away the pain from maybe inside of me, a little bit'. (P1).

'...some people, girls I know, cut their arms and do all that sort of stuff, and this was my way of releasing my pain'. (P7)

'The binge eating was, although I thought I was enjoying it, which at the times it was nice. But like when I went overboard...I just think subconsciously honestly I just want to

numb all my other pain. Because that hasn't stopped'. (P6)

By inflicting pain on their bodies each woman tried to relieve their mental anguish and torment. Self-injury offered immediate relief from terrifying or overwhelming feelings and, as such, self-injury became a prescription for the relief of pain. Not surprisingly, chronic self-injury rapidly ensued as self-injury was identified and internalised as a relief from painful emotional and mental states.

8.7.4 Self-injury And Rage

Four women in the study described episodes of self-injury resulting from intense feelings of rage. When becoming overwhelmed with intense anger, women would direct the anger towards their bodies and express it in acts of self-injury. Calof (1997) explains that self-injurious behaviours often develop because survivors of childhood abuse must manage their traumatic rage and its attendant wishful aggression while bound by injunctions that prohibit the outward expression of affect, stifle dissent, and blunt judgment. In most abusive systems the injunctions to be in control at all times, to not ask for help, to accept blame, to not show pain or weakness and to not show feelings, especially rage, are powerful directives. In a context of powerlessness and dependency that inhibits the ability to act, and which may become more dangerous when fighting back, victims learn to turn their rage inward. Self-injury is a way to express yet contain their forbidden rage without violating the injunctions against its direct expression.

For the women in my study, rage was not directed at the perpetrator or his actions, which seemed completely irrelevant. Rather, rage was self directed at their own bodies for 'just being there' when the abused happened, for having basic human needs and desires, and for responding in unwanted ways during the actual abuse and later during vivid traumatic re-experiencing.

One young woman succinctly articulates the meaning that self-harming has for her.

'...when I feel angry at my body, I hurt it.'(P1)

In response to the question, 'What do you want to punish your body about?' she replied:

'For just being there. Being there...' and further, 'I don't know how to explain...maybe for not doing anything or maybe for not, ah, it's hard to explain'. (P1)

Self-harming is punishment of her body for being there, for somehow making the abuse happen, and for not protesting or rebelling. It is her body that is responsible for the sexual abuse. Her description is a good example of the way in which the body becomes 'other', 'alien', 'suspect', imbued with a will and reactions of its own that are completely separate from the self. Harming is a response to feeling angry at and betrayed by the body for not behaving in the ways she wanted it to during the sexual abuse by her brother.

One of the study's participants described self-harming in response to an accretion of intense frustration. When her feelings would become overwhelming and unmanageable, she could distract herself by self-harming and escape from this unpleasant experience. When the frustration would peak she responded by hitting herself or banging her head on the wall.

'I don't know, sometimes I'd have all the feelings together...I don't know, Oh, probably just everything would have just peaked in frustration. Like it would be when everything was getting really bad. Probably I wouldn't want to see my [therapist] *or his family and everything. Everything was the wrong response. And then when I really just had enough of it, you know to the point of where you are suicidal and just, and that would be when I'd do that. That was more like when I just wanted out of it'. (P1)*

'Yeah, definitely just sheer frustration. Just pain. Just hurting so much. At those times, hitting and banging my head took away [the pain] *from it... Because your body has just had enough. Just a different pain, that's it'. (P1)*

The meaning attributed to self-harming is, 'if I hurt myself I will feel better'.

8.7.5 Self-injury And The Illusion of Control

Several women reported inflicting harm in response to feeling their bodies were out of control, but the function of self-injury was to reassert control. The following participant felt her body to be beyond her control. She interpreted self-injury as punishment to discipline her body.

'Sometimes I'd punish my body, like if I am having sex with someone, even someone that I really love, but by just trying to hate it. Trying to make my body do what it should have done back then. Don't know why. Stupid. But my mind would be trying to make it do what I wanted it to do back then. And, I hate it, again'. (P1)

In a more extreme enactment of the desire for control over the body, the next respondent describes how anorexia, laxative abuse and binge eating were attempts at punishing her body as well as bringing it in to her own control.

'Well paralysed in that you know when it's Christmas Day and everybody's like oh so full of food. I used to cry in pain of being so full that I couldn't even walk to the laxatives...I mean I did the whole hiding all the food and all that sort of stuff, but I would eat till it paralysed me...I think now it was about punishing. The anorexia was more control. I mean but when I took the laxatives it was control, not like before when the abuse happened and I was never in control of my body'. (P8)

With a similar desire for control another participant described numerous self-injurious behaviours, some were specifically utilised as a way of establishing control over her body.

'And I suppose then I'd go onto different things and there'd be the cutting and the bleeding and the trying to stop urinating because that was a control thing, and then over stuffing myself with stuff and eating things that I knew I wasn't allowed to eat'. (P6)

Self-injury was motivated by the powerful desire to have mastery over the body, in response to feeling that the body is out of control and behaving in ways that require discipline and/or punishment. Self-injury was also motivated by the belief that I can hurt myself worse than you can hurt me or a correlative stance: I can survive your punishment because I can survive my own worse punishment. For the woman whose statement appears above, this stance embodies an illusion of self-control, encouraging self-injury as a way to manage the anxiety and fearfulness associated with feeling out of control. For the woman whose statement appears below, self- injury also reflects the desire for bodily control. By inflicting pain upon herself she almost tauntingly, expresses her perceived power over her body by claiming *'you can't harm me as much as I can harm myself'*. (P7)

'... anorexia's not a pleasant thing you do to yourself and neither is bulimia or taking laxatives or bingeing to cause yourself pain. Then for me it's just like representing exactly what another person did to me, but I'm doing it to me. So it's very much about me. You know that whole control thing. Because at that stage none of my family, nobody was acknowledging me or my pain and I think it was my way of acknowledging it, of being in control of it, and if that meant harming myself and then releasing it through taking laxatives and doing all that sort of stuff, it was probably a bit of a, well you can't harm me as much as I can harm myself'. (P7)

Self-injury is also embedded with destructive intent. Because she felt that no-one in her family was listening to her, acknowledging her pain and the injustice of the sexual abuse, she self-harmed to attract attention, to exact revenge and to punish others, believing that she could make someone else hurt by hurting herself. The bodily communication was 'when I hurt myself, you will feel the pain'.

8.7.6 Self–injury And Bodily Ownership

The illusion of control also appeared to underlie self-injury that was motivated by the desire to mark out body ownership and boundaries. Not surprisingly, for women who

have been abused, the desire to reassert bodily boundaries was strong. The following statements vividly demonstrate the perception that 'this is my body and I'm the only one who can hurt it'.

'Having had enough food and knowing that I'd had enough food and then to turn around and add more food on top, knowing that I was going to feel like over stuffed. And had to wander around 2 or 3 hours feeling over stuffed and feeling really wretched, horrible. And I'd do that on purpose. And I knew, and even the first time. It's like with the bladder control thing, even the first time. When it first happened and I knew that it was a control thing and I could turn it into a control thing, because there was pain involved, you see I could do that. So I could do that again if I wished... Well then I was forced to wander around for 2 hours feeling horrid and over stuffed. But I did that on purpose. Because I knew, the first time I did that you know you're going to feel over stuffed. You're not going to do that again, but I'd do it again and then the next time I did it I did it on purpose. Because I knew what it was going to feel like. It wasn't a curious thing any more. This was a planned thing. Now it was planned by me'. (P6)

Another respondent also self-injured in response to her need to clearly mark out body ownership and boundaries.

'Some people, girls I know, cut their arms and do all that sort of stuff, and this was my way of releasing my pain. Because although it was really painful and I cried, [the excessive overeating] *it was my pain. I was doing it to me. That's what I'm saying. It wasn't like re-enacting it, if that makes sense. It was like I was doing it; I'm allowed to do this to me'. (P7)*

While needing to claim ownership of her body and of her own pain, self-injury also reflected the woman's belief that 'I can hurt myself worse than you can'. The logic is that I am therefore in control and more powerful than the offender.

8.7.7 Self-injury, Dissociation And Trance States

Sexual objectification and the paradoxical internalised communications of sexual abuse perpetrators potentiate depersonalisation and derealisation in survivors of childhood sexual abuse. In addition, biophysiological and psychological responses to trauma often demand dissociative adaptations. In such a context of derealisation, depersonalisation and dissociation, survivors question whether they are alive, whether their experiences are real, and are often confounded by the absence of physical and emotional feeling that characterises their everyday experience. Simpson (1975) and others have observed that depersonalisation and feelings of unreality often precede self-injury, and so the practice sometimes functions as a defence against these states (Calof, 1995). Gioviaccini (1956) for example, proposed that pain associated with self-injury creates a self-representation: feeling is associated with life, non-feeling with non-existence. Miller and Bashkin (1974) suggest that, in the presence of a perceived threat of psychic dissolution, self-injury reconstitutes the self, thus ending the episode of depersonalisation. Certainly, for the women in my study, self-injury was used at times, as a strategy for reducing derealisation and dissociation, as an attempt to feel alive and to experience feeling.

'It was punishing my body. Yeah, it's also a way of trying to feel something'. (P2)

When dissociation was chronic, self–injury was enacted in response to the belief that 'I can't know I am alive unless I hurt or bleed'. I was told that self-injury was often experienced without pain or with greatly dulled pain. At times this functioned to increase feelings of depersonalisation and detachment from the self. For example,

'But the other cutting was like I didn't care. It didn't matter that I cut myself and so all the time there wasn't any pain. There was no pain. So I didn't care. I mean it was almost like I could have someone else's hand and I was cutting'. (P6).

Bleeding constituted proof that she was alive and real.

'It was like not caring that you're losing blood. Like your body's made up of blood and

stuff, and you're just losing this blood. You're letting this blood drain out of you. Like you don't care that it's not coming back. It's running and it's gone and it's not going to go back in there, you know. You know that it's probably going to take a lot out, you're experiencing this strange thing. But to just sit there and watch it and not care that you're bleeding. That you should try and stop the bleeding... It was about just letting it happen. Not doing anything about it. Like well obviously I didn't care. Because you don't just sit there. I mean if I cut myself now it's like oh oh and I'll get a band aid, you know, and I'll continue on without thinking about it. But I didn't even think about it. I'd just sit there and watch it bleeding. It's weird'. (P6)

When the cutting caused bleeding, the sense of depersonalisation decreased somewhat, as if bleeding constituted proof that she was alive and capable of feeling something. I was constantly assured that hurting and bleeding was evidence of life and feeling.

'I couldn't believe I was doing it. With my eyes I was seeing me cutting my own skin and thinking you're mad in one sense. I'm seeing it and thinking and your mind was you know, this is not right here. And the bleeding the blood's coming out and just sitting there watching it is like wow, something real odd here. Because you don't cut yourself up and watch the blood rolling down and dropping on the floor...The meaning of that was about, one was about pain. Finding out what was the pain threshold I suppose, because there was a little bit of that is cut yourself, how painful it's going to be and can you really do that or should you find an alternative viable solution to suicide. And to sit and watch yourself bleed is like, I don't know. I can't really explain that'. (P7)

While self-injury provided a way for these women to reduce the bluntness and numbness associated with dissociation or depersonalisation, it could be done without having to feel disturbing emotions or distressing or painful body states. Unfortunately, self-injury became an external feedback loop, an attempt to feel while not really feeling; yet again it gave rise to feelings of depersonalisation and dissociation.

8.7.8 Self–injury And Escaping the Body

The link between childhood sexual abuse and self-destructive behaviours in child victims and adult survivors has been well documented in the research literature. Increased rates of substance abuse, eating disorders and revictimisation have been reported among those sexually abused in childhood. Such behaviours have commonly been described as 'self destructive', with the implication being that the behaviour is designed to damage or destroy the self. While engaging in behaviours that are inherently self-harming and ultimately may lead to death, self-destructive behaviours of this kind also served another function. For three women, drug and alcohol abuse, disordered eating, chroming,[101] petrol sniffing and other self-destructive behaviours were in part, an expression of the wish to hurt and punish the body, but were more strongly linked with the desire to escape the body.

The woman below describes a long history of substance abuse and disordered eating, explaining that the purpose of much of her behaviour was the desire to escape from her body, and presumably, distressing thoughts and feelings.

' a long history of drugs, and alcohol and food addiction [over eating]*...a long time. A long time. Nearly 20 years...Some of it was about getting away. Definitely about getting away, running out, not having to face reality'. (P3)*

Not only did drug and alcohol abuse provide an escape from the body, but paradoxically, made her feel safer and more in control. Looking back, she realises the illogicality of her thinking and actions. Harming the body through the use of drugs, alcohol and food provided an escape that soon became addictive trap, and while making her feel safer, actually exposed her to more danger.

'Ah in some ways it enabled me to be social...When I was about 18 I started using harder

[101] 'Chroming' is a word used in Australia to describe the practice of inhaling substances such as paint, glue and other solvents.

drugs intravenously. I think when I look at it now, it was the first time in my life I actually became safe enough to be social with people. Even though the whole drug scene is not safe, and I was not safe I had a sense of being a bit invincible'. (P3)

The following respondent also describes the using a variety of self-destructive behaviours to escape from her body and her pain.

' Okay. Yeah petrol sniffing. I did that. Petrol sniffing. Anything that was going to be an escape. Anything that was going to stop my mind from thinking. All the time thinking but not getting anywhere thinking. Round and round in circles and driving myself crazy trying to work it all out. But I needed to stop myself thinking. And the only way to do that was to immerse yourself in something you could escape in. Alcohol, petrol sniffing, drugs, smoking...I did that. I did that in a lot of ways. Drug taking, petrol sniffing, car polish sniffing, paint sniffing. Whatever smell, I was sniffing it. Shocking'. (P6)

8.7.9 Self-injury And Revictimisation

Becoming the victim of sexual aggression has been found by many studies to be linked to an increased probability of being victimised again (Herman, 1981; Russell, 1986; Fromuth, 1986; Briere and Runtz, 1988; Wyatt, Guthrie and Notgrass, 1992; Krahe, Scheinberger-Olwig, Waizenhofer and Kolpin, 1999). The enhanced risk of revictimisation does not appear to be limited to women whose primary victimisation occurred once they had started to be sexually active but also holds true for women who were sexually abused as children. Explanations for increased levels of revictimisation among those sexually abused as children are multiple and diverse. My participants perceived revictimisation as a consequence of never having learned what it was to be safe or how to keep oneself safe and protected. Revictimisation was also thought to result from not feeling powerful enough to resist, or being so constrained by fear that protest was undermined. Revictimisation was also linked with dissociative states. Participants felt that cutting off and numbing out prevented them from acting self-protectively. Revictimisation resulted in overwhelming feelings of shame and poor self-worth that produced a powerlessness and passivity so engulfing that it damaged the capacity for

self-care. Revictimisation also functioned as a form of self-harming. Two women reported putting themselves in dangerous situations, indirectly inviting harm. Harming could therefore be considered to occur at the hands of oneself and at the hands of others.

'I'd put myself into situations which were extremely dangerous...the end result ... was possible serious injury and I didn't care.' (P9)

8.7.10 Self-injury: Internalising the Perpetrator

One participant was courageous enough to reveal how she had become troubled by persistent and increasing episodes of self-abuse that were sexual in nature. It was unclear from her story whether the behaviour constituted a re-enactment of the abuse perpetrated on her. What was clear, however, was the internalisation of the voice and actions of the perpetrator, including the learning and reinforcing of a deviant arousal pattern that sets the scene for the victim abusing herself and becoming sexually aroused to the abuse of others.

'Well I then in turn, it's almost like the user and the abusee. Like I'd become the abuser of my body. Well masturbation for instance. I may not feel like masturbating but I'd force myself to because it was a sick bloody thing I used to do occasionally. And I would be conjuring up these things, saying to myself, 'Shut up and do this' you know, its really abusive...Well yeah and that sort of worries me when I started to get really aroused about rape stuff and I thought, that freaked me out a little bit. I thought, 'Oh hang on'. (P6)

'Because I didn't know much about it and when I was sort of learning about this, aggressor or aggressee or the abuser becomes the abusee sort of can happen. And I think that's what I did to myself. I didn't realise until after. I got an understanding. Oh my God, I was abusing myself you know'. (P6)

8.7.11 Self-injury And Suicide

In an extensive review of the literature on suicidality and self-harm, Walsh and Rosen (1988) traced a fifty year history of attempts to distinguish self-mutilation from suicide and other forms of self-harm. The history began with efforts to distinguish between suicide and attempted suicide, and led to the description of a wide variety of extra suicidal behavioural syndromes or impulse control disorders, including among others wrist cutting syndrome, parasuicide, non-fatal deliberate self-harm, and indirect self-destructive behaviour. Clinicians agree that there is a need to distinguish between self-injurious and suicidal behaviour (Steele, 1990; van der Kolk et al, 1991; Calof, 1995). The distinction is often made on the basis of the underlying intent, motive and function of self-injurious acts. Calof writes that, 'self-injurious acts can be seen as attempts to manage life (survive), rather than as acts meant to destroy it' (1995:12). Unlike suicidal behaviour, acts of self-injury reveal a distinct survivor mentality, a stance of 'I will manage it' rather than a stance of 'I will end it' evident in suicidal intent.

Making the distinction between self-injurious and suicidal behaviour is clearly important, especially for clinicians. Gil, Briere and Calof (1993) found that victims who chronically self-injure most often feel misunderstood when clinicians frame self-injury as suicidal. For my respondents, self-injury had complex and multiple meanings and was often not about suicidal intent. Yet, despite this finding and the cautions in the clinical literature, three of the women in the study reported engaging in self-injurious behaviour with suicide as a motive.

'.. a part of me just wanted to die'. (P3)

'Some of it was a self-destructive thing...but at times when you feel really bad you just don't want to be here and I want my body and myself to just die'. (P3)

'I was feeling like I wanted to kill myself, which is what I felt when I was 6. I just wanted to die...I used to say 'I want to die' to myself...I was expressing how I felt because

nobody was listening to how I felt and I never had the opportunity to talk about how I felt'. (P5)

The following quote neatly distinguishes between self-injury with suicidal intent and self-injury with alternate functions.

'Oh I'd physically cut my body. Because the scars here like, yeah, some of them are definite suicide, tried to kill myself stuff. But other little nifty ones are not. It's just bullshit. And I'd sit there, cut, and watch it bleed and go...Yeah sometimes you're at the point where this was suicide and this was a serious deal here'. (P6)

Clearly, for some of the women some of the time, self-injury was motivated by such despair that they wished to die.

The stories of participants and their experiences of self-injury reveal many complex motivations and functions for self-injury. Each of the acts of self-injury was interpreted by women themselves to have underlying or symbolic meanings. Although at the time, the meanings were not clear to women and they felt they were engaging in 'crazy' behaviour, upon reflection, all could attribute important meanings that returned sanity to their actions. While on some occasions self-injury reflected suicidal intent, much of the time, self-injury was engaged in frequently as a mechanism for self-protection and self-control over overwhelming thoughts and feelings and bodily responses. As such self-injury was an understandable response to beliefs that women attributed to themselves and their bodies, symbolic of their pain, distress and struggles to survive.

The prominent research literature on self-injury describes self-injury as usually motivated by various forms of 'distorted thinking' resulting from early abuse. Respondents however, came to understand their self-injurious behaviours as representative of inherently meaningful personal struggles. Unfortunately, physiological states and the accompanying meanings women constructed about themselves and their bodies served to perpetuate and maintain self-injury. For several informants, the body continued to be a

symbol of their distress, confusion, ambivalence, shame and fear. Chronic self-harming ensued and became a way to manage the pain and distress of everyday existence.

The current research literature explains victims' self-reported body symptoms and pain as related to psychological conflicts (Gelinas, 1983; Finkelhor, 1984, 1985,1986), or to the tendency of abuse victims to engage in more health risk behaviours and unhealthy lifestyles. Similarly, much of the current literature on self-injury (based on trauma theory) emphasises the use of self-injury to manage unwanted feelings, sensations, behaviours, and thoughts. However, my participants' accounts of bodily pain and self-injury more often than not told a story about their abuse and revealed particular and personal meanings that women had assigned to their bodies in the context of that abuse. Often pain and self-harming reflected meaningful configurations of the nature of the abuse and the personal meanings it held, or represented critical dilemmas that the women negotiated in continuing to live in and with their bodies, precisely because of the meanings that were ascribed to them.

8.8 Denying The Body

As the above discussion shows, self-harming often involved deliberate, overt and conscious acts of harm that were inflicted on the body. These behaviours originated in various physical, psychological and emotional states and served a variety of functions. Participants' accounts also demonstrated that a significant element in self-harming was its basis in bodily denial. Denying the body, its needs, desires and demands frequently resulted in harm. At times, self-denial was active and conscious. Women intentionally denied the claims their bodies made upon them. In this instance, denying the body was a form of silencing and punishing the body for making its presence known and for insisting upon its desires. At other times, bodily denial was more passive and involved a lack of awareness of the body that remained only at the fringe of consciousness. In this instance, the body and its needs and desires were ignored. The resulting lack of attention and care often resulted in harm. Clearly, denying the body, either actively or passively, led to injurious effects, and therefore denying the body can be regarded as a form of self-

harming behaviour.

Bodily denial was a feature of five women's stories. Their accounts capture a process that begins in the disavowal of the body and ends in the punishment of the body. Bodily denial begins in the refusal to acknowledge the existence of the body:

'I felt nothing of my body...I wasn't to recognise anything about my body...Its not feeling anything or needing anything, so there is nothing to say, nothing to hear or know about because nothing is happening, nothing is there...' (P6).

Bodily denial was then exercised in the ignoring of bodily needs:

'This body didn't have needs. It was much easier that way too. The body had no needs and if it did feel I could easily squash them... I could turn away.' (P6)

'I felt nothing and if I did feel something I could control it or punish it. I was definitely not going to recognise needs...its easier to cope like that...' (P9)

Ignoring the body's needs were demonstrated and as a consequence doing harm were evident in reports such as:

'I'd do things I did not have the fitness for and knew that I did not have the stamina for...' (P9)

'I can disregard discomfort to an enormous extent. But what it's meant is that I've paid in some regards. I really, um, I have really injured myself. I've injured my feet and my ankles from walking when it was really cold and keeping on walking even though it was hurting'. (P3)

'It's being cold or hot...I didn't notice it...I wouldn't notice it for ages. And then I'd suddenly realise that I was unbearably cold or unbearably hot. And, even then, sometimes when I'd register, I wouldn't do anything about it'. (P2)

Several women became so adept at denying the body that pain tolerance became extreme:

'The amount of pain I could bear was always huge. I consider it to be a lot bigger than it should have been and I grown up with different circumstances.' (P6)

If the body refused to be silent, to disappear, if the demands became too persistent, insisting on attention, women would intensify their efforts, and finally respond in punitive ways.

'I would become angry at my body for having needs and feelings, and for being so demanding as to bring them to my attention...I just wanted to punish my body for having those needs. Yes and for bringing them to my attention'. (P2)

'I've used food as a way of trying to shut up all sorts of needs, so um, I've eaten and I've hurt myself eating, and I could feel it hurting...Overeating was kind of like trying to shut myself up or something. It was, um, savage. It was kind of 'Oh for God's sake, have that and be quiet'. (P3)

'I remember brushing my hair for example, and getting really furious with the knots. Instead of teasing them out gently, I kind of ripped at them. I'd punish my body for being unco-operative. So you are at war with your body in some sort of basic way. And that goes for eating, or any other objections your body makes...Rather than stop and listen, I just tend to override what my body is telling me.' (P2)

When I asked my participants to explain why they engaged in bodily denial and subjugated their basic needs, women explained that the self-denial was a reflection of the messages they had received about themselves and their body and learnt as a result of the abuse. The abuse had conveyed to them the powerful and lasting message that their body was unimportant or irrelevant, a mere object that can be used, cast aside or made never to have existed. At best, personal needs are secondary to those of others. Also, women had

learned to fear their body. Self-denial involved rejecting or neutralising femaleness where femaleness and femininity were associated with sexual power, unruly desire, and uncontrollable male sexuality. Paradoxically, the activities and techniques of self-denial actually reinforced what women knew to be the social directives of femininity.

Female desire was a particularly significant theme that was fraught with difficulty. Female needs and desires were feared because they would inevitably become unruly, dangerous, and consuming, so they needed to be silenced, controlled or punished. The entitlement to needs and to satisfy desires was also feared because it was threatening to others who had the primary claim to women's bodies and would inevitably provoke rejection, disapproval or anger from others and possibly invite harm. Such needs had therefore to be made non-existent. Any departure from the requirements of femaleness and femininity, any expression of need, desire, 'self-fullness', or protest that unwittingly escaped or insisted on visibility needed to be punished.

'Oh, I'm just so afraid of needing anything, because needing anything's such a dangerous thing. It's because you're trained that your needs are secondary or supposedly non-existent, and because there's been anger when you've had needs, you get angry with yourself for having them.' (P2)

'It's just safer to not allow yourself to have any needs, to silence your body and make it do what you want'. (P9)

'It's everything, it's food, it's clothes, it's friendship, it's comfort, it's warmth, it's any desire. You're not allowed to desire it, and it's not safe to.'(F2)

Denying the body was, for my participants, bound with symbolic meanings about the body that were derived from their individual experiences of sexual abuse in childhood and intertwined with the broader social significance they attributed to female bodies.

8.9 Summary

In this chapter I have highlighted the personal meanings that women attached to their body and to the symptoms and problems of embodiment they experience after childhood sexual abuse. I have argued that women's bodies become important symbolic sites and that their bodily struggles convey essentially meaningful communications constructed or derived from their abuse experiences and the surrounding context. My examination of the themes, bodily pain and bodily harming and bodily denial reveals that the concomitant distressing and disturbing problems reflect more than physiology or than biological responses to trauma. They also 'speak' of a 'wounded body' that is hurting or hurt as a consequence of its violation and the interpretations formed by that violation.

My discussion of the key findings has thus far revealed that victims' body symptoms and problems of embodiment can be understood in various ways; as the biophysiological effects of trauma, as 'attempted solutions' to living in a body that has been violated, as 'existential struggles' that reflect the inescapable dilemma of female embodiment, and as symbolic communications of facts known by the body, a site invested with personal and social significance. In the next chapter I examine women's stories of recovery from the bodily effects of childhood sexual abuse. Just as physical, sexual, social and symbolic bodies are implicated in women's accounts of body symptoms and problems of embodiment after violation, they are also invoked in their stories of recovery.

CHAPTER NINE

'WALKING WITH NO SHOES ON THE GRASS': THE RE (DIS) COVERED BODY

9.1 Introduction

In this chapter I present women's stories of recovery, examining the factors they believed were important to their healing. Just as women's stories of the impact of child sexual abuse pointed to the centrality of the body, so did their reflections on recovery. My analysis of their accounts revealed that overcoming the effects of sexual abuse was tied to the creation of a new kind of subjective reality with quite a different perception of one's physical self. This new physical reality was created through a recursive process in which the rediscovering and reclaiming of the physical body allowed for the creation of new meanings for the body, while the creation of new meanings for the body led to new and different perceptions of the physical self. The chasm between body and self created by sexual abuse and its impact and the consequent conflicts and difficulties with embodiment, were replaced in recovery, with an embodied sense of self and the resolution of many body troubles.

Central to the process of reconstituting the embodied self was the role of both materiality and culture. By this I mean that recovery was linked to both bodily praxis, (the activities, practices, rituals and enactments of the body) and the reconstruction of subjective meanings for the body, in particular the revisioning of femaleness, the female body and femininity. Both experiencing and thinking about the body differently was made possible by a number of factors. These included the importance of understanding the bodily impact of childhood sexual abuse (specifically, how the abuse had resulted in numerous body symptoms), problematic behaviours in relation to the body and struggles with embodiment, the use of non-traditional therapies (particularly body therapies), the support, encouragement and nurturing of an empathic other, trusting oneself through the recovery process, and finally, the importance of spirituality.

While each of these aspects of recovery are interconnected and all involve re-envisioning the self and the body, I discuss them under separate headings, 'Reclaiming the Body', 'Rethinking the Body' and 'Re-Envisioning the Female Body'. I do so to emphasise that women's accounts of the 're(dis)covered body' were based on three core elements: physically experiencing the body differently through bodily practices and enactments (reclaiming the body); creating alternative personal and symbolic meanings for the body (rethinking the body); and critically examining social and cultural constructions of femininity, female roles and the female body (re-envisioning the female body).

I am aware that this discussion way suggests a split between the body and the mind and a distinction between the body as physically experienced and subjectively understood, and that such dualistic terms continue to suggest the rupture between body and self. Our language is so replete with the mind/body split it is almost unavoidable. However, while the words used suggest this split, participants' bodily practices were a means of overcoming the effects of dualism and of experiencing the embodied self as a connected whole. I am also aware that making distinctions between levels of bodily experience may suggest that a linear or causal process was involved in healing the victim's body. However, in previous chapters I have proposed that women's bodily experience is constituted through a recursive process in which the physical experience of the body and the subjective attitudes to the body create bodily experience, while cultural norms and expectations are simultaneously translated into subjective experience and physical perceptions. While this understanding has been used throughout to explain the process by which women came to suffer body symptoms and problems of embodiment, in this chapter, it is highlighted again in my elucidation of the process of women's healing. My argument is therefore that the body is created; shaped and transformed in an interaction between experience, will, and available social meanings.

I begin this chapter by examining the bodily rituals that were transformative for women.

9.2 Reclaiming The Body

For several participants the transformation of recovery was tied to having physically experienced the body in a new or different way. Participants adopted several activities that were central to transforming the body. Whether it be massage, body work, Reiki, or some form of physical exercise, such as swimming or pushing weights in the gym, activities that focused on the body were beneficial in assisting women to become reacquainted with their bodies and to re-experience their bodies in positive and integrated ways. Such activities reduced dissociation, bodily fragmentation and distortion, and assisted with coordination, confidence building, strength, and the release of bodily pain and body memories associated with the abuse.

'Everybody gets a good feeling out of different things. It could be swimming or could be jogging. It's about experiencing new things, really nice things. Although it's a sport it's still teaching your body to do and feel things that are totally different'. (P7)

Women who felt 'recovered' from the bodily effects of sexual abuse all spoke about the way their body *feels* and what these feelings meant to them. When they spoke of this 'inner' experience of their body, it was most often in the context of physical practices that they enjoyed and through activities which continued to transform the meaning their body had for them.

9.2.1 Physical Exercise: Feeling Through the Body

Physical exercise was important to recovery in a number of ways. But it was not just the activity that alone effected the transformation but the meaning that the activity had for participants.

'When I went for a swim, I could feel the water on my body, I loved that feeling. It's not just the physical activity, but it also makes me feel stronger and fitter'. (P3)

'I get into the pool and I say 'Hello arms'. You know and I start moving my arms and I'd think 'oh oh hello, hello...I'd sort of say hello to all you bits. And then there was one day when I realised that my body was a whole and that I was whole. And I thought 'this is new, not just, sort of a collection of bits'. (P2)

Getting acquainted with the previously 'unknown' or 'dis-integrated' body was possible through physical exercise. In becoming more connected to the physical body, new feelings of confidence and trust were ascribed to the body, so that as much as the activity itself, these new meanings 'recreated' the body for victims.

'Practical things like walking and swimming is essential...I did a self-defence course and as part of that I chose a really crowded street on a Saturday afternoon after a footy match and decided that I would hold the centre all the way down for quite a long way. And, I just; they parted like the Red Sea. I mean those kind of practical body things, there would be a million things like that which you could do which teach you how to occupy social space which would be so good'. (P2)

The new physical activities became the means to experience the body and self more fully, became ways to experiment with body boundaries and to experience greater freedom. As a consequence, participants reported an increased sense of connection with self, others and the social world.

9.2.2 Body Therapies: Knowing through the Body

The importance of the physical body to recovery was also demonstrated in women's reports of the helpfulness of body therapies. For several women in the study, engaging in non-traditional therapies such as bodywork, massage, Reiki or body harmony was important to the healing process.[102] These rituals were helpful in two main ways. First, they assisted participants in bringing about an awareness of parts of the body they had learnt to disregard and fear, helping them to reconnect with the body as an ally, as part of

[102] The role of physical therapies in recovery is discussed by Martin (1989) and by Garrett (1998) in her

the self, rather than as enemy or appendage of self.

'With Reiki I found that type of thing very you know healing....and it might be because you are touching a part of the body that might be relating to the pain and distress, like the heart or whatever, and combined with the touch, and where you are touched it might have an effect, it is where the trauma might be.' (P4)

'My body became lighter and I know I relate that a bit to other therapies. Like shiatsu and Tai Chi and stuff. I would notice when I did it, when your energy was flowing, you know when it is just flowing through you, there's this lightness and you're more supple. You know you can just do more things. I felt the lightness coming into my legs and it was like taking a layer or two off'. (P2)

Second, body-therapies, were an alternative way to knowledge, providing participants with forms of knowing that extended beyond the instrumental and the rational.

'I believe you can heal without having to go the mental way. Sometimes body-work is really helpful. You can just feel it, and it's releasing. You might not quite know what is going on but you know you can just be healing in the process'. (P3)

'...body work-body harmony ...it's just been so powerful...it's been amazing. I like it because it's my body being listened to and my body being followed in the way that it wants to heal...It's totally about the practitioner just receiving what's in my body, what's wanting to be released. So in that way it doesn't reinvent trauma because it does not impose anything onto the body. It's by invitation only...you are just listening to the story that's been locked into your body tissue. And it's been just incredible'. (P5)

While assisting women to reconnect with their body and to safely experience their body in physical ways, body therapies also gave them access to kinds of body intelligence that

---

exploration of recovery from anorexia.

dominant intellectual, rational and logical forms of knowledge could not provide.

'I mean just like you might be able to talk something out with a therapist and well, that helps some people. Well, I guess sometimes you know if it's in your body, sometimes there is, there is a persistence and it might be necessary to work this out in other ways'. (P4)

'If I have a therapy session, I tend to get more out of going into things on my body, what's going on in my body, working out, you know. There's more of a definite release, or a completion happens now. If I work with a therapist now on a more talking level or intellectual level, I feel it does not take me anywhere now.'(P3)

Biodynamic massage, for example, allowed women to draw on notions of healing based in ideas that energy moves through the body and is capable of powerful emotional and physical effects.

'Deep tissue massage isn't like massage. Basically you know it works different areas of the body...Things used to come up, body memories and sensations... not images or pictures, just body feelings, emotions and different things...I think it was healing because I wanted stuff to be out there, because there was part of me that just wanted to sort of take the lid off the bottle and just sort of let it come out and I didn't even know what I wanted to come out'. (P3)

Similarly, Reiki, also depending on the ancient belief of healing through the hands, was felt by several participants to be a source of inspiration and healing. Each of these 'techniques' or 'means of healing' assumes that one may come to 'know' through the body, that such knowledge is 'holistic' rather than 'fragmented' and that much of this kind of knowing is inexpressible in words. Further, what each of these forms of activity strives to express is the relationship between body and mind: the thought that the body gives rise to meaning and vice-versa.

9.2.3 The 'Imaginary Body' In Rituals Of Recovery

The stories participants told about the body in recovery were about a rediscovering of an 'authentic' body; of listening to, feeling and moving closer to their body, and of the 'mind' reconnecting with the body. Although the body/mind dualism was still evident in their words, it did not necessarily prevent recovery. Rather, the body rituals could be considered non-dualistic practices that mitigated against dualism.

The bodily transformations of recovery were made possible through reconceptualising the body via practices like swimming, jogging and weight-lifting and the language that accompanied them. As well as the physical sensations participants experienced in their new, positively oriented rituals, a major change occurred in the way they conceived their body. Gatens (1983) describes the significance that each person ascribes to 'the body as lived', as the 'imaginary body'. The physical body to which participants referred, far from being a pre-existing body was continuously shaped through practices and language. Thus the 'imaginary body' is also a body which is socially constructed. It is the imaginary body which is the object of ritual transformation and this, in turn, has effects on the biological body. For example, the muscular development which takes place in swimming or weight lifting, is not the primary object of the exercise; rather it is the creation of an imaginary body through language, visualisation and sensory experience which leads to a new respect for the body. The 'imaginary body' made possible new meanings about body and self. Participants were then able to engage with discourses like Tai Chi and Reiki which not only allocated specific psychological meanings to parts of the body and contributed ideas about the rhythms, energies, needs, meanings and the cultural possibilities of the body, but which also allowed participants to feel new sensations, and in this sense, have a physical experience of recovery.

9.3 Rethinking The Body

For all the women in the study, it was important to make sense of the body problems they suffered following childhood sexual abuse. The process of 'making sense' of their

responses occurred through a process of deconstructing and reconstructing their experiences. Central to this process was acknowledging the trauma of the abuse, developing an understanding of trauma and its impact, specifically the bodily responses to trauma, connecting body symptoms and problems of embodiment to the childhood sexual abuse, articulating the problematic beliefs and meanings that had been attributed to the body, and in so doing, untangling complex and confusing relationships that had developed with their bodies. Participants were then able to create new and more helpful meanings about themselves and their body that permitted reconnection, and importantly, an increase in feelings of safety and control and a decrease in anxiety, fear, panic, self-blame, shame, self-destructiveness and feelings of craziness.

'Understanding the abuse. And understanding my reaction to it and why I might have felt the way I felt when I was younger and not being able to deal with it. And to understand what that means you're not battering yourself any more...All the sorts of body symptoms, body problems, confusions that I've had. When I look back on them... it was just a craziness. Out of control craziness. Now they actually have a meaning to them'. (P7)

9.3.1 Understanding Trauma

Central to victim's recovery was developing an understanding of the nature and bodily manifestations of traumatic reactions, especially re-experiencing and dissociation. One of the clearest findings emerging from the study was the extent to which bodily symptoms and bodily reactions were feared and not understood by victims, and the extent to which body problems were the least discussed of all the impacts of childhood sexual abuse. Bodily feelings were the most difficult to articulate because they were without words. The frightening, intense and seemingly weird activities of the body were not available in language, nor was the depth of fear, horror and pain that would be evoked. Intensifying the experience of being without words was the silencing that resulted from victim's fear and mistrust of their own body and its responses, and their possibly greater fear of the anticipated reactions of others. Given how distressing, persistent and unmanageable body symptoms were, and how difficult they were to articulate, understanding how, why and when they occurred was a first step in their management.

'I guess you do learn on your way as you go along, but just even to know when you're splitting, because you're going all numb, which isn't necessarily helpful...Maybe there should be fear there, but if you know that that's what that feeling is and you're more aware of it, it's better'. (P6)

'Understanding the bodily re-experiencing and feeling safe when this was happening, trusting the process. Getting reassurance from someone else when the re-experiencing takes place and finding a way through it'. (P5)

Understanding their bodily responses and the nature of traumatic reactions assisted women to feel safer, less crazy, and more able to take some control over their body. Even though they could not prevent the bodily responses from occurring or body conflicts manifesting, understanding the meaning of bodily experience was an essential step in the recovery process.

9.3.2 Body Problems As Abuse Impact

Not having an understanding of the bodily impact of trauma or of the way that childhood sexual abuse had problematised and confused the relationship with their body, many women explained their symptoms and problems of embodiment as psychopathology, as evidence of their 'craziness'. Once they were able to connect current body symptoms and conflicts and dilemmas around embodiment with their prior childhood sexual abuse, some healing was possible. Recognising that body symptoms and struggles to live comfortably in the body following child sexual abuse were understandable reactions to the trauma of abuse, and to the meanings created at the moment of the trauma and in its aftermath, assisted women to feel safer and more in control. Consequently, they were more able to be present in their bodies, to reclaim their bodies and to reconnect body with mind in an embodied selfhood.

'Because of my understanding of the abuse and all the surrounding stuff that happened with my family, it made it so much easier for me to walk past that and then my body started to do the same thing. The feeling started to happen. Oh wow. And I only noticed

because that I was understanding things that I didn't before. Feelings I hadn't noticed, because all my life it wasn't happening. There was no feeling here and it's like wow, now there's feeling here. Okay. Alright. I was like wow, free, free'. (P7)

'I do believe now that my body's my temple and without it I'm not me. Like my personality doesn't just live there. It's part of the same thing, the emotional expression, the physical mannerisms and the tone of the voice all go together, and now that they do it's easier to work with. I mean you don't have to worry about control. There's no such thing as control because it's all happening'. (P6)

Attending to the abuse experience, making sense of the myriad of ways it disrupted the ability to live comfortably in the body, and consequently challenging the ways in which the body had become devalued, disconnected and separate from the self, created the possibility of redeveloping a trusting relationship with a body, enabling the body to become a valued and integral part of self.

9.3.3 Talking Therapies

Significant to the process of understanding the impact of child sexual abuse, and in particular, the ramifications of the abuse on the body and subsequent embodiment, was the participants' engagement in therapy. All but one of the women in the study reported that a significant improvement in body symptoms and increased feelings of safety and comfort in their bodies were associated with therapy. Both body therapies and talking therapies assisted women to find alternative ways to express the psychological and emotional distress associated with abuse impact, and specifically, to resolve internal conflicts and dilemmas connected to the abuse that had manifested in body symptoms and painful struggles with embodiment.

'When I started therapy, I think the physical symptoms were so severe and so instant it was like I couldn't believe how much they manifested for me...it's been more and more safe to be in my body and to express feelings as my healing journey has gone

on...Because when I look back now, when I first started doing any kind of therapy, I was just so scared of being in my body and struggling the whole time with it, you know'. (P3)

The process of therapy was helpful to women in several ways. It supported and encouraged women to find words for their experiences. As noted earlier in my work, traumatic events disrupt victims' capacities to construct narrative.[103] Lost and fragmented memory, altered cognitive and emotional capacities, unspeakable experiences that illuminate the poverty of language, the destruction of time, shattered assumptions about self and the world, despair, hopelessness, and the seeming unreality of it all, constrain and limit the possibilities for narrative. In the process of therapy, victims were assisted in finding the words with which to tell their stories. Therapy simultaneously provided an audience, present and willing to hear and to understand the words as they were intended; a person who could empathically bear witness to their stories.

Therapy was important in another significant way. Therapy encouraged women to articulate the conscious beliefs and meanings they ascribed to their bodies and to speak about the intentional actions that followed such beliefs about their bodies. For example, the connection between conscious beliefs and their intended outcomes in bodily actions are evident in the following description.

'...overeating, you know being really quite overweight, it was a way for me to protect myself. It carried the belief that if I make myself ugly it will protect me. Yeah, I'd be safe because then I'm not part of the cultural picture of what a women should look like'. (P3).

Therapy also facilitated the articulation of previously *unarticulated* beliefs and meanings that participants had attributed to their bodies and which had been followed by *unintended* outcomes. For example,

'It was my belief that I had to have done something to have made it [the sexual abuse] *happen...I did something, so I felt ashamed. Then when I felt so much shame I hurt and*

[103] See Chapter five, pp. 116-167.

punished my body'. (P6)

Articulating both the conscious and unconscious beliefs and making overt the intended and unintended consequences of these beliefs enabled victims to 'rethink' their bodies. The process of therapy therefore allowed the articulation and reconstruction of women's experience and of the vital meanings of that experience that were enfolded in their bodies.

9.4 Re-Envisioning the Female Body

Women's subjective experience of childhood sexual abuse and its impact were frequently associated with many negative beliefs about femininity, female roles and the female body. Deconstructing the beliefs and meanings victims had about their body and untangling the confused and uncomfortable relationship that had developed with their female body were important aspects in the healing process. In re-examining and reconstructing ideas about what it was to be a female and to have a female body, and creating a new set of positive beliefs about power, sexuality, desire and female embodiment, women became more able to live comfortably in and with their body. Some felt liberated, empowered and able to enjoy the pleasures inherent in embodiment for the first time. Implicated in the re-envisioning of the female body were yet again, engagement in bodily practices and rituals, especially those culturally associated with femininity and negotiations with alternative cultural discourses on femininity, the availability of which made transformation possible.

9.4.1 Power And Pleasure

Several women commented on the importance of re-defining the power associated with female bodies. For most, femaleness had been associated with a dangerous powerlessness and/or a disquieting powerfulness, due to its equation principally with sexuality and embodiment.[104] However, as women began to re-experience their body in positive ways

[104] See my discussion of 'The Dangerous Body' in Chapter seven (pp.198-200), which illuminates

and create new meanings for them, the needs, desires and agency afforded by their body were no longer felt to be dangerous.

'I began to trust my body and as I did I could allow it to have more of my attention, without getting so scared that my body was bad and its needs were dangerous, I could listen to it more and when I did I kind of felt better'. (P10)

'...it started by experiencing really nice things, and being taught nice things. Because I had to find out for myself... Learning to feel things again, to have pleasure with the body, safe touch...'(P10)

Feeling safer in and with their female bodies meant that power and pleasure were no longer fraught.

'I began to realise, I started to realise that I had to get comfortable with power. That I actually had power and I had to give up all my old ways of thinking about it, that I wasn't dangerous, that power could be affirming'. (P2)

'I am learning not to be afraid of my power, learning that you can use power constructively. (P4)'

'But I'm learning to embrace, to feel comfortable with my power and my strength, although this challenges and threatens men because it starts to have an impact when they want to be the one's with power'. (P2)

For several women being able to find pleasure in embodiment, in their female embodiment, was a significant move towards healing from the bodily effects of violation. Access to pleasure had disrupted victims' relationship to their own pleasure, and had also

---

participants' problematic relationship to power.

isolated victims from intimate relationships with others. [105] Experimenting with activities traditionally associated with femininity was a challenge for some who had so profoundly and stubbornly refused female embodiment and the techniques of femininity.

'I think for me it was a small step. Like having a nice bath, say, for instance, but being able to do this was a really long process...but now I can... '(P7)

'The first thing I started off with was, which is really good, is silly things like facials. A manicure. Like really simple things. So you're getting touched but it's not like full on... I couldn't be exposed. If it was just nice simple things where I wasn't too exposed. So there's that. And then I would put oils on, just having nice oils smelling. That would be another thing. I found music to be a huge thing and it didn't matter if it was like really calming or those really beautiful African CDs, or if it was AC/DC. It really wouldn't bother me. It was like I was feeling... '(P7).

For others, the pleasures of embodiment could still be found by refusing limiting social constructions of femininity and the female body and instead by redefining femininity. In the case below, alternative constructions of female bodies meant being entitled to possess and enjoy one's own body while celebrating the female body of others.

'It's like being able to go outside and just go yes! Yeah and it's hard to take pleasure without feeling guilty about taking pleasure...It's a real freedom. It's a freedom to be who you want to be. Not who you have to be. You can be who you want and not who you have to'. (P8)

'We saw this woman and my girlfriend and I. Well, there's this woman, really beautifully voluptuous. Now she was sun-baking without a top and I was just thinking 'gee she looks great' and 'she looks gorgeous'. I was really surprised, my girlfriend said to me, she goes 'don't you just love it...that woman?' And I'm sort of looking, because I thought the

[105] For a more thorough examination of violence and its impact on the victim's access to pleasure, see MacCanneli & Flower-MacCanneli (1993).

same thing but I didn't really say it because I thought oh yeah this might, women are like so in touch with their own bodies and that she feels really confident, to just do that. I said to my girlfriend, 'yeah she's got these great purty boobs. She just goes 'oh my God yeah'. (P7)

9.4.2 Sexuality And Desire

Women's accounts of healing also showed them embracing desire; the desire to connect with their body, their sexuality and sensuality, and with others. Sexual abuse experiences had created problematic meanings about sex, sexuality and female embodiment, and had consequently disrupted intimacy with self and others. Most participants felt sexually objectified, were frightened about sex, and saw sexuality as representing a frightening loss of control, resulting in further abuse or a kind of uncontrolled promiscuity. Several had become disconnected from, confused and fearful about sexuality. Recovered sexuality and desire was achieved in part by participants' renewed relationship with their body, and, in part, by the relationship their partners and friends had with their body.

'I noticed myself touching my face in a gentle way and I'd think 'What?' As opposed to either not doing it at all or doing it and not registering it as being anything to do with intimacy or sensuality or anything. At first, I'd not registered it as being a caring thing to do for myself...Then I just started to think well what did I used to do before? Oh, I don't recall touching my face. Or I do recall touching my face lots of times but not thinking about the way in which I did it. I thought about the way I do that now is so totally different to what I did before when I touched my face.' (P8)

'It was so important to me that [partner] *liked my body, but it was not really my body, he loved me, so I could feel good and safe about my body with him and I could enjoy sex, in a way that I was not able to before. I was really present.' (P9)*

'A combination of touch and being in a sympathetic environment, being with a nice caring person, that was a real release for me'. (P4)

For women who became mothers, their previously held negative views about their bodies and their sexuality were challenged by the experience of pregnancy and motherhood which restored beauty, magic, purity and goodness to the female body.

'I'm a mother, and having been pregnant is fantastic and having a baby. Breast feeding a baby was just fantastic...It wasn't just me that was involved. So I could afford to, I was entitled to be selfish because I was actually, I actually had to think about somebody else...it was the first time I really started to, I really appreciated my body...I just kind of moved into my body in a big way, and I breastfed and it was fantastic...It was like a redemption or something, it was incredibly healing for me. And to have a baby that needed you, and who grew just because of what you were giving it was incredibly affirming...Rather than having a dangerous body, it turned me into this person who had a great body that wasn't dangerous and it was actually the opposite of dangerous which was benign and you know, beneficial...And of course, I had a daughter, another daughter'. (P2)

In reconnecting with their body through both experiencing them differently and ascribing new meanings to them, participants' fear of female embodiment decreased. In particular, fear of the sexual body diminished. For the victims in my study, all of whom equated their sexual abuse with their female embodiment and vice versa, the confirmation and expansion of their sexuality, the extending of the boundaries of their body and the possibility of sharing the body with themselves and others (partners, friends and children) was a significant step in the recovery process.

9.5 Allies In Healing: Relationship with Others

Central to recovering from the devastating impact of childhood sexual abuse was the support, nurturing and encouragement of a sympathetic friend, therapist or partner. All

the women interviewed in the study commented on the healing and restorative power of intimate and trusting relationships.

9.5.1 Partners, Family Members And Friends

Women's stories of recovery are a testament to the healing power of loving and supportive relationships with partners, family and friends. One participant spoke of the particular significance of her relationship with her husband, who had been a devoted and caring partner, both prior to her disclosure of childhood abuse and after.

'It is a journey and I'm 100% sure that [husband] *was sent to me for a reason because without him there is no way I could have made it... Yeah and he's like that. It's just him. I'm lucky'. (P8)*

While the ongoing support and commitment from her husband was important to the process of healing, of particular significance was the approval and validation she received from him and from her children following her disclosure.

'When I told the kids, my son wanted to go and smash him, [the perpetrator], *how dare he have done this to his mother. And the others were like good on you for doing something about it Mum... So everything from that was positive... Yes. It was the hugest thing that I could ever have experienced, was their total acceptance of me.'(P8)*

Tragically, for five other women in the study, not having the belief, support and validation of parents or family members following disclosure, meant that the abuse continued, the negative impact of the abuse was intensified, the symptoms were more persistent, and recovery was severely compromised. One woman commented on the value of supportive and loyal female friends in helping her to recover from the childhood abuse experiences and the unhelpful responses of her family. Their assistance was particularly important at a time in her life when the symptoms resulting from the abuse had become especially problematic.

'I found women who just stuck with me... That was an amazing thing for me. It was like being mothered for the first time... It was like being born or something. Born again. It was particularly at a time when I felt hideously ugly and was beginning to get sick and so on, being looked after by other women was unbelievable. So it was as though I found a family...I thought well maybe there is salvation after all. Maybe I can live after all'. (P2)

9.5.2 Therapists

Several of the women in the study commented on the importance of therapists to their recovery. Of significance were not the mode, style, technique or theoretical approach of the therapist, but two other factors. The first was the importance of the therapist providing them with information to help them understand and untangle the problematic body symptoms and behaviours associated with sexual abuse and trauma. The second aspect central to recovery was the empathy, care and compassion shown by the therapist. Having a therapist who could help make sense of bodily symptoms and feelings, especially the apparently 'crazy and weird' sensations associated with traumatic re-experiencing sensations, was very reassuring. Simply providing information to victims about the nature of trauma and the psycho-physiological responses that can be expected to occur as a consequence of trauma was both liberating and normalising experience for victims. Having such information helped women to make sense of previously incomprehensible and frightening bodily symptoms, reducing fearfulness and anxiety about their body.

'I can do a little bit myself but having someone there like when I felt like my body was feeling the abuse all over again. It's a very frightening thing, particularly if you didn't have that assurance all the time that no this isn't a mad thing, this is normal... What helped was counselling and it was during counselling, that she[therapist] *could tell what me what I need to find out, what is actually happened that makes me feel that discomfort in my body.'(P5)*

In addition to providing critical information about the nature and consequences of trauma, and the impact of trauma on the body, victims' highly valued therapists who

acknowledged the depth of their pain and distress and responded with care and empathy.

'I've had all types of therapy. I've had from a really clinical psychologist to somebody who's just oh yeah, to the healers, to cutting out certain foods, to everything that would attribute to this. And what I found for me was the most helpful is... that you have this backup...the most important thing is to not feel so isolated in it... to feel your pain is acknowledged and valid...I need to know that I'm deserving of being loved. I need to know that first of all just to start experiencing compassion. That's the first thing...that I deserve it, that I want it. That it's okay to have that. That it's a safe place... '(P5)

Seeing that a therapist is meaningfully and empathically connected to the victim's pain was especially important for one woman who commented,

'You've seen their eyes and they have that pain. And so for you it's like my pain is real. That for me has been the most helpful...It was like I'd done 6 months of therapy in one glimpse, and for me like that stayed in my mind like for so long. It was like God she felt, I didn't have to even speak. It was like she really got my desperation, she really got my pain and when you get that it's like you're feeling better about yourself. Because you're saying well if this person is kind of going through that, that's really hard. They're not even saying it. They're saying we believe in you, you're worthy. Because it comes to all those things. It's about being compassionate and loving... ' (P8)

For two of the women in the study, the availability of therapists was also important.

'That's what I hate most about the medical profession and a lot of therapists is that they think, they believe that we should have a limit put on us, especially when it feels so bad for us. Like that again is people putting control on us. Whereas you wouldn't do that if somebody had a heart attack. You wouldn't do that. I actually get more offended by that because they should really get it. But sometimes they're the worst. They don't get it at all. They don't realise that if you've been abused, one thing you're starved of is like compassion, empathy, love and you're working with a real person. Forget that. Like people forget that's what's happened'. (P7)

9.6 Trusting Oneself: Relationship with Self

Several women commented on the importance of trusting themselves throughout the painful journey of recovery.

'A very difficult and important initial thing was for me to have that belief in myself. Because there was no outside validation or acknowledgment. Even though I'd tried to tell people right from when I was little about the abuses. There was no outside confirmation of what had happened So to believe in yourself is an important thing'. (P5).

'It's like just me being able to stand in myself and say well this is who I am and to keep the sense of value of that, no matter what's going on around me. No matter what someone else's idea is of who they think I should be. I think that is very much what it's about. And very much on a body level too. Saying well this is my body how it is right now and yeah I'm OK, outside of what anyone else thinks I should look like'. (P3)

The idea that in order to heal it was necessary to trust oneself was reiterated by another woman, who added that the ability to trust oneself was strengthened by support and encouragement from others.

'I think that the fact that people actually know how to go on their own journey and how to heal themselves, you know, is something that is said a bit. I'd probably go by that so that if people affirm that and give you that respect, that just gives you the confidence. They do the same with mothering. That's probably important, like someone from my situation, that you know you do have in yourself ideas about it, but because of your experiences, your belief in yourself and even your belief in whether my arm's reliable, is lost' (P5).

Valuing oneself throughout the process of recovery was closely associated with dispensing with self-blame.

'You're not blaming yourself, saying it's my fault, it's my fault. While you're doing that you can't go anywhere because you're just so fully involved. But once you get away from

that you have to then move along and it becomes different'. (P7)

One woman in the study explained how dispensing with self blame was, for her, closely associated with the offender admitting responsibility for the abuse.

'And then another thing that was extremely liberating was when...he first totally denied everything ...and then ... he admitted it...But he admitted it. But not only did he admit that he did it to me, that he had done it to other people. So it wasn't just me...I knew then that it was him...that I really was not to blame...Then I started to sleep a whole night and that was brilliant. I'd never slept. Fear of him coming to my bedroom. Door shut. Bad dreams' (P8)

Dispensing with self-blame was linked with the belief, support and validation of friends, partners and significant others, reconstructing long held negative beliefs about being responsible for the abuse, and for some women, having their experience of reality validated by offenders admitting that the abuse did occur.

9.7 Spirituality

'...healing is a spiritual journey'

Four women in the study reported that spirituality was important to their recovery. Although spirituality had different meanings to each of them, what women shared was a sense of spirituality that implied a notion of wholeness, a connectedness between body and the mind. They believed in the necessity for reconnecting and integrating body and mind for healing to occur, claiming that the disavowal of the body and the disconnection between body and mind resulting from the trauma of sexual abuse had led to many of their problems in living. Acknowledging the body as an integral part of being and attending to the body was instrumental in repairing the myriad of ways in which women had become disconnected and alienated from, punitive and mistrusting of, shamed and betrayed by, and denigrating of and hateful towards their own body and the actuality of female embodiment. Women's sense of spirituality also encompassed finding a set of

beliefs that would enable them to find patience, to value themselves, to accept what had happened without self-blame and to engage with behaviours that were elevating and constructive rather than debilitating and destructive of mind and body.

'Central to my healing has been my spiritual beliefs. Yeah, I use the word spiritual for want of a better word. My beliefs, I guess above all... What is very important in my healing has been that belief, trying to work on love an forgiveness and not get into blaming and then going back and living in the past and saying this happened to me because of this, and 'poor me'. It is supportive if I can just well accept something happened and it wasn't right what happened. It happened and you have to move on, and you can go on from it'. (P3)

'My healing process had to do with my spiritual beliefs. As such it was to do with forgiveness, you know. That's forgiving yourself and forgiving my father and it's not to do with saying it was right or anything that it went on, but it was just like you have to, you know, let it go and do it. So that was a lot of it'. (P4)

'Giving myself the time to be, like just sit with myself and be really still, and because in that way it is really valuing myself and giving myself attention and time and also looking after my body as best as I can because you know, it houses the spirit ...the spiritual process of just sitting with the basic question of who I am has helped to resolve unhelpful beliefs that I have held within myself'. (P3)

Grant acknowledges the psychological and spiritual challenges faced by victims of trauma, claiming that 'trauma, in spite of its brutality and destructiveness, has the power to open victims to issues of profound existential and spiritual significance' (1999:2). My participants explained that for them, spirituality was a path that enabled them to move towards re-envisaging and re-experiencing themselves and their body, providing alternative sets of beliefs and behaviours that permitted and guided recovery from the profound effects of sexual abuse.

Before closing the chapter I attenuate three significant dimensions of recovery that are highlighted in women's stories; the reciprocity of body and language, the constitution of an embodied selfhood, and the centrality of relationship to healing.

9.8 The Reciprocity of Body And Language

Women's accounts of recovery illustrate that recovery is linked to experiencing the body in new ways, that is through bodily practices, rituals and physical enactments, and through language, that is, via the words, meanings, beliefs and attributions that are ascribed to the body. It would be a misunderstanding and simplification to reduce this process to a dualist experience in which nature/culture, biology/society and mind/body remain separate and binary, and to privilege one of the paired opposites over the other. It would also be a distortion to read the body in this process as a solely a material reality, as a pregiven biological entity, unmediated by language and cultural practice. The converse reading, in which the body is thought never to be unmediated by language and by cultural discourses, its' corporeality always being filtered and apprehended through social and cultural lenses, would also be only a partial representation of the process. However, each of these representations does not fully reflect the process of embodiment that women described. Their experiences suggests that the relation between the body and the mind is reciprocal - that the body gives rise to meaning and that meaning in turn influences the body, and further, that in the experiencing of the body, cultural norms and expectations are translated into subjective attitudes and physical perceptions, while physical sensations are interpreted through the available cultural meanings.[106]

---

[106] Lakoff & Johnson (1980) and Johnson (1987) explore the idea that the body gives rise to meaning and vice versa in their work by showing the reciprocity of body and language. In *The Body In the Mind* (1987), Johnson is concerned with the ways in which bodily schemata are fundamental to language, claiming that these bodily schemata give rise to the linguistic metaphors through which we make sense of our existence. Thus, rather than disocurse determining our bodily experience, bodily schemata already constrain discourse because our understanding is 'our way of being in, or having, a world' and this is 'very much a matter of one's embodiment'. Language arises from bodily experience, but then language is used to enhance, develop, shape and 'recreate' bodily awareness and knowledge of the body.

9.9 The Embodied Self

Throughout this chapter both my participants and I refer to the integration of body with self as an essential aspect of recovering from the bodily effects of sexual abuse. The concept of the 'self' has been defined in numerous ways by philosophers; as whatever it is whose persistence accounts for personal identity over time, as that which holds bodily continuity, as that which is constituted by continuity of memory, character traits, or other psychological characteristics that makes someone the same person over time. There is also the view, held by poststructuralists that the self is narrative, which is a version of the view that psychological continuity constitutes personal identity. In ethics, the self is viewed as the locus of autonomous agency and responsibility and hence the subject of praise or blame. Most traditional accounts of the self have been individualistic, based in the assumption that one can individuate selves and determine criteria for their identity over time independent of the social context in which they are situated. In contrast, feminist accounts of the self have focused on the ways in which the self is formed in relation to others and sustained in a social context. Such accounts view the self as related to and constructed by others in an ongoing way, not only because others continue to shape and define us throughout our lifetimes but because our own sense of self is couched in descriptions whose meanings are social phenomena (Scheman, 1983).

Participants' accounts reflect notions of the self (particularly the embodied self that is reconstituted in recovery), that more closely resemble feminist descriptions of the relational self (Gilligan, Ward and Taylor, 1988; Meyers, 1989, 1992; Gilligan, 1992; Held, 1993). The view of the self as the locus of autonomous agency which freely makes choices and wills actions is fundamentally impaired in the act of physical and sexual violation. The loss of control over self and environment experienced in this moment is then reinforced by the autonomy-undermining and involuntary symptoms of trauma, and by the subsequent fears, dangers and difficulties accompanying embodiment in a particular social and cultural context. In re-establishing the self in the aftermath of trauma, participants' accounts highlighted the importance of relationship. It was in establishing and re-establishing connection with themselves (their bodies, feelings, and

actions), and with others, that the embodied self was constituted. [107]

9.10 Relationship And Healing

A significant feature of women's stories of healing from the effects of childhood sexual abuse, and specifically from the body problems that ensued in the aftermath of abuse, was the importance of relationship. Returning to Watzlawick et al's. (1967) notions of analogic and digital communication, I argue that just as these kind of communications were implicated in the abuse experience, contributing to powerful and negative experiences of the female self for the victim, digital and analogic communications were also conveyed in the context of positive and caring relationships with empathic others, but with quite a different effect. These new experiences, both felt and said, in the context of a non-abusive relationship positively reconstructed the experience of the female self. Women also spoke of the importance of a renewed relationship to self, likewise achieved through a process of experiencing the self differently (ie. in analogic ways), and via the new meanings they created for their bodies (ie. digital communications, eg. 'my body is stronger'). In addition, several of the participants' stories of recovery highlighted their relationship to the 'cosmos', which was often described as 'spirituality'.[108] The practices associated with spirituality, such as meditation, Reiki and yoga, all gave women access to bodily experience (bodily awareness, movement, physical, embodied knowledge) as well as to language that was used to enhance and develop the knowledge of the body. Consequently, women's relationship to themselves, and to a broader spiritual world also involved both the digital and analogic experience of their bodies.

9.11 Summary

Just as women's stories of the impact of child sexual abuse pointed to the centrality of the body, so did their reflections on recovery. Of importance to their healing was

---

[107] Brison (1997), in a similar vein to Herman (1992), argues that traumatic events and their consequences invoke a loss of the self of the victim. She argues that the victim's 'self' is restored in the context of relationship, where the autonomous self and relational self are compatible and complementary.

[108] Interestingly, subjects' souls and spiritualities are not often discussed in early or modern theories of bodies or identities.

understanding the impact of childhood sexual abuse, and specifically, how the abuse had resulted in body symptoms, problematic behaviours in relation to the body and struggles with embodiment. The use of non-traditional therapies, particularly body therapies, was vital to rediscovering the body and experiencing it in new ways, while the support, encouragement and nurturing of an empathic other (usually a therapist or friend) was central to the process of reconstructing subjective meanings victims had derived from their personal experience and social context and attached to their body. Trusting oneself and developing a set of spiritual beliefs also guided women through the recovery process.

In this chapter I have highlighted the significance of both materiality and culture to women's experience of healing. It is in the actual experiencing of the body in new and different ways and in reconstructing meanings about the body and its painful and unspeakable experiences that recovery occurs. This interweaving of physical enactment and the reconstruction of personal and social stories of the female body permits the hitherto unattainable integration of self and body. Recovery was also made possible through the telling of painful stories, through the discovery of words that became vehicles for what had been unspoken. However, their stories were not simply created by given narrative forms, they were born in the context of the relationship in which they were presented. Women's accounts provide testament to the healing power of relationship in which relationship between the teller and the told allows victims' painful stories to be constructed. But intimate narrative is not just constituted by the words, explanation or 'facts' that pass between the people in this relationship. For the women in my study, intimate narrative was equally constructed by the listening, feeling, empathy and body awareness of the teller and the told. Felt as well as spoken experience were an essential part of successful narrative relationship. Moreover, women's accounts reveal that the intimate narrative that is created between teller and told consists of more than words. It encompasses the feelings, emotions and embodied responses of each.

'In talking about it I got an understanding of the abuse. That was one thing that was important. Being able to put a name to the way I felt and to the effect it was having on me...It was sort of like, the words hadn't been there' (P8)

Significantly, just as women's bodily struggles after sexual abuse could be understood by attending to the significance of the physical body and to individual embodied experience, and by appreciating the social, sexual and symbolic meanings attributed to their bodies, body symptoms and problems of embodiment, women's stories of recovery could be understood in a similar way. The process is most fittingly described by Kleinman, 'the recurrent effect of narrative on physiology, and of pathology on story is the source and shape and weight of lived experience' (1988:55). Or in the words of one of my participants, *'It just can't be one or the other, you can start off talking if you do therapy, but at the same time its like experimenting with your body, like, walking with no shoes on the grass'. (P8)*

CHAPTER TEN
CONCLUSION AND IMPLICATIONS

While the prominent discourses on child sexual abuse have thus far largely overlooked the body, the narratives of the women in my study highlight the centrality of the body for victims of sexual abuse. The findings presented in the preceding five chapters illustrate the profound and complex impact of abuse on the body. The experience of abuse calls into question how to live with and in a body that has been violated, a body that is dangerous, a body that is out of control, a body that is damaged, and a body that is in pain. Beginning with the physical violation of the body's boundaries, the trauma of abuse continues to reverberate not only in physiological symptoms and perceptions of the body, but in problems of embodiment that communicate struggles around the social and cultural meanings of the female body. Moreover, both the intimate and uniquely personal physical reality of women's embodied experiences, and the public and cultural constructions of women's bodies, are powerfully implicated and inextricably entwined in women's subjective experience of sexual abuse trauma and its consequences.

In the preceding five chapters I have identified and examined the key findings emerging from my research. The significance of the body in women's experience of child sexual abuse was highlighted by my description of the many ways the body featured in women's stories. My analysis focused on the role of the physical body in shaping women's experiences; the body as a metaphor and site of personal and social meanings women attached to the abuse; the centrality of sexed body to the sexual abuse and its' impact, and finally, on the importance of materiality and culture in constructing women's experience of the body following childhood sexual trauma. While endorsing recent writings from the trauma field that attend primarily to the physiological body, my research reveals this to be an important but narrow and unidimensional view of the body. Women's accounts of the impact of child sexual abuse on the body indicate the need for extended and alternative conceptualisations of the body and body experience, including those that encompass an appreciation of individual embodied experience and the sexual, social and cultural significance of the body. Applying a more complex and multifaceted analysis of

this kind may prove useful to understanding the experience of victims, many of whom carry the burden of child sexual abuse into adulthood in profound, chronic and distressing body symptoms and problems of embodiment.

This thesis contributes to emerging research based on women's subjective experiences. It affirmed a number of findings from previous trauma research, in particular the myriad ways in which the body is implicated in trauma and its impact. Its unique contribution lies in the exploration of the meaning of traumatised bodies for women who have been sexually abused in childhood, and its exploration of the ways in which sexually traumatic experiences, embodiment and identity, and the social context are interconnected. The following summary of conclusions focuses on the unique aspects of my findings.

10.1 Major Conclusions

1. Women's responses cannot be understood by applying one predominant discourse. As important as they have been in revealing the psychological impact of child sexual abuse on victims, psychiatric discourses have also concealed significant aspects of victims' experience. Previous feminist analyses of medicine and psychiatry have argued that the narrow focus on individuals and the creation of diagnostic and illness categories have obscured the social context in which these individual experiences are located, precluding an analysis of the social and cultural dimensions of symptoms. In this thesis I have shown that the emphasis of psychiatric discourses on the psychological problems experienced by adult survivors has largely obscured considerations of the body and the effects of abuse on embodiment. My study has made visible the body of victims and highlighted the profound and lasting effects of sexual abuse trauma on the body, while using a range of discourses to elucidate and account for women's responses. None of these alone are sufficient, and each illuminates only part of the picture.

2. Far from being unimportant or unworthy of attention, the body is significant and central to childhood sexual abuse and its impact on victims. The trauma of abuse

reverberates in serious and disturbing symptoms of the body and in ongoing problems of embodiment.

3. Of particular importance to victims was the bodily impact of sexual abuse. My study showed that victims' perceptions of their body were constituted by individual embodied experience, that is the material, physical and felt experiences and sensations of the body, and by the personal and social significance of the body, constituted by women's interactions with the social context. Only when both these factors were taken into account could the nature of victims' bodily experiences be understood.

4. Embodiment after the violation of sexual abuse is particularly problematic, as victims' physical experience of their bodies and subjective attitudes to their bodies' combine to create a chasm between body and self. The rupture between body and self brings major conflicts and difficulties with embodiment that perpetuate and often exacerbate the original struggles with the physical, embodied self.

5. While trauma theories have provided a way of making sense of traumatic bodily reactions suffered by victims, termed 'body symptoms' in my study, they rest on notions of a unidimensional 'object' body, and on the identification and description of particular 'abnormal'/illness responses of the body. They, in a similar vein to psychiatric and psychological theories, assume a neutral, unsexed body. The subjective meanings that victims ascribe to their body and the social factors which inform these meanings are largely irrelevant. In contrast, my thesis shows that personal and social meanings are a critical dimension of victims' perceptions and experiences of their bodies, and that victims' responses cannot be understood without attending to the meanings ascribed to the sexed body and the social context which shapes and informs them.

6. Personal, symbolic and social meanings ascribed to the body are all-important facets of the body problems women experience in the aftermath of sexual abuse. Their body

problems cannot simply be understood as reactive symptoms of a traumatised, object body. Given the personal, social, sexual and symbolic significance victims attributed to their bodies and to their struggles with embodiment after violation, the body can also be considered as metaphor and cultural object, and 'problems of embodiment' can be seen to be constituted by dilemmas around identity, gender, sexuality and embodiment after sexual violation. In attempting to resolve the conflicts and dilemmas inherent in female embodiment after sexual violation survivors seek recourse in the body. The disturbing symptoms and problems of embodiment that follow, rather than 'illnesses' or 'psychopathologies', can be seen as 'attempted solutions' to the problems inherent in embodiment after violation and can be understood as embodying phenomenological coherence (eg. attempts to own the body), to perceive it as self (not other), known (not uncharted and unpredictable), and impenetrable (not invaded and controlled from the outside).

7. Of particular importance in making sense of the bodily impact of childhood sexual abuse is the significance of the sexed body. While the sexual specificity of the body is disavowed in most discourses concerned with the impact of sexual abuse, for female victims, the sex of their body is absolutely central to their understanding of the abuse and to the chronic and serious nature of their subsequent body problems. The social and patriarchal disavowal of the specificity of women's bodies may be a factor of the phallocentrism invested in regimes of knowledge-medicine, psychiatry, science - in which women are submerged under male categories, values and norms. My study highlights the need to recognise and represent the particularities and specificities attached to female embodiment for female victims.

8. This project highlighted that the body symptoms and problems of embodiment suffered by female victims were, in part, constituted by the meanings women ascribed to femaleness, female bodies and femininity within contemporary Australia, and the meanings associated with sexual abuse. These meanings were drawn from women's practical and discursive consciousness. The meanings were not always readily available for women's own interrogation as those known through practical

consciousness or analogic communications were often unarticulated, unconscious or on the 'fringe of consciousness'. Clearly however, there is an inextricable connection between participants' body problems and the cultural context that conferred particular and powerful meanings upon female bodies. This finding provides further evidence that different kinds of bodies, especially different sexed bodies, generate different meanings, both individually and socially.

9. Victim's experiences of abuse impact and their stories of recovery show that the body gives rise to meaning and that meaning in turn influences the body, and further, that in the experiencing of the body, cultural norms and expectations are translated into subjective attitudes and physical perceptions, while physical sensations are interpreted through the available cultural meanings.

10. For female victims of sexual abuse, numerous 'bodies' are evident in their stories, the physical body, the socially constructed/ imaginary body, the symbolic body, the sexed body and the body politic. Each dimension of embodiment is evident in victims' experiences and perceptions of their bodies and each are linked through the reciprocity of body, mind and language. To focus on less than a multidimensional view of the body may obscure particular and important dimensions of embodiment for victims. As a consequence, opportunities for understanding, analysis and helpful interventions are foreclosed.

10.2 Implications

There are many implications of my conclusions for clinical practice with female victims of child sexual abuse. However, I have limited myself to noting three important implications.

- The need to broaden therapeutic practice with victims in ways that acknowledge and attend to the bodily impact of abuse and accompanying body symptoms and problems of embodiment. Such work would need to recognise the centrality and recursivity of

both individual embodied experiences and the meanings victims ascribe to their body. It would also need to take account of the role of bodily praxis and language in creating and recreating meanings for the body, as such meanings inevitably shape and inform body problems in the aftermath of abuse, while also constituting the process of recovery.

- Therapeutic work with victims needs to take into account the social context in which the abuse has occurred and which gives meaning to the body of victims. In particular, therapy needs to address and examine the nature, form and impact of social discourses on the sexed body and to deconstruct with victims, the meanings and impacts of these ideologies on their bodies and identities.

- In recognising that practical and discursive consciousness informs and constructs victim's knowledge of female bodies and embodiment in culture, therapy needs to address both levels of victim's experience of the body in culture. Similarly, if both digital and analogic communications have constituted victims' experience of interpersonal relationships, then the therapy process and the therapeutic relationship should provide a context in which all communications provide for a corrective and healing embodied experience.

10.3 Recommendations For Future Research

A number of implications for future research arise from this thesis.

- All participants in this project came from a clinical population. Whether the findings apply to other populations of 'victims' of childhood sexual abuse is worthy of investigation.

- An analysis of the experiences of victims of childhood sexual abuse who did not develop problematic body symptoms and problems of embodiment may shed light on the factors that mitigate the negative bodily impact of sexual abuse.

- This research focused on female victims of child sexual abuse and the existence of body problems in the aftermath of the abuse. Further research with male victims may reveal similar or different findings with respect to the prevalence, nature and frequency of body problems.

- My research findings emphasised the relationship between female victims' problems of embodiment, the sexed body, and social discourses on femaleness, the female body and femininity. Research with male victims that examines the bodily effects of sexual abuse may illuminate whether body problems in male victims are also connected with the sexed body and social scripts of masculinity and male bodies.

- A larger, qualitative study of female victims may support or challenge my finding that victims' constructions of the nature of *female* identity and embodiment were inseparable from the attributions they ascribed to their sexual abuse (ie. the belief that female identity and embodiment and sexual abuse were recursively related).

- Given the long-term nature of many of the body problems suffered by women after sexual abuse, longitudinal studies are required which focus on the factors that assist and impede resolution of these difficulties. In addition, more thorough, detailed and longitudinal studies of women's accounts of recovery from the bodily impact of abuse would be a welcome contribution to academics, clinicians and survivors. Of particular use would be the way that such studies could create and sustain new and alternative discourses on healing, which victims may draw upon.

- My research did not examine the possible differential effects on body problems of intrafamilial and extrafamilial sexual abuse experiences. While the women I interviewed had been abused primarily by intrafamilial offenders, subsequent research exploring the relationship of body problems to the type of offending may elicit a more detailed understanding of abuse impact.

10.4 Conclusion

In this thesis I have argued for a greater inclusion of victims' bodies into the analysis of sexual abuse and its impacts. I have shown that, for victims, the bodily effects of sexual abuse constitute the most profound, enduring and distressing of all the consequences of childhood sexual victimisation. Their troubled stories of body symptoms and problems of embodiment following violation are testament to the centrality of the body for victims. I have argued that to understand the nature, meaning and significance of body problems multiple discourses are necessary. Of particular importance, however, are discourses that permit an analysis of the body and society. While individual experiences are unique and important, they can only be understood when socially located. Women's experiences of their bodies after childhood sexual abuse were inextricably tied to their perceptions of the abuse and to the meanings they ascribed to having female bodies in Australian culture. Their body symptoms and problems of embodiment often embodied complex meanings that were constituted and perpetuated by bodily experience and by the social and sexual significance of their bodies. Only by acknowledging the multiple meanings of the body, in particular the sexually violated body, and by attending to the various dimensions of embodiment illuminated by victims' accounts can we hope to understand and find ways for victims to heal from the enduring bodily effects of childhood sexual abuse.

APPENDICES

Appendix 1: Literature Review on Child Sexual Abuse

CURRENT PERSPECTIVES ON CHILD SEXUAL ABUSE: A REVIEW OF THE LITERATURE

This appendix consists of a review of the current literature on child sexual abuse. As this review is lengthy (approximately 20,000 words), it has not been included in full in the appendices of the thesis. Instead, I have provided a summary of the contents of the literature review below. The entire review is available upon request in a separate volume.

The literature review is comprosed of three major sections. The first section involves a review of the literature on the nature of child sexual abuse. It examines definitions, incidence and prevalence, the criminological and cultural patterns evident in child sexual abuse, (including the significance of gender and age differentials), the dynamics of child sexual abuse, strategies of coercion, the process of victimisation, and the characteristics of intrafamilial, extrafamilial and sibling sexual abuse.

The second section provides a comprehensive overview of discourses that have been influential in shaping and informing how child sexual abuse is conceptualised in the Australian context. It includes a discussion of historical constructions of child sexual abuse and of contemporary discourses that have dominated the field. In particular, it examines discourses from psychiatry, (psychoanalytic, family dysfunction, family therapy theories), psychology (individual, behavioural, offender theories), feminism (structural, political, incest resolution, self-help theories), and psychobiology (trauma theories), as well as discourses on child sexual abuse from the law and child protection, media and popular culture, autobiographical accounts and fiction, and alternative therapies, self-help and recovery movements.

The final section of the literature review is concerned with the impact of child sexual abuse. It provides a detailed examination of the literature on short and long term effects of child sexual abuse. Research studies that have focused on the bodily impact of abuse

are also reviewed, specifically studies that have linked psychosomatic reactions, medical problems, chronic pain, bodily harming, dissociation and disordered eating, with childhood sexual abuse.

The review is concluded with a summary of the key themes and arguments, within which I situate my own research project.

Appendix 2: Letter of Introduction

LETTER OF INTRODUCTION

'SEXUAL ABUSE AND THE EXPERIENCE OF THE BODY'

Dear _____,

I am writing to invite you, _____(name of potential participant) to take part in a study that I am undertaking with women about the impact of childhood sexual abuse. The study focuses in particular on how the sexual abuse has affected feelings and perceptions about the body. As yet I do not have any personal information about you but _____(therapist's name) has agreed to send this letter on my behalf.

My name is Karen Sutherland and I am a social worker and family therapist also working at The Bouverie Centre. I am studying for my PhD. through Monash University where I am supervised by Dr Chris Goddard, Associate Professor in the Department of Social Work, and by Dr Helen Johnson from the Centre for Women's Studies.

From this study I am hoping to obtain information about the impact of child sexual abuse on woman's perceptions of their bodies, and to find out if there is a link between childhood sexual abuse and body symptoms for those who have been abused. The results of this study will be used to:

-Provide information to professionals about the views of women who have been abused and their needs in response to this abuse;
-To improve therapeutic services for women who have been sexually abused in childhood
-To broaden the knowledge base about childhood sexual abuse by extending Conceptualisation's of female childhood sexual abuse and its impact, and by extending medical and psychological understandings to encompass broader social and political

understandings, which attend to the context in which women's experiences of abuse and its consequences are situated.

Attached to this letter are details about the study explaining what will be required of participants who decide to participate in the study. Please remember it is completely up to you to decide whether or not you will participate in this study. Your decision whether to participate or not will not impact on your therapy, nor will it have any implications for the therapist in this agency.

The information that I obtain for this research is confidential.

If you would like to participate in this study, please sign the attached consent form and return it in the addressed, pre-paid envelope. However, if you would like more information before making a decision, please do not hesitate to contact me at The Bouverie Centre on 9376-9844.

Thank you very much for your time and for considering my research study.

Yours sincerely,

KAREN SUTHERLAND

Date:

Appendix 3: Information for Participants

INFORMATION FOR PARTICIPANTS

'SEXUAL ABUSE AND THE EXPERIENCE OF THE BODY'

Summary of a research proposal conducted by Karen Sutherland.
Supervised by Dr Chris Goddard, Associate Professor of Social Work
and Dr Helen Johnson, Lecturer, Centre for Women's Studies, Monash University.

1.What is the purpose of the research?

The research aims to present women's views about the impact of childhood sexual abuse on their feelings about and perceptions of their bodies, and to explore and examine problems or symptoms of the body that may be associated with history of childhood sexual abuse. It is hoped that the information obtained from the study will broaden understanding about the impact of childhood sexual abuse, and improve treatment provided to those who have been sexual abused.

2. How will the information be obtained?

The information will be obtained from interviews with women who have received counselling from The Bouverie Centre, and who have agreed to participate in the study. The interview will take about 2 hours to complete but it may be divided into 2 one-hour sessions if this is more suitable to participants. The interview will be conducted at the participant's home if this is convenient. The participant may have anyone with them during the interview to make her comfortable.

3. What will be discussed at the interview?

Broadly, the interview will cover the following topics:
-How did you experience the abuse?

-What is your view about how the sexual abuse has effected your life?

-Did the sexual abuse specifically effect your feelings about and attitude to your body?

-What, if any, were the body symptoms and problems of embodiment experienced?

-How do you understand the meaning of these feelings and experiences?

-What is the significance of having a female body before and after the sexual abuse?

-What has been, or would be helpful to recovery in relation to the body issues?

4. Will the names of the participants and the information obtained be confidential?

All identifying information (names, addresses, etc.) will be confidential and if necessary, altered to protect the participant's identity. The interview will be recorded on a cassette tape and the typed version of the interview will be kept by my supervisor, Dr Chris Goddard, in a secure cabinet at Monash University. This is kept for 5 years and then destroyed. The participants will each be allocated a code (eg. C3, W7) in any reports on the research. Feedback about the interview will be given to the participant.

5. How will consent be obtained?

A consent form is attached to this information. Those who agree to participate in the research study will be required to complete and sign the consent form. If the participant wishes to withdraw from the research, she may do so at any time.

6. What supports will be available for the woman after the interview?

Arrangements have been made for the women who participate in this study to be provided with support from their therapist at The Bouverie Centre, should they feel upset or disturbed following the interview. Alternatively, the researcher will agree to provide a further session to debrief participants should this be required.

7. What do you do to participate in the research?

Read all the enclosed information carefully. Complete and sign the consent form and return it to me in the stamped, self-addressed envelope provided by _____(date). I will then contact you and schedule a time to meet.

8. What do you do if you decide you do not want to participate in the research?

If you decide that you do not wish to participate in the research project, do not return the form.

9. What do you do if you have any complaints about the research?

If you have any complaints about the research or the manner in which it is conducted, please do not hesitate to contact the following Committee:

The Secretary,
The Standing Committee on Ethics in Research on Humans,
Monash University,
Wellington Road, Clayton, Victoria, 3168.
Telephone: (03) 9905 2052 Fax: (03) 9905 3866

Appendix 4: Consent Form

CONSENT FORM

I have read the information about the research that Karen Sutherland is conducting and I give my consent for:

Karen Sutherland to interview _____(participant's name) and to record this interview on a cassette as explained in the information.

For Karen Sutherland to inform my current therapist at The Bouverie Centre about my agreement to be involved in the research project.

My personal details are:

NAME:_____

ADDRESS:_____

_____

TELEPHONE:_____

SIGNATURE:_____

DATE:_____

Appendix 5: Information for Centre Staff

INFORMATION FOR AGENCY STAFF AT THE BOUVERIE CENTRE

'SEXUAL ABUSE AND THE EXPERIENCE OF THE BODY'

Summary of a research proposal conducted by Karen Sutherland.
Supervised by Dr Chris Goddard, Associate Professor of Social Work and Dr Helen Johnson, Lecturer, Centre for Women's Studies, Monash University.

1. What is the purpose of the research?

The research aims to present women's views about the impact of childhood sexual abuse on their feelings about and perceptions of their bodies, and to explore and examine problems or symptoms of the body that may be associated with history of childhood sexual abuse. It is hoped that the information obtained from the study will broaden understanding about the impact of childhood sexual abuse, and improve treatment provided to those who have been sexual abused.

2. How will the information be obtained?

The information will be obtained from interviews with women who have received counselling from The Bouverie Centre, and who have agreed to participate in the study. The interview will take about 2 hours to complete but it may be divided into two one hour sessions if this is more suitable to participants. The interview will be conducted at the participant's home of at The Bouverie Centre, depending on the participant's preference. The participant may have anyone with them during the interview to make her comfortable.

What is your role in the research process?

As a therapist employed by The Bouverie Centre, you will have access to female clients who have been sexually abused, through Bouverie's referral and therapy services. Having received permission from the Director of Bouverie, Dr Colin Reiss, to access Bouverie clients, I am asking your assistance in providing the names of clients who may agree to participate in this study. Prior to providing this information I would be asking you to attend a meeting in which I will explain the nature and process of the research and be available to answer any questions that you have. Following this meeting, you would need to review your client base and forward on information from about the research to potential participants. While I will undertake to conduct the interviews in a sensitive and respectful way and to ensure adequate debriefing from the interview process with each participant, I acknowledge that some level of distress or discomfort may arise for some participants. Should the interview cause such distress or raise issues that require therapeutic intervention, I would ask you to be available to your clients to address these matters.

4. What will be discussed at the interview?

Broadly, the interview will cover the following topics:

-How did the woman experience the abuse?

-What is the woman's view about how the sexual abuse has effected your life?

-Did the sexual abuse specifically effect the woman's feelings about and attitude to her body?

-What, if any, were the body symptoms and problems of embodiment experienced?

-How does the wc.nan understand the meaning of these feelings and experiences?

-What is the significance of having a female body before and after the sexual abuse?

-What has been, or would be helpful to recovery in relation to the body issues?

5. Will the names of the participants and the information obtained be confidential?

All identifying information (names, addresses, etc.) will be confidential and if necessary, altered to protect the participant's identity. The interview will be recorded on a cassette tape and the typed version of the interview will be kept by my supervisor, Dr Chris Goddard, in a secure cabinet at Monash University. This is kept for 5 years and then destroyed. The participants will each be allocated a code (eg. C3, W7) in any reports on the research. Feedback about the interview will be given to the participant.

6. How will consent be obtained?

A consent form is attached to this information. Those who agree to participate in the research study will be required to complete and sign the consent form. If the participant wishes to withdraw from the research, she may do so at any time. Participants will also be asked to agree to having their therapist informed about their agreement to participate in the research. The purpose of this measure is to act as a secondary support factor, so that therapists will be able to follow up with clients after the research interview to ensure they are not unduly distressed or unsettled.

7. What supports will be available for the woman after the interview?

Arrangements have been made for the women who participate in this study to be provided with support from their therapist at The Bouverie Centre, should they feel upset or disturbed following the interview. Participants will be encouraged to talk through any concerns that may have arisen with their therapist. Alternatively, the researcher will agree to provide a further session to debrief participants should this be required. There will be no cost to participants should referrals need to be scheduled after the interview or as a result of the research interview.

8. What do potential participants do if a decision is made to participate in the research?

Read all the enclosed information carefully. Complete and sign the consent form and return it to me in the stamped, self-addressed envelope provided by

_____(date). I will then contact the person and schedule a time to meet.

9. What do potential participants do if a decision is made <u>not</u> to participate in the research?

If potential participants decide that they do not wish to participate in the research project, they do not return the form.

10. What do participants do if they have any complaints about the research?

If you as a therapist involved in suggesting possible participants for this research, or your client, have any complaints about the research or the manner in which it is conducted, please do not hesitate to contact the following Committee:

The Secretary,
The Standing Committee on Ethics in Research on Humans,
Monash University,
Wellington Road, Clayton, Victoria, 3168.
Telephone: (03) 9905 2052 Fax: (03) 9905 3866

Appendix 6: The Interview Schedule And Proposed Questions

The following schedule and questions were designed to orient and guide the research interviews.

Focus Question (not asked)

What knowledges are implied in the narratives of women who have been sexually abused in childhood:
-about the body
-about society
-about femaleness
-about the experience of embodiment pre and post sexual abuse

Prompt Questions

A. General

What impact do you think the sexual abuse has had on you and your life?

B. Individual Experience

Is your body and your relationship with your body significant among these effects?

How significant and central? Why?

Has the abuse effected your feelings about your body, or your perceptions about your body?

If so, how and in what ways?
How has the abuse effected your sense of embodiment or embodied selfhood?

Have you suffered from any physical symptoms or body problems?

C. Personal Narrative And Meaning Construction.

Are there general or specific meanings or words that you think are represented or expressed by your body/body symptoms?

Do you think these may be related to the sexual abuse. If so, in what ways?

What meaning(s) do you give for these bodily responses?

How would you describe your feelings about, perceptions of and relationship with your body?

D. Social Significance

Do you think that having a female body was significant <u>to your experience</u> of the abuse?

If so, why do you think this, and in what ways? If not, why is this so in your view?

Do you think that having a female body was significant to the <u>consequences</u> of the sexual abuse? (ie. in terms of impact)

What is it like to live in and have a female body post sexual abuse?

Can you articulate some of the questions, issues, problems and dilemmas that arise or have arisen for you in relation to your body since the sexual abuse?
At what stage in your life have you been most affected by this? Why?

Do you think that male victims of sexual abuse would express similar body problems?

How do you think it relates to your experience of being a girl/woman?

What do you think is implied in being sexually abused:
-about the body?
-about society?
-about being female and having a female body?

E. Recovery And New Knowledges.

Have you read much about sexual abuse?

What do you know about the physical and bodily consequences of childhood sexual abuse for victims from your reading or from other knowledge sources?

How do you understand this?

Can you relate to the experiences described in the reading?

What is important from this knowledge? Is anything missing?

What do you think that professionals and the community need to know about the experience of the body before and after sexual abuse?

What has been helpful to your recovery from the sexual abuse, (or) what do you think recovery will involve?
Do you anticipate having a different perspective about your body/embodied self in the future?

How might this occur?

What would be involved in this transformation- personally, interpersonally, socially?

Appendix 7: Interview Themes

The following themes were used to guide the researcher.

A. Orienting the Interview

Invite participant to relate her experience/s of childhood sexual abuse and to reflect on the impact of these experiences.

Invite participant to discuss the impact of the abuse and ways in which the impact of the abuse manifested itself in the victim's life.

B. Attending to the Body

Specific questions about how the participant felt about herself and her body after the abuse.

Was the impact on the body significant, how and in what ways?

Have there been or were there body symptoms or problems of embodiment following the sexual abuse? Explore.

C. Bodily Experience

Understandings of body symptoms and problems of embodiment post childhood sexual abuse.

General and specific meanings attributed to their bodies.

Participant's feelings about, attitudes to, and relationships with their bodies (in the past and currently).

D. The Process of Embodiment

If/How perceptions of, attitudes towards, relationship with body has altered over time

What has been useful in the process of recovery?

E. Concluding Questions

What do you think it is important to know about victim's bodily experience?

If you were speaking to another woman who had been abused as a child, what would you

share with her about your experience of your body?
What do you think therapists/counsellors need to know about the body and its role in childhood sexual abuse?

F. Research Process
The woman's experience of participating in the research
Her expectations prior to and feelings after the interview
The experience of not knowing the researcher but discussing intimate information
What was helpful/unhelpful to the discussion

G. Background Information
Age
Education level
Occupation/Employment details
Family Status (ie. single, married, defacto, children or not)
History of abuse (by whom, when and for how long)

The themes and questions were intended as a guide only. I used several other questions, comments and reflections in conversations with participants, with the overall intention of trying to capture the complexities of individual perceptions and experiences.

Appendix 8: Demographic Details

1. Age of Participants

Age	18-25	25-30	30-35	35-40	40-45	45-50	50-55	Total
No. of Women	1	1	3	2	1	-	2	10

2. Educational Level

Highest Education Level Achieved	Number of Women
Secondary School Not Completed	3
Post Secondary Training	2
Tertiary Qualifications	4 completed and 1 not yet completed

3. Employment

Employment Status	Number of Women
Professional	4
Semi-skilled	1
Unskilled	1
Full time student	1
Unemployed	3

5. Nature of Abuse

Sexual Touching/ Masturbation	Sexual Penetration	Total
2	8	10

6. Relationship to Offender

Brother	4
Father	3
Grandfather	1
Friend of Family	2

7. Age at Onset of Abuse

3-6 Years	7-14 Years
5	5

8. Length of Time of the Abuse

Less Than One Year	-
1-3 Years	5
4 -7 Years	2
More Than 8 Years	3

9. Subsequent Revictimisation

Male Cousin	1
Uncle	1
Stranger/s	4
Acquaintance of Family	3

10. Couple Relationships

Couple Relationship	4
Not in Couple Relationship	6

11. Number of Children Per Interviewee

Number of Children	0	3	1
Number of Women	6	2	5

Appendix 9: Classification of Body Problems

1. Trauma Related Body Symptoms

Hyperarousal	7
Intrusion	8
Traumatic Re-experiencing	7
Avoidance	6
Numbing	6
Dissociation	5
Bodily Distortion/Fragmentation	4

2. Problems of Embodiment

Physical Pain/Symptoms	9
Bodily Denial	6
Bodily Harming	6
Disordered Eating	6
Gender/sexuality Conflicts	8

3. Physical Symptoms

Disordered Eating (includes, anorexia, bulimia, binge eating)	8
Throat Problems	3
Chest Pain	1
Cold Sores	1
Excema	2
Pelvic Pain	4

4. Sources of Self-Injury

Traumatic Re-experiencing	2
Self-loathing	3
Mental Pain	4
Rage/Anger/Frustration	5
Dissociation	3
Perpetrator Internalisations	1

5. Functions And Motivations Of Self-Injury

Regulating Body Responses And Affect	3
Controlling the Body	4
Escaping theBody	3
Bodily Ownership	2
Suicide	2
Punishing the Body	5

Appendix 10: Participants Profiles

The following are brief summaries of each woman's story.

Participant One (P1)

Participant one is 21 years of age and was raised with her family in the southeastern suburbs of Melbourne. She was born in Australia but her parents are of Russian descent, having immigrated to Australia as young adults. Her experience of child sexual abuse began at about the age of 13 when she was raped by her older brother. She was afraid of telling her parents when the first assault occurred, as she feared their reaction. When she summoned up the courage to tell her parents they disbelieved her. Consequently, the sexual abuse by her brother continued on a regular basis until she was 16 years of age, when she left home. Her brother also sexually abused her older sister. P1's leaving home was precipitated by the ongoing abuse. She did not disclose to her parents again until two years after she had left home while she was undertaking individual therapy to address the impact of the abuse. Despite experiencing many emotional and psychological difficulties associated with sexual abuse and with leaving her home and family, P1 managed to complete her secondary education at the local high school. She now lives interstate with her boyfriend. She commenced individual therapy during her final year of school, at 18 years of age, and continued therapy for about 18 months. She had attended for regular therapy to address the impact of the sexual abuse on her life and on her relationships with her family. Her family had also participated in several sessions of family therapy. Since moving interstate, the therapy had been discontinued, but finding herself experiencing further difficulties as a result of her experience of childhood sexual abuse, she had returned to Melbourne briefly, to resume therapy. It was during this time that the research interview was conducted with this participant.

Participant Two (P2)

Participant two is a 35-year-old woman, who lives in the outer eastern suburbs of Melbourne. She is employed as a residential child care worker with troubled adolescents who are living in state residential placements. She also works as a body harmony therapist, providing individual and group sessions in body healing. She was sexually and physically abused in childhood by her father from a very young age, reporting memories of physical and sexual violence from about the age of two. She was also subject to sexual abuse by her father's male friends and by several perpetrators involved in satanic ritual abuse. She reports that as a consequence of her long history of severe sexual and physical abuse, during adolescence and early adulthood, she believed abuse was just part of normal everyday experience and relationships with men. She has had difficulty knowing how to keep herself safe, has felt completely worthless and degraded, and as a consequence has engaged in a long history of self-destructive behaviours. Drugs and alcohol were used to erase the pain of her experiences. As a result, she often found herself vulnerable and in unsafe situations and was repeatedly sexually victimised in the form of date rape and gang rape during this period of her life. P2 has engaged in three lengthy periods of therapy at different stages of her life to address the impact of the abuse. In recent years her process of healing has taken on more embodied and spiritual dimensions as she found that traditional talking therapies had been extremely useful but inadequate on their own. She reports ongoing struggles with feeling safe in her body and particular difficulties with intimacy and sexuality that she attributes to her abuse experiences. At the time of the interview she was continuing work towards her healing and recovery.

Participant Three (P3)

Participant three is a 53-year-old woman who lives in inner city Melbourne. She returned to study as a mature age student and is now university educated and professionally employed. She is a mother and a grandmother. Her abuse history consists of sexual abuse by her father that began when she was about six years of age and persisted for several years. P3 reports being severely affected, not just by the actual physical violation

involved in the sexual abuse, but by pervasively negative beliefs and attitudes her father expressed towards female bodies and female sexuality. As an adult women, she was also sexually assaulted by a stranger whilst walking at night. The assault resulted in criminal court case. P3 has spent much time thinking about her own experience of sexual abuse and its impact on her life. She has also reflected a great deal on the social and political meanings of female child sexual abuse. She remains concerned about the frequency of childhood sexual abuse and interested in the changes that need to take place in society to redress this injustice. She has worked toward her own healing with the support and validation provided by female friends, through reading, through practical strategies to assist her with disabling symptoms and constraining sets of beliefs and behaviours, through body healing activities and physical exercise, and through therapy. At the time of the interview she was busily involved in her professional life and enjoying the relationships with her children and grandchildren.

Participant Four (P4)

P4 is a 55 year old woman who has worked most of her life as a teacher, but has in recent years experimented with a variety of other jobs. She has also trained as a massage therapist and provides therapeutic massage to individuals, including disabled children. P4 undertook a welfare course while in her forties and it was during this time, that the realities of her own childhood sexual abuse became a prominent issue for her. She began to make connections between the childhood sexual abuse and a number of psychological and physical problems she had suffered over the course of her life. The sexual abuse was perpetrated by her father and began when she was about 3 years of age. The abuse continued for a number of years, beginning as gentle but coercive, but over time gradually becoming more intrusive. The abuse was complicated by deeply ambivalent feelings about her father. She loved him but hated what he was doing and perceived him as very powerful but enormously vulnerable. As a result of her abuse P4 engaged in group therapy with other survivors of child sexual abuse, and later, individual therapy. These therapeutic approaches were experienced as limited in their capacity to assist her, as she described feeling unable to articulate or put into words many of the thoughts, sensations and body memories that she held. Of greater usefulness has been P4's

involvement in body oriented approaches to healing which have enabled her to release painful experiences and memories and re-experience her body in positive ways. Just prior to my interview with her, P4 had been worried by symptoms that she believed were an expression of her bodily identification with the perpetrator. She had recently sought therapy, in the form of EMDR to alleviate these disturbing sensations and perceptions.

Participant Five (P5)

P5 is a 38-year woman with two children, who has recently separated from her husband. She lives in the outer eastern suburbs of Melbourne, and was not employed at the time of the research interview. P5 explained that was not able to work because she had been, for a lengthy period, suffering from a range of mental and physical health problems, including depression, which she associated with her severe abuse history. She also attributes her marital breakdown, in part, to the chronic and disabling consequences of the abuse. P5 had engaged in ongoing counselling in relation to these difficulties and had also undertaken periods of therapy at other stages in her recovery. She was sexually abused by her grandfather from the age of about six. At thirteen years of age she was digitally raped by a group of schoolboys, at fifteen a young man who was a final year student at her secondary school sexually assaulted her. He then continued to stalk her and attempted to indecently assault her on several occasions. On one such occasion she was pulled off the street while walking home from school, and on another occasion, indecently assaulted on the train station. P5 also reported being indecently assaulted by a doctor during medical examination She described this event as one that sent her into crisis, stirring up all the previous sexual trauma and prompting her return to therapy. P5 has suffered from a vast range of physical and bodied manifestations of the trauma. Dissociation and traumatic re-experiencing have been particularly problematic aspects of P5's experience, having been disturbing and troubling for many years. She has found individual therapy, EMDR (eye movement desensitisation and reprocessing), and drawing to be helpful strategies assisting her recovery. At the time of the research interviews, P5 described herself as feeling quite vulnerable most days due to the depression and due to ongoing thoughts and body sensations related to her sexual abuse.

Despite the difficulties, she was able to see herself as a courageous woman and as one who had made important progress towards healing from the disabling effects of the abuse.

Participant Six (P6)

P6 is a 32-year-old woman who is currently living in the southern suburbs of Melbourne. She works full time in the hospitality industry, but has had a range of other jobs since completing a Diploma in Community Development three years ago. P6 came from a working class background, growing up in Tasmania with her parents, an older brother and sister and a younger sister. She was sexually abused by her older brother from about the age of 9 until 19. She is unclear of exactly how old she was when the abuse began, but it occurred in the context of watching her older sister being regularly sexually abused by the brother until she fell pregnant with his child. After this occurred, the sexual abuse of P6 became more frequent and continued for many years. She is unsure whether her brother also abused her younger sister but believes that there is a strong possibility that this occurred. P6 reports many occasions of sexual revictimisation. The revictimisation resembled a continuum, ranging from forced intercourse to a kind of passive compliance, where she often had sex with men although she did not want to. She managed to escape from a frightening situation in which she believes she would have been pack raped at a party when she was eighteen years of age, and was indecently assaulted by a girlfriend's father at the age of nineteen. The ongoing pattern of revictimisation resulted, she explained because she had no skills in knowing how to keep herself safe, she felt too powerless and fearful to speak up or resist, and she just did not care what happened to herself and her body. P6 described many problems that she believed were a result of her abuse. In particular, she has struggled with female/gender identity, with issues of intimacy and sexuality, and with finding ways of interpersonal relating that do not involve violence and abuse. She acknowledges being both victim and offender in relationships. P6 spent three years in individual therapy dealing with the impact of the abuse experiences she has suffered. At the time of our interview she had just recently finished her therapy and was holding down a job, for the first time in many years.

Participant Seven (P7)

P7 is a 39-year-old woman who lives in the outer southern suburbs of Melbourne and is employed as a primary school teacher. She is happily married and has five children and one grandchild. P7 was abused by a Catholic priest who was a friend of the family and a teacher at the Catholic Primary School where she attended as a child. The sexual abuse began when she was about seven years of age. P7 had not told any one about the sexual abuse except a close friend with whom she has remained friends since primary school, until about 18 months ago, when she began therapy, at her friends instigation. However, during the process of therapy, P7 has been able to disclose to her husband and children, to address the impact of the abuse on her life and to make connections between the sexual abuse experience and a number of physical and emotional problems she has experienced over the years. As part of her therapy and with the help of her therapist the perpetrator was confronted him about his sexual abuse of her. P7 finished therapy 12 months ago, finding it an extremely useful process. Therapy allowed her to address and resolve many physical health problems, fears and anxieties, and negative beliefs she has held about herself which have been problematic in her life and relationships. In particular, feelings of guilt and self-blame have been mollified since the perpetrator was confronted and admitted responsibility for the abuse. Of interest has been the way in which persistent physical health problems in the form of excema and chest pain have all but disappeared. At the time of the research interview, P7 felt that 'life was good'. Although the sexual abuse was still a factor in her life that did arise at certain times, she was much more able to manage the symptoms and to express associated concerns and anxieties.

Participant Eight (P8)

Participant 8 is in her mid-thirties. She is professionally employed as a social worker in a management position in a non-government welfare agency. She is of Italian background and the youngest of four children. She was raised on a farm in South Gippsland in an area that was quite isolated. P8 was sexually abused by her older brother. The abuse began when she was about 7 years old and continued for four years. She did not disclose the abuse to her parents because she was confused about what was happening to her and

because she believed she would be in trouble. She was conscious as she was growing up of the discrepancy in attitudes towards females in the family who she felt were treated as 'second best', and this context made it harder for her to 'tell on' her brother whose story and position she believed would be privileged over hers. P8 reported being unhappy during childhood, having few friends at school and becoming promiscuous when she was quite young. She now feels guilt and shame about the behavior, explaining it as a consequence of her early sexualisation. P8 was raped in her early twenties and fell pregnant as a result of the rape. She experienced a multitude of psychological, emotional and physical difficulties and engaged in an ongoing pattern of reckless and self-destructive behaviours, culminating in a suicide attempt. P8 reported particular problems with issues of trust, intimacy, sex and in living comfortably with her body. At the time of the interview she was engaged in ongoing individual therapy to address the impact of the abuse.

Participant Nine (P9)

P9 is a young woman in her mid-thirties who was anally raped by her older brother when she was 7 years of age. The abuse continued in several other forms over an extended period. She is the only daughter of two children, her brother being five years her senior. She was revictimised when she was a teenager by her uncle who sexually molested her, and again more recently, by a guest at a health resort where P9 was staying. Due to the severity of the difficulties associated with her abuse P9 has been unable to study, work or live independently. She lives with her mother, who was widowed following the recent suicide of her husband, P9's father. P9 has experienced severe and crippling depression, agoraphobia, seriously disordered eating, including anorexia and bulimia, and has had periods of hospitalisation for psychiatric care due to the severity of her symptoms. She has also struggled with suicidal thoughts and has, on several occasions, attempted suicide. Despite the severity of her difficulties, P9 is a bright, articulate and feisty woman who has managed to do battle with her symptoms while also fighting for acknowledgment of the reality the abuse and the extent of it and for validation of the pain and harm that she has suffered as a result. She has been particularly harmed by her family's denial and minimisation of the abuse and by the way her brother has been

protected and his abuse of her rationalised, while she has been demonised and pathologised, and her symptoms regarded as evidence of her 'craziness' or bad behavior. At the time of the interview, P9 was still struggling with difficulties related to the abuse and her family's response to it, but had managed to secure a part-time job as a nanny – a job she was enjoying and taking seriously because of her investment in protecting and caring for the child. She had also joined a gym hoping that physical activity may boost her confidence and assuage her depression. She was also continuing with individual therapy.

Participant Ten (P10)

P10 is a young woman in her late twenties who was sexually abused by a neighbour, by a cousin and by an intruder who broke into her flat while she was a student at university. The initial abuse was perpetrated by a paedophile who ingratiated himself to her and her family and engaged in regular and ongoing sexual victimisation on almost a daily basis for a period of 18 months when P10 was only seven years of age. The abuse became progressively more intrusive over time. A few years later, P10 was sexually abused by her cousin on several occasions when he and his family stayed over at her family home. A further terrifying incident occurred when as a young woman, an intruder broke into her room and assaulted her. P10 was raised in the country in a town about one and half-hours to the south east of Melbourne. She now resides in a neighbouring town. She is a qualified secondary school teacher and works at the local high school. She has recently married. At the time of the interview she was undertaking individual therapy in relation to the impact of the abuse. She had suffered from numerous negative effects of the abuse over an extended period, but was currently experiencing physical health problems that she attributed to the abuse and was deeply distressed by disturbing nightmares and episodes of traumatic physical re-experiencing. She was also having difficulties coping at work and her relationship with her partner was under significant stress.

BIBLIOGRAPHY

Abel, G.G. & Rouleau, J. L. (1990) The nature and extent of sexual assault. In W. L. Marshall, D. R. Laws and H. E. Barbaree (eds.) *Handbook of sexual assault: Issues, theories and treatment for the offender.* New York. Plenum.

Adams P. (1986) Versions of the body. *m/f.* Vol.11/12, pp.27-34.

Adams-Tucker C. (1982) Proximate effects of sexual abuse in childhood: A report on 28 children. *American Journal of Psychiatry.* 139, pp.1252-1256.

Acker, J., Barry, K. & Esseveld, J. (1983) Objectivity and truth: Problems in doing feminist research. *Women's Studies International Forum.* 6, (4) pp.423-435.

Aiosa-Karpas, C. Karpas, R., Pelcovitz, D. and Kaplan, S. (1991) Gender identification and sex role attribution in sexually abused adolescent females. *Journal of the American Academy of Child and Adolescent Psychiatry.* 30, pp.266-271.

Alcoff, L. & Gray, L. (1993) Survivor discourse: Transgression or recuperation. *Signs: Journal of Women in Culture and Society.* 18, (2) pp.260-290.

Alexander, P. (1985) A systems theory conceptualisation of incest. *Family Process.* 24, March, pp.79-88.

Allen, J. (2001) *Traumatic relationships and serious mental disorders.* Chichester. John Wiley and Sons.

Andrews, B. (1995) Bodily shame as a mediator between abusive experiences and depression. *Journal of Abnormal Psychology.* Vol. 104, No.2 pp.277-285.

Antleman, S.H. & Yahuda, R. (1994) Time-dependent change following acute stress: Relevance to the chronic and delayed aspects of P.T.S.D. In M.M.Murburg (ed.) *Catecholamine function in P.T.S.D.* (pp.87-98). Washington DC. American Psychiatric Press.

Armstrong, D. (1982) The doctor-patient relationship 1930-80. In P. Wright and A. Treacher (eds.) *The problem of medical knowledge.* Edinburgh. Edinburgh University Press.

Armstrong, H. (1992) Awareness grows but incest victims still mostly keep to themselves. *NOW* {Toronto} October 1-7, p.16.

Armstrong, L. (1994) *Rocking the cradle of sexual politics.* New York. Addison Wesley.

Atchinson, M. & MacFarlane, A. C. (1994) A review of dissociation and dissociative disorders. *Australian and New Zealand Journal of Psychiatry.* 28, pp.591-599.

Atmore, C. (1994) Witchhunts, Icebergs and the Light of Reason: Constructions of Child Sexual Abuse. *In Communication and identity: Local, regional, global: Selected Papers from the 1993 National Conference of the Australian Communication Association.* H. Borland, (ed.) ANZCA, Canberra, ACT.

Atmore, C. (1996) Cross-cultural media-tions: Media coverage of two child sexual abuse controversies in New Zealand/ Aotearoa. *Child Abuse Review.* 5, pp.334-345.

Atmore, C. (1997) Towards 2000: Child sexual abuse and the media. In A. Howe (ed) *Sexual Crime in the News.* Melbourne. Federation Press.

Atmore, C. (1997) Brand news: Using Foucault to theorise rape, the media and feminist strategies. In C. O'Farrell (ed.) *Foucault: The legacy.* Queensland. Queensland University of Technology.

Atmore, C. (1998) Rethinking moral panic and child abuse for 2000. In J.H. Bessant and R. Hill (eds.) *Reporting Law and Order*, Hobart. National Clearing House for Youth Studies.

Bagley, C. & McDonald, M. (1984) Adult mental health sequels of child sexual abuse, physical abuse and neglect in maternally separated children. *Canadian Journal of Mental Health.* 3, (1) pp.15-26.

Bagley, C. & Ramsey, R. (1986) Sexual abuse in childhood: Psychosocial outcomes and implications for social work practice. *Journal of Social Work and Human Sexuality.* 4, pp.33-47.

Bagley, C. & King, K. (1990) *Child sexual abuse: The search for healing.* London. UK. Routledge Publications.

Banks, C.G. (1992) 'Culture' in culture-bound syndromes: The case of anorexia nervosa. *Social Science and Medicine.* Vol.34, (8) pp.867-884.

Banyard, V. (1997) The impact of childhood sexual abuse and family functioning on four dimensions of women's later parenting. *Child Abuse and Neglect.* 21, (11) pp.1095-1107.

Barrett, M. (1991) *The politics of truth: From Marx to Foucault.* Stanford. Stanford University Press.

Barrett, M. (1992) Words and things: Materialism and method in contemporary feminist theory. In M. Barrett and A. Phillips (eds.) *Destabilising theory: Contemporary feminist debates.* Cambridge. Polity Press.

Barrett. M & Phillips, A. (1992) (eds.) *Destabilising theory: Contemporary feminist debates.* Cambridge. Polity Press.

Bass, E. & Davis, L. (1988) *The courage to heal.* New York. Harper and Row.

Bates, C. & Brodsky, A. (1989) *Sex in the therapy hour: A case of professional incest.* New York. Guilford Publications.

Beard, R., Belsey, E. & Leiberman, B. (1977) Pelvic pain in women. *American Journal of Obstetrics and Gyneacology.* 128, pp.566-570.

Becker, J. V. & Coleman, E. M. (1988) Incest. In V. B. Van Hasselt, R. L. Morrison, A. S. Bellack & M. Hersen (eds.) *Handbook of family violence.* New York. Plenum.

Beitchman, J.H., Zucker, K. J., Hood, J. E., DaCosta, G. A., Akman, D. & Cassavia (1992) A review of the long-term effects of child sexual abuse. *Child Abuse & Neglect.* 16, (1) pp.101-118.

Belsey, C. (1980) *Critical practice.* London. Methuen.

Benhabib, S. & Cornell, P. (1988) (eds.) *Feminism as critique: On the politics of gender.* Minneapolis. University of Minnesota Press.

Benhabib, S. (1994) *Feminism and the question of postmodernism.* The Polity Reader in Gender Studies. Cambridge. Polity Press.

Berkowitz, C.D. (1998) Medical consequences of child sexual abuse. *Child Abuse & Neglect.* 22, (6) pp.541-550.

Berliner, L. & Conte, J. (1990) The process of victimisation: The victim's perspective. *Child Abuse & Neglect.* 14, pp.29-40.

Birke, L. (1986) *Women, feminism and biology.* New York. Menthuen.

Boadella, D. (1985) *Wilhelm Reich: The evolution of his work.* London. Penguin Arkana.

Bordo, S. (1988) Anorexia nervosa: Psychopathology or crystallisation of culture. In I. Diamond & L. Quimby, (eds.) *Feminism and Foucault: Reflections on resistance.* Boston. Northeastern University Press.

Bordo, S. (1990) Postmodernism and gender scepticism. In L. Nicholson, (ed.) *Feminism/Postmodernism.* New York/London. Routledge.

Bordo, S. (1992) Postmodern subjects, postmodern bodies. *Feminist Studies.* 18, (1) pp.159-175.

Bordo, S. (1993) Feminism, Foucault and the politics of the body. In C. H. Ramazanoglu & J. Holland. (eds). *Up Against Foucault: Explorations of some tensions between Foucault and feminism.* London & New York. Routledge.

Bordo, S. (1993) *Unbearable weight: Feminism, western culture and the body.* Berkeley. University of California Press.

Bourdieu, P. (1977) *Outline of a theory of practice.* Cambridge. Cambridge University Press.

Bowlby, R. (1992) *Still crazy after all these years: Women, writing and psychoanalysis.* London. Routledge.

Braverman, L. (1986) The depressed woman in context: A feminist family therapist's analysis. In M. Ault-Riche (ed.) *Women and Family Therapy* (pp.90-99) Rockville Md. Aspen.

Breen, D. (1993) (ed.) *The Gender Conundrum: Contemporary psychoanalytic perspectives on femininity and masculinity.* London and New York. Routledge.

Bremner, J. D., Southwick, S., Brett, E., Fontana, A., Rosenheck, R. & Charney, D.S. (1992) Dissociation and post-traumatic stress disorder in Vietnam combat veterans. *American Journal of Psychiatry.* 149, pp.328-332.

Bremner, J. D., Steinberg, M., Southwick, S. M., Johnson, D. R. & Charney, D. S. (1993) Use of the Structured Clinical Interview for DSM-IV Dissociative Disorders for systematic assessment of dissociative symptoms in post-traumatic stress disorder. *American Journal of Psychiatry.* 150, (7) pp.1011-1014.

Briere, J.R. (1989) The trauma symptom checklist: Early data on a new scale. *Journal of Interpersonal Violence.*4, pp.151-163.

Briere, J. (1992) Medical symptoms, health risk and history of childhood sexual abuse. *Mayo Clinic Proceedings.* 67, pp.603-604.

Briere, J. (1992) Methodological issues in the study of child sexual abuse effects. *Journal of Consulting and Clinical Psychology.* 60, (2) pp.196-203.

Briere, J. (1992) *Child abuse trauma.* Newbury Park, California. Sage.

Briere, J. & Conte, J. R. (1993) Self-reported amnesia for abuse in adults molested as children. *Journal of Traumatic Stress.* Vol.6, (1) pp.21-31.

Briere, J. (1996) A self-trauma model for treating adult survivors of severe child abuse. In J.Briere, L. Berliner, J. Bulkley, C. Jenny & T. Reid (eds.) *The APSAC handbook on child maltreatment.* USA. Sage.

Briere, J & Gil, E. (1997) *Self-mutilation in clinical and general population samples: Incidence, correlates & functions.* Unpublished. Los Angeles, California. UCLA School of Medicine.

Briere, J. & Runtz, M. (1988) Post sexual abuse trauma. In G. E. Wyatt & G. Powell (eds.) *Lasting effects of child sexual abuse.* Newbury Park, California. Sage.

Briere, J. & Runtz, M. (1993) Childhood sexual abuse: Long-term sequelae and implications for psychological assessment. *Journal of Interpersonal Violence.* Vol. 8, No.3 pp.312-330.

Briggs, F., Hawkins, R. & Williams, M. (1994) *A comparison of the early childhood experiences of incarcerated, convicted male child molesters and men who were sexually abused in childhood and have no convictions for sexual offences against children.* Adelaide. University of South Australia.

Briggs, L. & Joyce, P. (1997) What determines post-traumatic stress disorder symptomatology for survivors of childhood sexual abuse? *Child Abuse & Neglect.* 21, (6) pp.575-582.

Brison, S.J. (1997) Outliving Oneself: Trauma, memory and personal identity. In D.T. Meyers (ed.) *Feminists rethink the self.* New York. Westview Press.

Brooks, A. (1997) *Post feminisms, feminism, cultural theory & cultural forms.* London & New York. Routledge.

Brown, G. R. & Anderson, B. (1991) Psychiatric morbidity in adult inpatients with histories of sexual and physical abuse. *American Journal of Psychiatry.* 148, pp.55-61.

Browne, A. & Finkelhor, D. (1986) Impact of child sexual: A review of the research. *Psychological Bulletin.* 99, pp.66-77.

Brownmiller, S. (1984) *Femininity.* New York. Linden Press.

Brownmiller, S. (1975) *Against our will: Men , women and rape.* New York. Simon & Schurter.

Bryam, V., Wagner, H. & Waller, G. (1995) Sexual abuse and body image distortion. *Child Abuse & Neglect.* Vol.19, No.4 pp.507-510.

Bryer, J.B., Nelson, B. A., Miller, J.B. & Kroll, P.A. (1987) Childhood sexual and physical abuse as factors in adult psychiatric illness. *American Journal of Psychiatry.* Vol.144, pp.1426-1430.

Burgess, A. & Holstrom, L. (1974) Rape trauma syndrome. *American Journal of Psychiatry.* 131, pp.981-986.

Butler, J. (1990*) Gender trouble: Feminism and the subversion of identity.* New York/London. Routledge.

Butler, J. & Scott, J.W. (eds.) (1992) *Feminists theorise the political.* New York, London. Routledge.

Butler, J. (1993) *Bodies that matter: On the discursive limits of sex.* New York. Routledge.

Butler-Evans, E. (1989) *Race, gender and desire: Narrative strategies in the fiction of Toni Bambara, Toni Morrison, and Alice Walker.* Philadelphia. Temple University Press.

Calam, R., Horne, L., Glasgow, D & Cox, A (1998) Psychological disturbance and child sexual abuse: A follow up study. *Child Abuse and Neglect.* 22, (9) pp.901-913.

Calof, D. (1995) Dissociation: Nature's tincture of numbing and forgetting. *Treating Abuse Today.* Vol.5 (3).

Calof, D. (1995) Chronic self-injury in adult survivors of childhood abuse: Sources, motivations, and functions of self-injury (part 1). *Treating Abuse Today.* 5, (3) pp.100-115.

Calof, D. (1995) Chronic self-injury in adult survivors of childhood abuse: Sources, motivations, and functions of self-injury (part 2). *Treating Abuse Today.* 5, (4/5) pp.4-9.

Calof, D. (1997) Chronic self-injury in adult survivors of childhood abuse: Developmental processes of anger in relation to self-injury (part 1). *Trauma.* 7, (1) pp.15-20.

Carmen, E.H., Rieker, P. & Mills, T. (1984) Victims of violence and psychiatric illness. *American Journal of Psychiatry.* 141 (March) pp.378-383.

Carmen (Hilberman), E., Ricker, P. & Mills (1984) Victims of violent psychiatric illness. *American Journal of Psychiatry.* Vol. 141, pp.378-383.

Cassell, P. (1993) (ed.) *The Giddens reader.* London. MacMillan.

Celemajer, D. (1987) Submission and rebellion: Anorexia and a feminism of the body. *Australian Feminist Studies.* pp.57-69.

Chapkis, W. (1986) *Beauty secrets.* Boston. South End Press.

Chernin, K. (1982) *The obsession: Reflections on the tyranny of slenderness.* New York. Harper & Row.

Chesler, P. (1972) *Women and madness.* Garden City. New York. Double day.

Chodorow, N. (1978) *The reproduction of mothering.* California. University of California Press.

Christianson, S.A. & Nilsson, L.G. (1984) Functional amnesia as induced by a psychological trauma. *Memory & Cognition.* 12, pp.142-155.

Christianson, S.A. & Nilsson, L.G. (1989) Hysterical amnesia: A case study of aversively motivated isolation of memory. In T. Archer & L.G. Nilsson (eds.) *Aversion, avoidance and anxiety.* (pp.289-310) Hillsdale. New Jersey. Erlbaum.

Cicchetti, D. & White, J. (1990) Emotion and developmental psychotherapy. In N. Stein, B. Lebanthal & T. Trebasso (eds.) *Psychological and biological approaches to emotion.* pp.359-382. Hillsdale N.J. Erlbaum.

Cixous, H. (1981) The laugh of the Medusa. In E. Marks & I. De Courtivron (eds.) *New French feminisms*. New York. Schocken Books.

Classen, C.F., N & Atkinson, A & Speigel, D, (1998) Representations of self in women sexually abused in childhood. *Child Abuse and Neglect.* 22, (10) pp.997-1004.

Connors, M.E. & Morse, W. (1993) Sexual abuse and eating disorders: A review. *International Journal of Eating Disorders.* 13, pp.1-11.

Conte, J. & Berliner, L. (1990) Sexual abuse of children: Implications for practice. *Social Casework.* 62, pp.601-608.

Conte, J. S. & Schuerman, J. R. (1987) Factors associated with an increased impact of child sexual abuse. *Child Abuse & Neglect.* 11, pp.201-211.

Conte, J. S. & Schuerman, J. R. (1988) The effects of sexual abuse on children: A multidimensional view. *Journal of Interpersonal Violence.* 2, (4) pp.381-390.

Coombs, A.& Syngg, D. (1959) *Individual behaviour: A perceptual approach to behaviour*. New York. Harper and Row.

Cook, J. & Furnow, M. (1986) Knowledge and women's interests: Issues of epistemology and methodology in feminist sociological research. *Sociological Inquiry.* 56, pp.2-29.

Coons, P. M. & Milstein, V. (1992) Psychogenic amnesia: A clinical investigation of 25 cases. *Dissociation.* 5, (2) pp.73-79.

Cosentino, C. E. (1990) *Gender role behavior and sexual behavior in girls who were sexually abused.* Unpublished doctoral dissertation. New York University.

Cosentino, C.E., Heino, F.L., Meyer-Bahlburg, Alpert, J. & Gaines. R. (1993) Cross-Gender Behavior and Gender Conflict in Sexually Abused Girls. *Journal American Academy of Child Adolescent Psychiatry.* 32, (5) September, pp.941 947.

Costin, C, (1996) Body image disturbance in eating disorders and sexual abuse. In M. Schwartz & L. Cohn (eds.) *Sexual Abuse & Eating Disorders.* New York. Brunner/Mazel

Courtois, C. (1988) *Healing the incest wound: Adult survivors in therapy.* New York. Norton.

Courtois, C. & Sprei, J.E. (1988) Retrospective incest therapy for women. In L. Walker *Handbook on sexual abuse of children.* pp.300-308. New York. Springer.

Coward, R. & Ellis, J. (1977) *Language and Materialism: Developments in semiology and the theory of the subject.* Boston. Routledge and Kegan Paul.

Coward, R. (1990) Female desire & sexual identity. In M. Diaz-Diocaretz & I. Zavala (eds.) *Women, Feminist Identity and Society in the 1980s.* Amsterdam. John Benjamins.

Craine, I. S., Henson, C. E. & Colliver, J. A. (1988) Prevalence of a history of sexual abuse among female psychiatric patients in a state mental hospital. *Hospital and Community Psychiatry.* Vol.39, pp.30-304.

Cross, L. (1993) Body and self in feminine development: Implications for eating disorders and delicate self-mutilation. *Bulletin of the Menninger Clinic.* 57, pp.42-65.

Culbertson, R. (1995) Embodied memory, transcendence and telling: Recounting trauma, re-establishing the self. *New Literary History.* 26, pp.169-195.

Culbertson, R. (1996) *Wounds to the body: Culture, memory and violation.* Virginia. University Press.

De Beauvoir, S. (1953) *The second sex.* Translated by H. M. Parshley. Harmondsworth. Penguin.

De Lauretis, T. (1987) The technology of gender. In T. de Lauretis, *Technologies of gender: Essays on theory, film and fiction.* Bloomington. Indiana University Press.

De Lauretis, T. (1987) The rhetoric of violence. In T. de Lauretis, *Technologies of gender: Essays on theory, film and fiction.* Bloomington. Indiana University Press.

De Lauretis, T. (1988) Displacing hegemonic discourses: Reflections on feminist theory in the 1980s. *Inscriptions.* 3, (4) pp.127-145.

Delbo. C. (1985) *Days and memory.* Trans R. Lamont. Marlboro. Vt. Marlboro Press.

Des Pres, T. (1976) *The survivor: An anatomy of life in the death camps.* New York. Oxford University Press.

di Stefano, C. (1990) Dilemmas of difference: Feminism, modernity and postmodernism. In L. Nicholson (ed.) *Feminism/Postmodernism*, New York/London. Routledge.

Domino, J.V. & Haber, J. D. (1987) Prior physical and sexual abuse in women with chronic headache: Clinical correlates. *Headache.* 27, pp.310-314.

Donaldson, M. A. (1983) *Incest victims years after: methods and techniques for treatment.* Paper presented at the annual meeting of the National Association of Social Workers, Washington DC. November.

Douglas M. (1966) *Purity and danger: An analysis of concepts of pollution and taboo.* London. Routledge.

Douglas, M. (1970) *Purity and danger*. London. Routledge and Kegan Paul.

Douglas, M. (1971) Do dogs laugh? A cross-cultural approach to body symbolism. *Psychosomatic Research*. 15, pp.387-390.

Douglas, M. (1982) *Natural symbols: Explorations in cosmology*. New York. Pantheon Books.

Draijer, N. (1989) Long-term psychosomatic consequences of child sexual abuse. In E. van Hallcarnforth, *The Free Woman: Women's Health in the 1990s*. New York. Parthenon. pp.696-709.

Du Bois, B. (1983) Passionate scholarship: Notes on values, knowing and method in social science. In G.B. & R.D.K. (eds.) *Theories of women's studies*. pp.105-116. Boston. Routledge and Kegan Paul.

Duncan, C. & Taylor, H. (1952) A psychosomatic study of pelvic congestion. *American Journal of Obstetrics and Gyneacology*. 64, pp.1-12.

Durkheim, E. (1915) *The elementary forms of religious life*. New York. The Free Press. 1961.

Dwyer, J. (1999) *Loss, trauma and the familial ideal: Some Australian women's responses to the incestuous abuse of their children*. Unpublished doctoral thesis.

Melbourne, Australia. University of Melbourne.

Dwyer, J. & Miller, R. (1996) Disenfranchised grief after incest: The experience of victims/daughters and mothers/wives. *Australian & New Zealand Journal of Family Therapy.* 17, (3) pp.137-145.

Dye, E. & Roth, S. (1990) Psychotherapy with Vietnam veterans and rape and incest survivors. *Psychotherapy.* Vol. 28, (1) pp.103-117.

Eagleton, T. (1983) *Literary theory: An introduction.* Oxford. Blackwell.

Eisenstein, Z.R. (1988) *The female body and the law.* California. University of California Press.

Eisnitz, A.J. (1984-5) Father-daughter incest. *International Journal of Psychoanalytic Psychotherapy.* 10, pp.495-503.

Elbow, M. & Mayfield, J. (1991) Mothers of incest victims: Villains, victims or protectors? *Families in Society.* 72, (2) (February) pp.78-86.

Elias, N. (1979) *The civilising process.* Oxford. Oxford University Press.

Ellenson, G. (1985) Detecting a history of incest: A predictive syndrome. *Social Casework.* November, pp.525-533.

Ellenson, G. (1986) Disturbances of perception in adult female incest surviviors. *Social Casework.* March, pp.149-159.

Engelhardt, H.T. (1975) Bioethics and the process of embodiment. *Perspectives in Biology & Medicine.* Vol. 18 (Summer) pp.486-500.

Epstein, J., Saunders, B., Kilpatrick, D. & Resnick H. (1998) PTSD as a mediator between childhood rape and alcohol use in adult women. *Child Abuse & Neglect.* 22, (3) pp.223-234.

Epston, D. & White, M. (1989) *Literate means to therapeutic ends.* Adelaide. Dulwich Centre Publications.

Evans-Pritchard, E. (1937) *Witchcraft, oracles and magic among the Azande.* Oxford. Oxforsd University Press.

Family Violence Professional Education Taskforce (1991) *Family violence: Everybody's business, somebody's life.* Sydney. The Federation Press.

Fausto-Sterling, A. (2000) *Sexing the body: Gender politics and the construction of sexuality.* New York. Basic Books.

Fay, B. (1987) *Critical Social Science.* Ithaca. Cornell University Press.

Fee, E. (1986) Critiques of modern science: The relationship of feminism to other radical epistemologies. In R. Bleier (ed.) *Feminist approaches to science.* (pp.42-56). New York. Pergamon Press.

Fenichel, O. (1945) *The psychoanalytic theory of neurosis.* New York. W. W. Norton & Co.

Figley, C. (1985) *Trauma and it's wake.* New York: Brunner/Mazel.

Figley, C. (1995) *Compassion fatigue: Coping with secondary stress disorder in those who treat the traumatised.* New York. Brunner/Mazel.

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

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

Finkelhor, D. (1986) *A sourcebook on child sexual abuse.* Beverley Hills. Sage Publications.

Finkelhor, D. (1995) The victimisation of children: A developmental perspective. *American Journal of Orthopsychiatry.* 65, (2) pp.177-193.

Finkelhor, D & Browne, A. (1985) The traumatic impact of child sexual abuse: A conceptualisation. *American Journal of Orthopsychiatry.* 55, pp.530-539.

Finkelhor, D., Hotaling, G., Lewis, I. A. & Smith, C. (1990) Sexual abuse in the national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child Abuse & Neglect.* 14, pp.19-28.

Fisher, S. & Cleveland, S.E. (1955) The role of body image in psychosomatic symptom choice. *Psychological Monographs.* 68, No. 17 pp.57-78.

Fisher, S. & Cleveland, S.E. (1968) *Body image and personality.* New revised edition. New York. Dover.

Fischer, D. G. & McDonald, W.L. (1998) Characteristics of intrafamilial and extrafamilial child sexual abuse. *Child Abuse & Neglect* Vol.22, (9) pp.915-929.

Flax, J. (1986) Gender as a problem in and for feminist theory. *American Feminist Studies.* June. pp.193-213.

Flax, J. (1987) Postmodernism and gender relations in feminist theory. *Signs: Journal of Women in Culture & Society.* 12, (4) pp.621-43.

Flax, J. (1990) *Thinking fragments: Psychoanalysis, feminism and postmodernism in the contemporary west.* Berkeley & Los Angeles. University of California Press.

Flax, J. (1990b) Postmodernism and gender relations in feminist theory. In L.Nicholson (ed.) *Feminism/postmodernism.* New York. Routledge.

Flax, J. (1992) The end of innocence. In J. Butler & J. Scott (eds.) *Feminist theorise the political.* New York/London. Routledge.

Foucault, M. (1972) *The archaeology of knowledge*. London. Tavistock.

Foucault, M. (1973) *The birth of the clinic.* London. Tavistock.

Foucault, M. (1977) *Discipline and punish.* New York. Vintage.

Foucault, M. (1980) *Power/Knowledge: Selected interviews and other writings 1972-1977.* C. Gordon (ed.) Sussex. Harvester Press.

Foucault, M. (1981a) *The history of sexuality: An introduction.* Vol. 1. Harmondswroth. Penguin.

Foucault, M. (1981b) The order of discourse. In R. Young (ed.) *Untying the text: A poststructuralist reader.* London. Routledge.

Fox, K. V. (1996) Silent voices: A subversive reading of child sexual abuse. In C. Ellis & A P. Bochner (eds.) *Composing Ethnography: Alternative forms of qualitative writing.* Walnut Creek, London, New Delhi. Altamira Press.

Frankel, V. (1946) *Man's search for meaning.* New York. Washington Square Press.

Fraser. N. & Nicholson, L. (1990) Social criticism without philosophy: An encounter between feminism and postmodernism. In L. Nicholson (ed.) *Feminism/Postmodernism.* New York. , Routledge.

Frederick, C. J. (1985) Children traumatised by catastrophic situations. In S. Eth and R.S. Pynoos (eds.) *Post-traumatic stress disorder in children.* (pp.73-99) Washington DC. American Psychiatric Press.

Frederickson, R. (1992) *Repressed Memories: A journal of recovery from sexual abuse.* NewYork. Simon & Schuster.

Freud, S. (1895) Project for a scientific psychology. In J. Strachey (ed.) *The standard edition of the complete psychological works of Sigmund Freud.* Vol. 1, pp.281-397. London. Hogarth Press.

Freud, S. (1915) The unconscious. In J. Strachey (ed.) *The standard edition of the complete psychological works of Sigmund Freud.* Vol. 14, pp.159-204. London. Hogarth Press.

Freud, S. (1923) The ego and the id. In J. Strachey (ed.) *The standard edition of the complete psychological works of Sigmund Freud.* Vol. 19, pp.1-59. London. Hogarth Press.

Freud, S. (1930) Civilisation and its discontents. In J. Strachey (ed.) *The standard edition of the complete psychological works of Sigmund Freud.* Vol. 21, pp.57-146. London. Hogarth Press.

Freund, P. (1970) (ed.) *Experimentation with human subjects.* New York. Braziller.

Freund, P. (1988) Bringing society into the body. *Theory & Society.* 17, pp.839-864.

Freund, P. (1999) The expressive body: A common ground for the sociology of emotions, health and illness. *Sociology of Health & Illness.* 12, (4) pp.452-77.

Freud, S. (1896a) The aetiology of hysteria. In Strachey, J. (1958) *The Standard Edition of the Complete Works of Sigmund Freud.* Vol.3. London. Hogarth Press. pp.187-221.

Friedrich, W., Urquiza, A. & Bielke, R. (1986) Behavioral problems in sexually abused young children. *Journal of Pediatric Psychology.* 11, (2) pp.47-57.

Friedrich, W. (1988) Behaviour problems in sexually abused children. *Journal of Interpersonal Violence,* Vol.2, pp.381-390.

Friedrich, W. (1995) *Psychotherapy with sexually abused boys: An integrated approach.* New York. Sage.

Friedrich, W.N. (1998) Behavioural manifestations of child sexual abuse. *Child Abuse & Neglect.* (6) pp.523-531.

Frieze, I.H., Parsons, J.E., Johnson, P.B., Ruble, D.N. & Zellman, G.L. (1978) *Women and sex roles: A social psychological perspective.* New York. W.W.Norton.

Fromm, E. (1965) Hypnoanalysis: Theory and two case examples. *Psychotherapy: Theory, research and practice.* 2, pp.127-233.

Fromuth, M. E. (1986) The relationship of childhood sexual abuse with later psychological and sexual adjustment in a sample of college women. *Child Abuse & Neglect.* 10, (1) pp.5-15.

Fromuth, M. E. & Burkhardt, B. R. (1991) The nature of childhood sexual abuse and its relationship with family background. *Victimology.* 4, pp.17-24.

Gadow, S. (1980) Body and self: A dialectic. *Journal of Medicine & Philosophy.* 5, (3) pp.172-185.

Garrett, C. (1995b) *Anorexia and theories of the body.* Feminist Cultural Studies Series No.2 Women's Research Centre. University of Western Sydney, Sydney.

Garrett, C. (1998) *Beyond anorexia: Narrative, spirituality and recovery.* London. Cambridge University Press.

Garvey, M.J., Schaffer, C.B. & Tuason, V.B. (1983) Relationship of headaches to depression. *British Journal of Psychiatry.*143, pp.544-547.

Gatens, M. (1983) The sex/gender distinction. In S.Gunew (ed.) (1990) *A reader in feminist knowledge.* New York. Routledge.

Gatens, M. (1986) Feminism, philosophy and riddles without answers. In E. Grosz & C. Pateman, *Feminist Challenges: Social & Political Theory.* Australia. Allen & Unwin.

Gatens, M. (1988) Towards a feminist philosophy of the body. In B. Caine, E.A. Grosz & M. de Lepervanche (eds.) *Crossing Boundaries: Feminism and the critique of knowledges.* (p.50-70) Sydney. Allen & Unwin.

Gatens, M. (1990) A critique of the sex/gender distinction. In S. Gunew (ed.) *A reader in feminist knowledge.* London. Routledge.

Gatens. M. (1992) Power, bodies and difference. In M. Barrett & A. Phillips (eds.) *Destabilizing theory: contemporary feminist debates.* (pp.120-113). New York. Polity Press.

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

Giddens, A. (1991) *Modernity and self-identity: Self and society in the late modern age.* Stanford. Stanford University Press.

Gil, E. (1983) *Outgrowing the pain: A book for and about adults abused as children.* San Francisco. Launch Press.

Gil, E. (1988) *Treatment of adult survivors of childhood abuse.* California. Launch Press.

Gil, E., Briere, J. & Calof, D. (1993) *Understanding and responding to self-injury.* Presentation at the 5th Eastern Regional Conference on Abuse and Multiple Personality, Alexandria, Virginia, USA.

Gilgun, J. (1991) Resilience and the intergenerational transmission of child sexual abuse. In M. Q. Patton (ed.) *Family sexual abuse*. USA. Sage.

Gilligan, C. (1982, 1993) *In a different voice: Psychological theory and women's development.* Cambridge. Harvard University Press.

Gilligan, C., Ward, J. & Taylor, J. (1988) *Mapping the moral domain.* Cambridge. Harvard University Press.

Giovaccinni, P. (1956) Defensive meaning of a specific anxiety syndrome. *Psychoanalytic Review.* 43, pp.373-380.

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

Glaser, B. (1992) *Basics of grounded theory analysis*. Mill Valley, California. Sociology Press.

Goddard, C. & Saunders, B. (1999) The gender and textual abuse of children in the print media. *Child Abuse Review.* Vol. 9, pp.37-48.

Goffman. E. (1959) *The presentation of self in everyday life.* Garden City. N.J. Anchor, Double Day.

Goffman, E. (1961) *Asylums.* New York. Anchor. Double Day.

Goldner, V. (1985) Feminism and family therapy. *Family Process.* 24, pp.31-45.

Goldner, V., Penn, P., Scheinberg, M. & Walker, G. (1990) Love and violence: Gender paradoxes in volatile attachments. *Family Process.* 20 (4), pp.343-364.

Gomes-Schwartz, B., Horowitz, J. M. & Cardarelli, A. P. (1990) *Child sexual abuse: The initial effects.* Newbury Park. California. Sage Publications.

Goodwin, J. (1985b) Post-traumatic symptoms in incest victims. In S. Eth & R. S. Pynoos (eds.) *Post-traumatic stress disorder in children.* (pp.157-168) Washington, DC. American Psychiatric Press.

Grady, K.E. (1981) Sex bias in research design. *Psychology of Women Quarterly.* 5, pp.628-36.

Grant, R. (1999) Sprituality and trauma: An essay. *Traumatology.* 5, (1) E2 pp.1-3.

Green, A. H. (1994) Impact of sexual trauma on gender identity and sexual object choice. *Journal of the American Academy of Psychoanalysis.* 22, (2) pp.283-297.

Green, A.M.D. (1991) Child sexual abuse and incest. In M. Lewis (ed.) *Child and adolescent psychiatry: A comprehensive textbook.* U.S.A. Williams & Williams.

Grimshaw, J. (1986) *Feminist philosophers: Women's perspectives on philosophical traditions.* Great Britain. Wheatsheaf Books.

Gross, R., Doerr, H. & Caldirola D. (1980-1) Borderline syndrome and incest in chronic pain patients. *International Journal of Psychological Medicine.* 10, pp.79-96.

Grosz, E. (1986) What is feminist theory? In C. Pateman & E.Grosz (eds.) *Feminist challenges: Social and political theory.* New South Wales. Allen and Unwin.

Grosz, E. (1987) Notes towards a corporeal feminism. *Australian Feminist Studies.* 5, (Summer) pp.1-16.

Grosz, E. (1990b) Inscriptions and body maps: Representations and the corporeal. In T. Threadgold & A. Cranny-Francis (eds.) *Feminine/masculine and representation.* Sydney. Allen & Unwin.

Grosz, E. (1990a) Contemporary theories on of power and subjectivity. In S. Gunew(ed.) *Feminist knowledge: Critique and construct.* London. Routledge.

Grosz, E. (1990) A note on essentialism and difference. In S. Gunew (ed.) *Feminist knowledge: Critique and construct.* Routledge. London.

Grosz, E. (1993) Bodies and knowledges: Feminism and the crisis of reason. In L. Alcoff & E. Potter (eds.) *Feminist Epistemologies.* New York. Routledge.

Grosz. E. (1994) *Volatile bodies: Toward a corporeal feminism.* Sydney. Alen & Unwin.

Grosz, E. (1995) *Space, time and perversion.* Sydney. Allen & Unwin.

Grosz , E. (1999) Psychoanalysis and the body. In J. Price & M. Shildrick, (eds.) *Feminist theory and the body.* (pp.267-271) Edinburgh. Edinburgh University Press.

Guillaumin, C. (1985) The masculine: Denotations/Connotations. *Feminist Issues.* 5 (Spring) p.65.

Gurevich, A. (1995) *The origins of European individualism.* Oxford. Cambridge. Blackwell.

Haaken, J. (1996) The recovery of memory, fantasy and desire: Feminist approaches to sexual abuse and psychic trauma. *Signs: Journal of Women in Culture & Society.* 21, (4) pp.1069-1094.

Haaken, J. & Schlapps, A. (1991) Incest resolution therapy and the objectification of sexual abuse. *Psychotherapy.* 28, (1) pp.39-47.

Haber, J. & Koos, C. (1985) Effects of spouse abuse and/or sexual abuse in the development and maintenance of chronic pain in women. In H.L. Fields (ed.) *Advances in pain research and therapy.* New York. Raven Press.

Halpern, N. & Henry, S. (1994) *Self-injury and dissociation.* Paper presented at 3rd annual conference of Australian Association of Trauma & Dissociation. Melbourne, September, 16-18.

Haraway, D. (1996) Situated knowledges: The science question in feminism and the privilege of partial perspective. In J. Agnew, D. Livingston & A. Rogers (eds.) *Human geography: An essential geography.* Oxford. Blackwell.

Harding, S. (1986) (ed.) *Perspectives on gender and science.* Lewes. Falmer Press.

Harding, S. (1986) *The science question in feminism.* Ithaca, New York. Cornell University Press.

Harding, S. (1987) The instability of the analytical categories of feminist theory. In S. Harding & J. O'Barr (eds.) *Sex and scientific inquiry.* (pp.283-302). Chicago. University of Chicago Press.

Harding, S. (1987) Introduction: Is there a feminist method? and Conclusion: Epistemological questions. In S. Harding (ed.) *Feminism and methodology: Social science issues.* (pp.1-12,181-190) Indiana. Bloomington.

Harding. S. & Hintikka, M. B. (1983) (eds.) *Discovering reality: Feminist perspectives on epistemology, metaphysics, methodology and philosophy of science.* Boston. D. Reidel.

Harrison, G. (1998) *The medicalisation of sexual violence: The social and political implications of diagnostic labelling.* Queensland. University of Queensland Press.

Harrop-Griffiths, J., Katon, W. & Walker, E. (1987) *Chronic pelvic pain: The relationship to psychiatric diagnosis and childhood sexual abuse.* Paper presented at the Conference on Mental Disorders in General Health Care Settings: A Research Conference. Seattle. WA. June 1987.

Hartsock, N. (1983) The feminist standpoint: Developing the ground for a specifically feminist historical materialism. In S. Harding & M. Hintikka (eds.) *Discovering reality: Feminist perspectives on epistemology, metaphysics, methodology and philosophy of science.* (pp.283-310) Boston. Reidel.

Healy, K. (1996) *Poststructural possibilities for activist social work: A discourse analysis of practice.* Doctoral thesis. St Lucia. University of Queensland.

Heilbrun, C.G. (1988) *Writing a woman's life.* New York. Ballantyne Books, Random House.

Held, V. (1993) *Feminist Morality.* Chicago. University of Chicago Press.

Herman, J. (1981) *Father-daughter incest.* Cambridge. Harvard University Press.

Herman, J., Russell, D. & Trocki, K. (1986) Long term effects of incestuous abuse in childhood. Am*erican Journal of Psychiatry.* 143, pp.1293-1296.

Herman, J. (1992) *Trauma & recovery*. United States of America. Basic Books.

Herman, J. & Hirschman, L. (1977) *Father daughter incest.* Signs. 2, (4) pp.735-756.

Hooper, C.A. (1992) Child sexual abuse and the regulation of women: Variations on a theme. In C. Smart (ed.) *Regulating Motherhood: Historical essays on marriage, motherhood and sexuality.* London. Routledge.

Horowitz, M. J. (1966) Body image. *Archives of General Psychiatry.* 14, pp.456-600.

Horowitz, M.J. (1997) *Stress Response Syndrome: P.T.S.D., grief and adjustment disorder.* 3rd edition. North Vale, Newbury. Aronson.

Humphreys, C. (1992) Disclosure of child sexual assault: Implications for mothers. *Australian Social Work.* 45, (3) pp.27-35.

Ife, J. (1997) *Rethinking social work.* Melbourne. Longman.

Irigarary, L. (1985) *This sex which is not one.* C. Porter (trans.) New York. Cornell University Press.

Jackson, M. (1983) Thinking through the body: An essay on understanding metaphor. *Social Analysis.* 14, pp.127-148.

Jackson, M. (1983) Knowledge of the body. *MAN.* 18, pp.327-345.

Jackson, M. (1987) Facts of life or the eroticization of women's oppression? Sexology and the social construction of heterosexuality. In P.Kaplan (ed.) *The cultural construction of sexuality.* London. Tavistock.

Jagger, A. (1989) Love and Knowledge: Emotion in feminist epistemology. In A.M. Jaggar & Bordo, S.R. (eds) *Gender/Body/Knowledge.* New Brunswick. Rutgers University Press.

Jagger, A, & Bordo, S. (1989) *Gender/Body/Knowledge.* New Brunswick. Rutgers University Press.

James, B. & Nasjleti, M. (1989) *Treating sexually abused children and their families.* California. Consulting Psychologists Press.

Jayaratne, T.E. (1983) The value of qualitative methodology for feminist research. In G. Bowles & R. Klein (eds.) *Theories of women's studies.* (pp.140-161). Boston. Routledge and Kegan Paul.

Jayaratne, S. & Stewart, A. (1991) Quantitative and qualitative methods in the Social Sciences: Current feminist issues and practical strategies. In M. Furnow & .J. Cook (eds.) *Beyond methodology: Feminist scholarship as lived research.* Indiana. Indiana University Press.

Jehu, D. & Gazan, M. (1983) Psychosocial adjustment of women who were sexually victimised in childhood or adolescence. *Canadian Journal of Community Mental Health.* 2, (20) pp.71-82.

Jehu, D., Gazan, M. & Klassen, C, (1984) Common therapeutic themes among women who were sexually abused in childhood. *Journal of Social Work & Human Sexuality.* 3,

pp.25-45.

Jenkins, A. (1987) *Invitations to Responsibility.* Adelaide. Dulwich Centre Publications.

Jimenez, M. A. (1997) Gender and psychiatry: Psychiatric conceptions of mental disorders in women 1960-1994. *Affilia.* 1, (2) pp.154-175.

Johnson, M. (1987) *The body in the mind: The bodily basis of meaning, imagination, and reason.* Chicago. University of Chicago Press.

Junjohann. E.E. (1990) Symptom as message: Psychosomatic reactions as signals in sexual exploitation of the child. *Acta Paedopsychiatrica.* 53, pp.54 –61.

Katon, W., Egan, K. & Miller, D. (1985) Chronic pain: Lifetime psychiatric diagnosis and family history. *American Journal Psychiatry.* 142, pp.1156-1160.

Keat, R. & Urry, J. (1982) *Social theory as science.* New York. Basic Books. 2nd edition.

Keller, E.F. (1978) Gender and science. *Psychoanalysis and Contemporary Thought.* 1, pp.409-433.

Keller, E.F. (1982) Feminism and science. *Signs.* 7, (3) pp.589-602.

Keller, E.F. (1983) Feminism as an analytic tool for the study of science. *Academe.* 69, (5) pp.15-21.

Keller, E.F. (1985) *Reflections on gender and science.* New Haven, Conneticut. Yale University Press.

Kelly, L. (1987) The continuum of sexual violence. In J. Hamner & M. Maynard (eds.) (pp.13-29) *Women, violence and social control.* London. MacMillan.

Kelly, L. (1988/9) From politics to pathology: The medicalisation of the impact of rape and child sexual abuse. *Radical Community Medicine.* Winter. pp.14-18.

Kelly, L., Burton, S. & Regan, L. (1994) Beyond victim or survivor: Sexual violence, identity and feminist theory and practice. In H. Radford & L. Kelly (eds.) *Women, violence and male power: Feminist activism, research and practice.* London, Open University Press.

Kelly. L., Burton, S. & Regan, L. (1994) Syndromes and disorders: The dangers of medicalising the impacts of sexual violence in legal cases. *Rights of Women Bulletin.* Autumn/Winter pp.2-6.

Kelly, L., Burton, S. & Regan, L. (1995) The dangers of using syndromes and disorders in legal cases. *Rights of Women Bulletin.* Spring pp.7-11.

Kleinman, A. (1988) *The illness narratives: Suffering, healing and the human condition.* New York. Basic Books.

Kondrat, M. E. (1992) Reclaiming the practical: Formal and substantive rationality in Social Work. *Social Service Review.* 66, (2) pp.237-255.

Krahe, B., Scheinberger-Olwig, R., Waizenhofer, E. & Kolpin, S. (1999) Child sexual abuse and revictimization in adolescence. *Child Abuse & Neglect.* 23, (4) pp.383-394.

Krueger, D.W. (1989) *Body self and psychological self.* New York. Brunner/Mazel.

Kuhn, T. (1962) *The structure of scientific revolutions.* (2nd edition) London. University of Chicago Press.

Kuhn, D., Amsel, E. & O'Loughlin, M. (1988) *The development of scientific thinking skills.* San Diego. Academic Press.

Laing, R.D. (1965) *The divided self.* Middlesex. England. Penguin Books.

Lakoff, G. & Johnson, M. (1980) *Metaphors we live by.* Chicago and London. University of Chicago Press.

Langer, L. (1995) (ed.) *Admitting the Holocaust.* New York. Oxford University Press.

Lechner, M.E., Vogel, M. E., Garcia-Shelton, L. M., Leichter, J. L. & Steibel, K. R. (1993) Self-reported medical problems of adult female survivors of childhood sexual abuse. *Journal of Family Practice.* 36, pp.633-638.

Leder, D. (1984) Medicine and paradigms of embodiment. *Journal of Medicine & Philosophy.* 9, pp.29-43.

Leder, D. (1990) *The absent body.* Chicago. University of Chicago Press.

Lee, S. (1996) Reconsidering the status of anorexia nervosa as a Western culture-bound syndrome. *Social Science & Medicine.* Vol.42, (1) pp.21-34.

Lerner, H.G. (1974) The hysterical personality: A 'woman's disease'. *Comprehensive Psychiatry.* 15, (2) pp.157-164.

Lerner, H.G. (1988) *Women in therapy.* New York. Harper & Row.

Leonard, P. (1997) *Postmodern welfare: Reconstructing and emancipatory project.* London. Sage.

Lewis, H. B. (1976) *Psychic war in men and women.* New York. New York University Press.

Linberg, F.H. & Distad, L. J. (1985) Post-traumatic stress disorders in women who experienced childhood incest. *Child Abuse & Neglect.* 9, (3) pp.329-334.

Lipovsky, J. (1991) Disclosure of father-child sexual abuse: Dilemmas for families and therapists. *Child Abuse & Neglect.* 23, (11) pp.85-103.

Litz, B.T.& Keane, T.M. (1989) Information processing in anxiety disorders: Application to the understanding of post-traumatic stress disorder. *Clinical Psychology Review.* 9, pp.243-257.

Lloyd, G. (1984) *The man of reason: 'Male' and 'female' in Western philosophy.* Minneapolis. University of Minneapolis Press.

Loewenstein, R.J. (1990) Somatoform disorders in victims of incest and child abuse. . In R. P. Kluft (ed.) *Incest related syndromes of adult psychopathology.* Washington, DC. American Psychiatric Press.

Lukianowicz, N. (1976) Incest. *British Journal of Psychiatry.* 120, pp.201-212.

Lykes, M. B. & Stewart, A.J. (1986) Evaluating the feminist challenge to research in personality and social psychology: 1963-1983. *Psychology of Women Quarterly.* 10, pp.393-412.

Lynn, S.J. & Rhue, J. (1995) (eds.) *Dissociation: Clinical and theoretical perspectives.* New York. Guilford Press.

Lyotard, Jean Francois (1984) *The postmodern condition.* Manchester. Manchester University Press.

MacCannell, D. & Flower MacCannell, J. (1993) Violence, pleasure and power: A revisionist reading of Foucault from the victim perspective. In C. Ramazanoglu & J.

Holland (eds.) *Up Against Foucault: Explorations of some tensions between Foucault and feminism.* pp.203-238. London. Routledge.

MacLeod, M. & Saraga, E. (1988) Challenging the orthodoxy: Towards a feminist theory and practice. *Feminist Review.* 28, pp.16-55.

MacSween, M. (1993) *Anorexic bodies: A feminist and sociological perspective on anorexia nervosa.* London & New York. Routledge.

Maltz, W. & Holman, B. (1987) *Incest and sexuality: A guide to understanding and healing.* Lexington, MA. Lexington Books.

Maltz, W. (1988) Identifying and treating the sexual repercussions of incest: A couples therapy approach. *Journal of Sex & Marital Therapy.* 14, (2) pp.142-170.

Mandel, B.J. (1980) Full of life now. In J.Olney (ed.) *Autobiography: Essays theoretical and critical.* Princeton. Princeton University Press.

Marcuse, H. (1962) *Eros and civilisation: A philosophical inquiry into Freud.* New York. Vintage Books.

Marcuse, H. (1968) *Reason and revolution.* London. Routledge and Kegan Paul.

Margolis, H. (1987) *Patterns, thinking, and cognition.* Chicago. University of Chicago Press.

Margolis, J. (1976) The concept of disease. *Journal of Medicine and Philosophy.* 1, pp.238-254.

Martin, S. (1989) *Body and soul: Physical therapies for everyone.* London. Penguin. Arkana.

Marques, J. K. & Nelson, C. (1989b) Understanding and preventing relapse in sex offenders. In M. Gossop (ed.) *Relapse and addictive behavior.* Beckenham, Kent, UK. Routledge.

Marx, K. (1867) Capital. In T.B. Bottomore, (trans.) *Karl Marx: Selected writings in sociology and social philosophy.* London. McGraw Hill. 1964.

Masson, J. (1984) *The assault on the truth: Freud's suppression of the seduction theory.* New York. Farrar, Strauss & Giroux.

Masson (1990) *Against therapy.* London. Fontana.

Matsakis, A. (1996) *I can't get over it: A handbook for trauma survivors*. Second edition. Oakland, California. New Harbinger Publications Inc.

Matthews, F. (1993) To know the world: Approaches to science in feminist theory. In F. Matthews (ed.) *On the edge of discovery.* Sydney. Allen & Unwin.

Mauss, M. (1979) *Sociology and psychology: Essays*. London.

Mauss, M. (1985) Techniques of the body. *Economy & Society.* 2, (1) pp.70-87.

McElroy, L. & McElroy, R. (1991) Countertransference issues in the treatment of incest families. *Psychotherapy.* 28, (1) pp.17-27.

McFarlane, A. C., Weber, D. L. & Clark, C.R. (1993) Abnormal stimulus processing in P.T.S.D. *Biological Psychiatry.* 34, pp.311-320.

Mc Millan, C. (1982) *Women, reason and nature.* Princeton. New Jersey. Princeton University Press.

Meiselman, K.C. (1978). *Incest: A psychological study of causes and effects with treatment recommendations.* San Francisco. Jossey-Bass.

Mendelsohn, E. (1977) The social construction of scientific knowledge. In P.W.E. Mendelsohn & R. Whitley (eds.) *The social production of scientific knowledge.* Boston. Reidel.

Merchant, C. (1980) *The death of nature: Women, ecology and the scientific revolution.* New York. Harper and Row.

Merleau-Ponty, M. (1962) *Phenomenology of perception.* Trans. C. Smith, London. Routledge, Kegan & Paul.

Merleau-Ponty, M. (1963) *The primacy of perception.* Evanston. Northwestern University Press.

Meyer, I., Muenzenmaier, K., Cancienne, J. & Struening, E. (1996) Reliability and validity of a measure of sexual and physical abuse histories among women with a serious mental illness. *Child Abuse & Neglect.* 20, (3) pp.213-219.

Meyers, D.T. (1989) *Self, society, and personal choice.* New York. Columbia University Press.

Meyers, D.T. (1992) Personal autonomy or the deconstructed subject? A reply to Hekman. *Hypatia.* 7, (1) pp.124-132.

Meyers, D.T. (1997) (ed.) *Feminists rethink the self.* New York. Westview Press.

Mian. M. Wehrspann, W., Klajner-Diamond, H., LeBaron, D. & Winder, C. (1986) Review of 125 children 6years of age and under who were sexually abused. *Child Abuse & Neglect.* 10, pp.223-229.

Mies, M. (1983) *Towards a methodology for feminist research.* Boston. Routledge and Kegan Paul.

Miller, J. (1976) *Toward a new psychology of women.* Boston. Beacon Press.

Miller, K. J. (1993) Prevalence and process of disclosure of childhood sexual abuse among eating disordered women. *Eating Disorders: The Journal of Treatment and Prevention.* 1, (3,4) pp.211-225.

Miller, F. & Bashkin, E. (1974) Depersonalization and self-mutilation. *Psychoanalytic Quarterly.* 43, pp.638-649.

Miller, R. & Dwyer, J. (1997) Reclaiming the mother-daughter relationship after sexual abuse. *Australian & New Zealand Journal of Family Therapy.* 18, (4) pp.194-202.

Miller, R. & Sutherland, K. (1999) Partners in healing: Systemic therapy with survivors of sexual abuse and their partners. *Journal of Family Studies.* Vol.5, (1) pp.97-111.

Millett, K (1977) *Sexual Politics.* London. Virago.

Mills, T., Ricker, P. & Carmen. E. (1984) Hospitalization experiences of victims of abuse. *Victimology.* Vol.9, pp.436-439.

Minichiello, V., Aroni, R., Timewell, E. & Alexander, L. (1990) *In-depth interviewing: Researching people.* Melbourne. Longman Cheshire.

Minsky, R. (1996) (ed.) *Psychoanalysis and gender.* London and New York. Routledge and Kegan Paul.

Monahon, C. (1993) *Psychic trauma in children: A parents guide to helping children heal.* New York. Lexington Books.

Morris, M. (1982) *If I should die before I wake.* New York. Dell.

Morrison, J. (1989) Childhood sexual histories of women with somatization disorder. *American Journal of Psychiatry.* Vol. 146, (2) pp.239-241.

Morrison, T. (1981) *The bluest eye.* London. Panther.

Mukai, R. (1989) Anorexia nervosa from within. *Women's Studies International Forum.* Vol.12, No. 6 pp.613-663.

Mullen, P. E. (1993) Child sexual abuse and adult mental health. *Journal of Interpersonal Violence.* 8, (3) pp.429-431.

Mullen, P., Martin, J., Anderson, J., Romans, S. & Herbison, G. (1994) The effects of child sexual abuse on social, interpersonal and sexual function in adult life. *British Journal of Psychiatry.* 165, pp.35-47.

Mullen, P., Martin, J. L., Anderson, J.C., Romans, S. E. & Herbison, G. P. (1996) The long-term impact of the physical, emotional and sexual abuse of children. A community study. *Child Abuse & Neglect.* 20, (1) pp.7-21.

Mullen, P.E. & Fleming, J. (1998) Long-term effects of child sexual abuse. *Issues in child abuse prevention.* Australia. Australian Institute of Family Studies. Autumn, (9) pp.1-11.

Oakley, A. (1981) Interviewing women: A contradiction in terms. In H. Rose (ed.) *Doing feminist research.* (pp. 30-61).Boston. Routledge and Kegan Paul.

Ochberg, F. (1991) Post-traumatic therapy. *Psychotherapy.* 28, (1) pp.5-15.

O'Donnell, C. & Craney, J. (1982) Incest and the reproduction of the patriarchal family. In C. O'Donnell & J. Craney (eds.) *Family violence in Australia.* Victoria. Longman Cheshire.

Oppenheimer, R., Howells, K., Palmer, R. L. & Chaloner, D.A. (1985) Adverse sexual experience in childhood and clinical eating disorders: A preliminary description. *Journal of Psychiatric Research.* 19, pp.357-361.

Orne, M. (1959) The nature of hypnosis: Artifact and essence. *Journal of Abnormal and Social Psychology.* 46, pp.213-225.

Parnell, L. (1999) *EMDR in the treatment of adults abused as children.* New York. W.W. Norton.

Peile, C. (1998) Emotional and embodied knowledge: Implications for critical practice. *Journal of Sociology & Social Welfare.* 15, (4) pp.39-59.

Pitman, R.K., Orr, S.P. & Shalev, A (1993) Once bitten, twice shy: Beyond the conditioning model of PTSD. *Biological Psychiatry.* 33, pp.145-146.

Plugge, H. (1970) Man and his body. In S. F. Spicker (ed.) T*he philosophy of the body: Rejections of Cartesian dualism.* New York. Times Publishing Co.

Polhemus, T. (1978) (ed.) *Social aspects of the human body.* Harmondsworth.

Polkinghorne, D.E. (1989b) Phenomenological research methods. In R. S. Valle & S. Halling (eds.) *Existential-phenomenological perspectives in psychology.* (pp.41-60). New York. Plenum Press.

Polkinghorne, D. E. (1991) Qualitative procedures for counseling research. In C. Edward Watkins Jr. & L.J. Schneider (eds.) *Research in Counseling.* (pp.163-204). Hillsdale,

New Jersey. Lawrence Erlbaum Associates Inc.

Post, R.M., Weiss, S.R.B., Li, H., Smith, M.A., Zang, A., Xing, G., Osuch, E. A. & McCann, U.D. (1998) Neural Plasticity & Emotional Memory. *Development & Psychopathology.* 10, pp.829-855.

Pringle R. & Watson, S. (1992) Women's interests and the poststructural State, in *Destabilising theory: Contemporary feminist debates*. Cambridge. Polity Press.

Putnam, F.W. (1985a) Dissociation as a response to extreme trauma. In R. P. Kluft (ed.) *Childhood antecedents of multiple personality disorder.* Washington DC. American Psychiatric Press.

Randall, J. (1994) The legacy of abuse: How it contributes to illness. *Substance Abuse and Mental Health Services Administration.* 3, pp.6-11.

Randall, M. (1987) *This is about incest.* New York. Ithaca.

Ransom, J. (1993) Feminism, difference and discourse: The limits of discursive analysis for feminism. In C. Ramazanoglu (ed.) *Up against Foucault: Explorations of some tensions between Foucault and feminism.* London/New York. Routledge.

Ramazanoglu, C. (1989) *Feminism and the contradictions of oppression.* London. Routledge.

Ramazanoglu, C. (1993) *Up against Foucault: Explorations of some tensions between Foucault and feminism.* London. Routledge.

Raskin, D.E. (1984) Diagnosis in patients with chronic pain. *American Journal of Psychiatry.* 17, pp.132-136.

Read, J. (1998) Child abuse and severity of disturbance among adult psychiatric impatients. *Child Abuse & Neglect.* Vol.22. No. 5 pp.359-368.

Reichenbach, H. (1938) *Experience and prediction.* Chicago. University of Chicago Press.

Reiger, K. (1985) *The Disenchantment of the Home.* Oxford University Press. Melbourne.

Reviere, S. (1996) *Memory of childhood trauma: A clinician's guide to the literature.* New York. Guilford Press.

Rimza, M.E. & Berg, R.A. (1988) Sexual abuse: somatic and emotional reactions. *Child Abuse & Neglect.* 12, pp.201-208.

Roberts, H. (1981) (ed.) *Doing feminist research.* Boston. Routledge and Kegan Paul.

Robertson, M. (1992) *Starving in the silences: An exploration of anorexia nervosa.* Sydney: Allen & Unwin.

Rodriguez, N., Vande Kemp, H. & Foy, D. (1998) Posttraumatic stress disorder in survivors of childhood sexual and physical abuse: A critical review of the emprical research. *Journal of Child Sexual Abuse.* Vol.7, (2) pp.17-45.

Root, M. (1991) Persistent, disordered eating as a gender specific, posttraumatic stress response to sexual assault. *Psychotherapy.* 28, pp.96-102.

Root, M. (1992) Reconstructing the impact of trauma on personality. In L.Bass & Ballou, M. (eds.) *Personality and psychopathology: Feminist reappraisals.* (pp.229-265) New York. Guilford.

Rooth, G. (1973) Exhibitionism, sexual violence and pedophilia. *British Journal of Psychiatry*. 122, pp.705-710.

Roth. S. & Lebowitz, L. (1988) The experience of sexual trauma. *Journal of Traumatic Stress*. 1, pp.79-107.

Roth, S. & Newman, E. (1991) The process of coping with sexual trauma. *Journal of Traumatic Stress*. 4, pp.279-299.

Roth, S. & Newman, E. (1993) The process of coping with incest for adult survivors: Measurement and implications for treatment and research. *Journal of Interpersonal Violence*. Vol.8, No. 3 pp.363-377.

Rose, D. (1991) A model for psychodynamic psychotherapy with the rape victim. *Psychotherapy*. 28, (1) pp.1-17.

Rose, H. (1983) Hand, brain and heart: A feminist epistemology for the natural sciences. *Signs*. 9, (1) pp.73-90.

Rose, H. (1986) Beyond masculinist realities: A feminist epistemology for the sciences. In R. Bleier (ed.) *Feminist approaches to science*. (pp.57-76) Pergamon Press. New York.

Rothschild, B. (2000) *The body remembers: The psychophysiology of trauma and trauma treatment*. New York & London. W.W. Norton.

Rush, F. (1974) The sexual abuse of children: A feminist point of view. In N. Connell & C. Wilson (eds.) *Rape: The first source book for women*. New York. Plume.

Rush, F. (1980) *The best kept secret: Sexual abuse of children*. New York. McGraw-Hill.

Russell, D. E. (1983) The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. *Child Abuse & Neglect.* 7, pp.133-146.

Russell, D. (1986) *The secret trauma: Incest in the lives of girls and women.* New York. Basic Books.

Ryan, G. & Associates (1999) *Web of meaning: A developmental-contextual approach in sexual abuse treatment.* Brandon, VT. Safer Society Press.

Sacks, O. (1973) *Awakenings.* London. Duckworth.

Salter, A. (1988) *Treating child sex offenders and victims: A practical guide.* London. Sage.

Salter, A. (1992) Response to the abuse of the child sexual abuse accommodation syndrome. *Journal of Child Sexual Abuse.* 1, (4) pp.173-184.

Salter, A. (1995) *Transforming trauma: A guide to understanding and treating adult survivors of child sexual abuse*. California. Sage.

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

Saunders, B. E., Villeponteaux, L .A., Lipovsky, J. A., Kilpatrick, D. G. & Veronen, L. J. (1992) Child sexual assault as a risk factor for mental disorders among women: A community study. *Journal of Interpersonal Violence.* 7, (2) pp.189-204.

Scarry, E. (1985) *The body in pain: The making and unmaking of the world.* New York & Oxford. Oxford University Press.

Schalev, A.Y. & Rogel-Fuchs, Y. (1993) Psychophysiology of PTSD: From sulfur fumes to behavioural genetics {Review} *Journal of Nervous and Mental Disease.* 55, (5) pp.413-423.

Schechter, M.D.R., L. (1976) *Sexual exploitation.* In R. E. Helfer & H. Kempe, (eds.) *Child abuse and neglect: The family and the community.* Cambridge, Massachusetts. Ballinger.

Scheman, N. (1983) Individualism and the objects of psychology. In S. Harding & M. Hintikka (eds.) *Discovering reality: Feminist perspectives on epistemology, metaphysics, methodology, and philosophy of science.* Boston. D. Reidel.

Scheper-Hughes, N. (1987) (ed.) *Child survival: Anthropological perspectives on the treatment and maltreatment of children.* Boston. Dordrecht. D. Reidel.

Scheper-Hughes, N. & Lock, M. M. (1987) The mindful body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly.* 10, pp.6-41.

Schenck, D. (1986) The texture of embodiment: Foundation for medical ethics. *Human Studies.* 9, pp.43-54.

Schetky, D. H. (1990) A review of the literature on the long-term effects of childhood sexual abuse. In R. P. Kluft (ed.), *Incest related syndromes of adult psychopathology.* Washington, DC. American Psychiatric Press.

Scheuneman, J.D. (1986) The female perspective on methodology and statistics. *Educational Researcher.* 15, pp.22-23.

Schilling, C. (1993) *The body and social theory.* London. Sage.

Schwartz, M.F, & Gay, P. (1993) Physical and sexual abuse and neglect and eating disorder symptoms. *Eating Disorders: The Journal of Treatment & Prevention.* 1, (3,4) pp.265-281.

Schwartz, M. F. C. & Cohen. L. (1996) *Sexual abuse and eating disorders.* West New York: Brunner/Mazel Inc.

Scutt, J. (1983) *Even in the best homes: Violence in the family.* Victoria. Penguin Books.

Sedney, M. A. & Brooks, B. (1984) Factors associated with a history of childhood sexual experiences in a nonclinical female population. *Journal of the American Academy of Psychiatry.* 23, pp.215-218.

Seymour, A. (1998) Aetiology of the sexual abuse of children: An extended feminist perspective. *Women's Studies International Foru.m.* 21, (4) pp.415-427.

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

Showalter, E. (1985) *The female malady: Women, madness and English culture, 1830-1890.* New York. Pantheon.

Showalter, E. (1985) ed. *The new feminist criticism: Essays on women, literature, and theory.* New York. Pantheon Books.

Simpson, M. (1975) The phenomenology of self-mutilation in a general hospital setting. *Canadian Psychiatric Association Journal.* 20, pp.424-434.

Sloan, G. & Leichner, P. (1986) Is there a relationship between sexual abuse or incest and eating disorders? *Canadian Journal of Psychiatry.* October, pp.656-660.

Smyington, N. (1986) *The analytic experience: Lectures from Tavistock.* London. Free Association Books.

Sontag, S. (1988) *Ilness as metaphor.* London. Penguin.

Sommer, D. (1988) Not just a personal story: Women's testimonials and the plural self. In B. Brodzski & C. Schenk (eds.) *Life/Lines: Theorizing women's autobiography.* Ithaca. Cornell University Press.

Sorrenti-Little, L., Bagely, C., & Robertson, S. (1984) An operational definition of the long term harmfulness of sexual relations with peers and adults by younger children. *Canadian Children: Journal of the Canadian Association of Young Children.* 9, pp.46-57.

Spataro, J., Moss, S. & Wells, D. (2001) Child sexual abuse: A reality for both sexes. *Australian Psychologist.* Vol. 38, No. 3 pp.177-183.

Speigel, D. (1990) Trauma, dissociation, and hypnosis. In R. P. Kluft (ed.) *Incest related syndromes of adult psychopathology.* pp.247-261. Washington, DC. American Psychiatric Press.

Speigel, D. & Cardena, (1991) Disintegrated experience: The dissociative disorders revisited. *Journal of Abnormal Psychology.* 100, pp.366-388.

Spinelli. E. (1997) *Tales of the Un-Knowing: Therapeutic encounters from an existential perspective.* Great Britain. Duckworth.

Springs, F. E. & Friedrich, W. N. (1992) Health risk behaviours and medical sequelae of childhood sexual abuse. *May ' Clinic Proceedings.* 67, pp.527-533.

Stanley, L. & Wise. S. (1983) *Breaking out: Feminist consciousness and feminist research.* London. Routledge and Kegan Paul.

Stanley. L. & Wise, S. (1990) Method, methodology and epistemology in feminist research process. In L.Stanley (ed.) *Feminist Praxis.* Great Britain. Routledge and Kegan Paul.

Starzecpyzel, E. (1987) The Persephone complex: Incest dynamics and lesbian preference. In *Lesbian Psychologies.* Boston Lesbian Psychology Collective, (pp.261-282) Urbana and Chicago. University of Chicago Press.

Steele, B. (1986) Notes on the lasting effects of early child abuse throughout the life cycle. *Child Abuse & Neglect.* 10, pp.283-191.

Steele, K. (1990) Treatment of multiple personality disorder. *Contemporary Clinical Issues: Master Clinician Series.* Seattle. Family Psychotherapy Practice.

Steier, F. (1991) (ed.) *Research and reflexivity.* London & California. Sage.

Steiner-Adair, C. (1990) The body politic: Normal female adolescent development and the development of eating disorders. In C. Gilligan, N. Lyons & T.J. Hamner (eds.) *Making Connections: The relational worlds of adolescent girls at Emma Willard School.* Cambridge. MA. Harvard University Press.

Steiner-Adair, C. (1991) When the body speaks: Girls, eating disorders and psychotherapy. In C. Gilligan (ed.) *Women, girls and psychotherapy: Reframing resistance.* New York. Haworth Press.

Strauss, E. (1963) *The primary world of the senses.* New York. Basic Books

Strauss, A. (1987) *Qualitative analysis for social scientists*. Cambridge. Cambridge University Press.

Strauss, A. & Corbin, J. (1990) *Basics of qualitative research.* California. Sage.

Strouse, J. (1974) *Women & analysis*. New York. Grossman.

Tayson, S. (1998) *Feminist postmodernism and the body.* Ph.D. thesis. University of Queensland. St Lucia, Queensland.

Terr, L. (1991) Childhood traumas: An outline and overview. *American Journal of Psychiatry*. 148, (1) pp.10-20.

Tennant, M. (1998) *Emotional and embodied knowledge in social work practice.* Masters thesis. University of Queensland. St Lucia. Queensland.

Thompson, L. (1992) Feminist methodology for family studies. *Journal of Marriage & Family Therapy.* 54, (February) pp.3-18.

Tomm, K. (1990) A critique of the DSM. *Dulwich Cente Newsletter.* South Australia. Dulwich Publications. pp.5-8.

Tong, R. (1989) *Feminist thought: A comprehensive introduction.* London. Unwin Hyman.

Toomey, T. C., Hernandez, J. T., Gittleman, D. F. & Hulka, J. F. (1993) Relationship of sexual and physical abuse to pain and psychological assessment variables in chronic pelvic pain patients. *Pain.* 53, pp.105-109.

Turner, B. (1982) The discourses of diet. *Theory, Culture & Society.* Vol.1, (1) pp.23-32.

Turner, B. (1984) *The body and society.* Oxford, U.K. Blackwell.

Turner, B. (1987) *Medical power and social knowledge.* London. Sage.

Ussher, J. (1997) *Fantasies of femininity: Reframing the boundaries of sex.* London. Penguin.

van der Hart, O., Steele, K., Boon, S. & Brown, P. (1993) The treatment of traumatic memories: Synthesis, realization, and integration. *Dissociation.* 6, pp.162-180.

van der Kolk, B. (1987) *Psychological Trauma.* Washington, DC. American Psychiatric Press.

van der Kolk, B. & Saporta, J. (1991) The psychobiology of trauma: Mechanisms and treatment of intrusion and numbing. *Anxiety Research.* 4, pp.199-212.

van der Kolk, B. & van der Hart, O. (1991) The intrusive past: The flexibility of memory and the engraving of trauma. *American Imago.* Vol.48, (4) pp.425-454.

van der Kolk, B. (1994) The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry.* 1, pp.253-265.

van der Kolk, B. & Fisler, R. (1995) Dissociation and the fragmentary nature of traumatic memories: Review and experimental confirmation. *Journal of Traumatic Stress.* 8, (4) pp.505-525.

van der Kolk, B. (1996) The complexity of adaptation to trauma: Self-regulation, stimulus discrimination, and characterological development. In In B.van der Kolk, A. McFarlane & L. Weisaeth (eds.) *Traumatic Stress: The effects of overwhelming experience on mind, body and society.* New York and London. Guilford Press.

van der Kolk, B., van der Hart, O. & Marmar, O. (1996) Dissociation and information processing in P.T.S.D. In B.van der Kolk, A. McFarlane & L. Weisaeth (eds.) *Traumatic Stress: The effects of overwhelming experience on mind, body and society.* New York and London. Guilford Press.

van der Kolk B., Weisaeth, L. & van der Hart, V. D. (1996) History of trauma in psychiatry. In B.van der Kolk, A. McFarlane & L. Weisaeth (eds.) *Traumatic Stress: The effects of overwhelming experience on mind, body and society.* New York and London. Guilford Press.

van der Kolk, B & McFarlane A.C. (1996) The black hole of trauma. In B.van der Kolk, A. McFarlane & L. Weisaeth (eds.) *Traumatic Stress: The effects of overwhelming experience on mind, body and society.* New York and London. Guilford Press.

van der Kolk, B. Pelcovitz, D., Roth, S., Mandel, F., McFarlane,A., & Herman, J. (1996b) Dissociation, somatization and affect dysregulation: The complexity of adaptation to trauma. *American Journal of Psychiatry.* 153, (7) pp.83-93.

van der Kolk, B. (1997) The psychobiology of posttraumatic stress disorder. *Journal of Clinical Psychiatry.* 58, (9) pp.16-24.

van der Kolk, B. (1998) The psychology and psychobiology of developmental trauma. In A. Stoudemire (ed.) *Human behavior: An introduction for medical students.* pp.383-399. New York. Lipppincott-Raven.

Vanderlinden, J., vandereycken, W., vanDyck, R. & Vertommen, H. (1993) Dissociative experience and trauma in eating disorders. *International Journal of Eating Disorders.* 13, pp.187-194.

Vice, S. (1998) Psychoanalytic Feminist Theory. In S. Jackson & J. Jones, *Contemporary Feminist Theories.* Edinburgh. Edinburgh Press. pp.162-176.

Walby, S. (1990) *Theorising patriarchy.* Oxford. Blackwell.

Waldby, C. (1987) *Breaking the silence: A report based upon the findings of the women against incest phone-in survey, Sydney, 22-24 February,* 1984. Sydney.

Walker, E., Katon, W., Harrop-Griffiths, J et al. (1988) Relationship of chronic pelvic pain to psychiatric diagnosis and childhood sexual abuse. *American Journal of Psychiatry.* 145, pp.75-80.

Walker, E. A., Gelfand, A. N., Gelfand, M. D. & Katon, W. J. (1995) Psychiatric diagnoses, sexual and physical victimization, and disability in patients with irritable bowel syndrome or imflammatory bowel disease. *Psychosomatic Medicine.* 25, pp.1259-1267.

Walsh, B. W. & Rosen, P. M. (1988) *Self-mutilation: Theory, research and treatment.* New York. Guilford Press.

Ward, E. (1984) *Father-daughter rape.* London. The Women's Press.

Wattenberg, E. (1985) In a different light: A feminist perspective on the role of mothers in father-daughter incest. *Child Welfare.* 64, (3) pp.203-211.

Watzlawick, P., Beavin, J. & Jackson, D. (1967) *Pragmatics of human communication: A study of interactional patterns, pathologies and paradoxes.* New York. W. W. Norton.

Wearing, B. (1986) Feminist theory and social work. In H. Marchant & B. Wearing (eds.) *Gender reclaimed: Women in social work.* Sydney. Hale & Iremonger, Pty Ltd.

Weedon, C. (1987) *Feminist practice and poststructuralist theory.* Oxford. Blackwell.

Weitzel, J. (1991) Universal mental health classification systems: Reclaiming women's experience. *Affilia.* 6, (8) pp.8-31.

Weiss, G. & Fernhaber, H. (eds.) (1999) *Perspectives on Embodiment: The intersections of nature and culture.* New York and London. Routledge.

Westcott, M. (1979) Feminist criticism of the social sciences. *Harvard Educational Review.* 49, pp.422-30.

Wilson, E.A. (1999) Introduction: Somatic compliance – feminism, biology and science. *Australian Feminist Studies.* Vol.14, No. 29 pp.7-18.

Winnicott, D.W. (1971) *Playing and reality.* London. Tavistock.

Wurtele, S., Kaplan, G. & Keairnes, M. (1990) Childhood abuse among chronic pain patients. *The Clinical Journal of Pain.* 6, pp.110-113.

Wyatt, G. E., Guthrie, D. & Notgrass, C. M. (1992) Differential effects of women's child sexual abuse and subsequent sexual revictimization. *Journal of Consulting & Clinical Psychology.* 60, (2) pp.167-173.

Yeatman, A. (1994) *Postmodern revisionings of the political.* New York/London. Routledge.

Young, I. M. (1989) Throwing like a girl: A phenomenology of feminine comportment, motility, and spatiality. In J. Allen & I. M. Young (eds.) *The thinking muse: Feminism and Modern French philosophy.* Bloomington. Indiana University Press.

Young, L. (1992) Sexual abuse and the problem of embodiment. *Child Abuse & Neglect.* Vol.16, pp. 89-100.

Young, S., Alpers, D. H., Norland, C.C. et al. (1976) Psychiatric illness and irritable bowel syndrome: Practical implications for the primary care physician. *Gastroenterology.* 70, pp.162-166.

Zimny, G.H. (1965) Body image and physiological responses. *Journal of Psychosomatic Research.* 9, pp.185-188.

Zlotnick, C., Shea, M.T., Pearlstein, T., Simpson, E., Costello, E. & Begin, A. (1996) The relationship between dissociative symptoms, alexythmia, impulsivity, sexual abuse and self-mutilation. *Comprehensive Psychiatry.* 39, pp.266-268.

Zucker, K. J. & Kuksis, M. (1990) Gender dysphoria and sexual abuse: A case report. *Child Abuse & Neglect.* Vol. 14, pp.281-283.