"I AM NOT A VICTIM, I AM A SURVIVOR": HEALTHY SEXUALITY AS A CONTEXT FOR RESILIENCE IN WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

by

KIMMERY C. NEWSOM

B.S., Kansas State University, 2004
M.S., Kansas State University, 2006

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

School of Family Studies and Human Services
College of Human Ecology

KANSAS STATE UNIVERSITY
Manhattan, Kansas

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Abstract

The current study was conducted with women survivors of childhood sexual abuse (CSA) about their experiences of resilience in the context of interpersonal and sexually intimate relationships. Six women between the ages of 18 and 55, who self-identified as resilient on the pre-screening form, were invited to participate in the study. Qualitative methods with a phenomenological lens were employed. One-on-one interviews were conducted with participants. The results revealed the perspective and focus the survivors have regarding resilience and sexuality in interpersonal relationships. The participants had very similar thought patterns, which supports the idea that women survivors who self-identify as resilient have very similar experiences when it comes to resilience, relationship functioning and the view of themselves as sexual beings. Some of the main themes that emerged included but were not limited to bouncing back, moving forward, determination, confidence, use of voice, safe, loving relationships, empowered, church, God, religion, etc. Although each woman's experience is not exactly the same, their views regarding their mental, emotional, and physical experiences as survivors of CSA were very similar.

Keywords: resilience, sexuality, survivors, CSA

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Approved by:

Major Professor
Karen Myers-Bowman, PhD, CFLE

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Dedication

I dedicate this project to my son Kendall. You have added so much joy to my life. I love you my son. To the survivors of CSA who contributed to this study and survivors everywhere, thank you for all you are, have been and will become. The world deserves to know your story in your words. I hope this project will be a step in that direction.

Chapter 1 - Introduction

I remember calling Ellen one day a few months after I had remembered the incest. I counted the rings--two, three, four--she had to be home! She had to be! Five, six, seven--if I didn't talk to her right now, I knew I couldn't last through the afternoon. Eight, nine, ten--well, maybe she was outside folding the laundry and was just slow getting to the phone. Eleven, twelve, thirteen--I cannot stand another moment of this pain. My heart hurts and I can't take anymore. Fourteen, fifteen…

"Hello, this is Ellen," she said cheery and calm. "Ellen this is Laura. Look you've got to tell me just one thing. Will I ever get through this? Is there ever an end? I can't take it anymore, and if you'll just tell me I can get to the other side, I'm sure I can last through the week." I was talking fast, my sentences piling up on each other. "Hello Laura. I'm glad you called." Her voice was smooth, reassuring. "And yes, you can make it. Healing is possible. You're already well on your way."

"Well on my way? How can you say that? I can't sleep, and when I do, it's all I dream about. I can't even think about anything else. Every child I see on the street reminds me of incest. I can't make love, I can't eat, my whole body feels like a giant piece of rubber. I'm crying all the time. My whole life is flashbacks, going to therapy, and talking about incest. Half the time I don't even believe it happened, and the other half I'm sure it was my fault."

"It did happen, Laura. Look at what you're going through. Would anyone willingly choose to go through this torture? Why would you ever want to invent something this bad? You were just a little girl, Laura. He was what--seventy years old? You were a victim. You were innocent. You didn't do anything. It wasn't your fault." Over and over, Ellen repeated those simple phrases: "It wasn't your fault. I believe you. Healing is possible. You're going to make it.

You're going to be okay." I expressed every doubt I could think of. Then I made up some new ones. I knew other survivors didn't make up this sort of thing, but I was the exception. I'd always been the exception, all my life.

"You can fight all you want, Laura," she said finally, "but the door's been opened, and you're in the healing process whether you like it or not." There was a long silence. Then I said, "Isn't there any way out?"

"The only way out is through, honey; I'm sorry."

I was quiet for a long time. "But it hurts, Ellen. It hurts so much."

"I know, Laura. I know. But there's a way through this stuff, and I know you're going to find it." (Bass & Davis, 2008, p. xvii-xviii)

This story is found in an introduction from *The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse, 4th Edition* (Bass & Davis, 2008). This book also has a workbook and the set can be used as a tool in the healing process for some women survivors of childhood sexual abuse (CSA). I included this story because it is a good example of the turmoil that some women deal with as they are struggling to find ways to cope with the memories of sexual abuse.

Many women wrestle with the negative aspects of coping, as outlined in the story above; however, later they make their way to living functional, fulfilling lives. The very concept I seek to examine has functional lives at the very heart of its definition—resilience.

Statement of the Problem

Childhood sexual abuse (CSA) is a topic that has been widely studied in the literature. Most of the time the focus is on the negative aspects of coping and maladaptive long-term adjustment. For example, the mental health and relational affects of CSA are emphasized in the

literature (Bryant-Davis, Chung, & Tillman, 2009; Futa, Nash, Hansen, & Garbin, 2003; Zinzow, Seth, Jackson, Niehaus, & Fitzgerald, 2010) and CSA has been linked to a range of difficulties including depression, post-traumatic stress disorder, personality disorders and substance abuse (Murthi & Espelage, 2005). There has been very little research on how CSA survivors have overcome the odds to experience positive long-term adjustment outcomes. Researchers who discuss and bring to light the positive adaptation of women survivors of CSA often refer to what these women have as resilience (Banyard, Williams, Siegel, & West, 2002; Feinauer & Stuart, 1996; Hyman & Williams, 2001).

Resilience is a topic that has been discussed in a wide range of disciplines. There have been studies specifically about resilience as an aftereffect of trauma related to September 11, 2001 and various natural disasters. These are usually stories of triumph and thriving despite the circumstances the survivors once faced. Also, resilience researchers usually study three types of phenomena: good developmental outcomes in children from high-risk backgrounds who have overcome great odds; sustained competence under conditions of stress; and individuals who have successfully recovered from serious childhood traumas such as war and political violence (Werner, 2000). It is imperative that the positive aspects of coping and positive long-term adjustment of women survivors of CSA be examined through the lens of resilience as well. Attention to those positive aspects of life after CSA provides practitioners and the survivors with whom they work with another way to view the aftereffects of such abuse. Additionally, sexual self-concept (the way women survivors of CSA feel about themselves as sexual beings) has not been examined in this population of women. It is imperative that survivors are able to talk about and think about themselves as healthy sexual beings in spite of their experience(s) with sexual abuse. This is because survivors' voices and needs are not expressed in current literature. There

is something to be said about having overcoming the negative aspects of a traumatic experience. Therefore, this ability to speak about their feelings regarding sexuality may provide survivors with an opportunity to examine their belief systems, positive and negative, which have formed as a result of the abuse experience.

There are many women who do not succumb to the negative effects of the abuse and are able to thrive in their lives. Because so little research has been conducted to understand the positive side of adjustment in women survivors, I believe it is important to shine a light on those aspects and what influences survivors to lead more or less resilient lives. Even though they may be few, some of the researchers that discuss resilience in women survivors of CSA also reveal the reasons women are resilient. In other words, they include characteristics that define what it means for these women to be resilient as survivors of CSA.

The current study will seek to expand on the positive aspects of coping, specifically resilience in women survivors of CSA, particularly in the context of relationship functioning and sexuality, with women as they recover from their childhood trauma.

Rationale for the Study

There has been a lot of research conducted with women survivors of childhood sexual abuse (CSA). Many of those studies investigated the mental health and relational affects of CSA on women survivors but little attention was given to the positive aspects of coping and adjustment. This qualitative study on resilience in women survivors of CSA who consider themselves resilient, specifically in the context of relationships and sexuality is important for several reasons. First, there has been limited discussion related to the positive aspects of coping in survivors. The focus has been primarily on the negative aspects of coping and not the resilience that many women who have experienced CSA display. Another reason this study is

important is because it provides a glimpse of the ways in which women survivors view themselves as sexual beings. This aspect of the study will provide an understanding of intimate and interpersonal relationships among survivors that would not be revealed otherwise.

Outline of Dissertation

The remainder of this dissertation contains a review of the CSA literature, the resilience and CSA literature, the sexual self-concept literature, along with explanations of the use of resilience and symbolic interactionism theoretical frameworks, which guided the study. Chapter three includes the research methods, with sampling techniques, data collection and data analysis methods. Chapter four details the results of the study including content from the interviews conducted with participants, themes that emerged from those interviews and whether or not those themes helped to answer the research questions. Chapter five is where the findings/results are discussed as well as the conclusion of the study with implications for future research and Family Life Educators (FLE).

Chapter 2 - Review of the Literature

In this chapter, I will review the literature related to childhood sexual abuse, resilience and sexuality. First, I will discuss the definition and prevalence of CSA and the negative effects that have been identified within most of the research on women survivors of CSA.

Childhood Sexual Abuse Defined

Childhood sexual abuse (CSA) has been defined as bodily contact of the sexual nature occurring before age 18 by a perpetrator of any age or relationship to the victim (Wyatt & Mickey, 1987) and consists of two overlapping but distinguishable types of interactions: (a) forced or coerced sexual behavior imposed on a child, and (b) sexual activity between a child and a much older person (defined as 5 years or older than the child) whether or not obvious coercion is involved (Browne & Finkelhor, 1986). Recently, CSA was defined as contact or interaction between an adult and child when the child is used for sexual stimulation of an adult or another person; a sexual act committed by a minor when the person is at least 5 years older than the victim (Walker, Carey, Mohr, Stein, & Seedat, 2004).

Despite the similarity of the conceptual definitions used in studies of CSA, there have been persistent differences in operational definitions of CSA between the studies (Walker et al., 2004). Unfortunately, a limited number of studies provide the operational and/or general definitions of CSA. This makes it difficult to compare findings across studies. Throughout this literature review, I will explicitly identify the operational definitions when possible.

Prevalence

Sexual abuse of children has been disrupting family life for many years. However, only recently, within the last 20 or 30 years, has it become a problem that has been extensively

addressed and researched (Browne & Finkelhor, 1986). The prevalence of sexual abuse and the negative effects and negative coping in women who have experienced CSA have received the most attention (e.g., Banyard, Arnold, & Smith, 2000; Schuetze & Eiden, 2005; Walsh, Fortier, & DiLillo, 2010); however, a clear picture of the prevalence is not available. For example, Peters, Wyatt, and Finkelhor (1986) found that the prevalence of CSA ranged from 6-62% in girls and 3%- 31% in boys. This represents an extremely wide range in the percentages of those who have been sexually abused, which illustrates the difficulty resulting from the variety of operational definitions. The discrepancy also may be due to the reality that CSA often goes unreported.

MacMillan et al. (1997) found that a greater percentage of females reported CSA (12.8%) than males (4.3%), which is consistent with other research on prevalence of CSA (Finkelhor, Hotaling, Lewis, & Smith, 1990). Other studies have confirmed a higher incidence of CSA with females than males. In a community sample of more than 122,000 individuals, CSA rates of 8% in girls and 2% in boys were documented (Harrison, Fulkerson, & Beebe, 1997). Data from the National Comorbidity Survey were used to determine that CSA reported in women was 13.5% as compared with 2.5% of men (Molnar, Buka, & Kessler, 2001). Moreover, these rates show that men are less likely than women to report CSA (Finkelhor et al., 1990). Although all the studies cited here are self-report prevalence rates, it is still difficult to have accurate and consistent prevalence rates because of the diversity of operational definitions and because many cases of sexual abuse go unreported.

Negative Effects of CSA: Emotional, Cognitive and Relational Aspects

Over the years, there have been several research studies on the mental health and relational effects of CSA (e.g., Batten, Follette, & Aban, 2001; Bryant-Davis, Chung, & Tillman,

2009; Ginzburg et al., 2006; Zinzow et al., 2010). Some of the long-term negative effects include depression, self-destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, tendency toward revictimization, substance abuse, difficulty trusting others, sexual maladjustment, post sexual abuse trauma, dissociation and sleeping disturbances (Banyard et al., 2002; Feinauer, Mitchell, Harper, & Dane, 1996; Webster, 2001).

Not only did female survivors of CSA display emotional/mental health consequences, but they also had more difficulty dealing with stress in general. Coping refers to the different thought processes and behaviors used to manage the internal and external demands of a stressful or threatening situation (Folkman & Lazarus, 1980). Coping can refer to the strategies used in response to a particular stressor as well as to strategies that are linked to particular events (Walsh et al., 2010).

> There is a long-standing and widely held conviction among researchers and practitioners in the fields of mental health and behavioral medicine that the ways people cope with demands of a stressful event make a difference in how they feel emotionally. (Folkman & Lazarus, 1988, p. 466)

Coping for CSA survivors can be defined as "learned behaviors that contribute to survival in the face of life-threatening dangers" (Folkman & Lazarus, 1988, p. 466). Most of these behaviors are initiated by fear and fear motivates the behavioral response to the stressor (Folkman & Lazarus, 1988). CSA may "prompt the use of particular coping strategies across more general domains of functioning as well as specific stressful situations" (Walsh et al., 2010, p. 2). Several researchers have studied coping of survivors of childhood sexual abuse (i.e., Filipas & Ullman, 2006; Futa et al., 2003; Hund & Espelage, 2005; Oaksford & Frude, 2003;

Walsh et al., 2010; Weierich & Nock, 2008). The main finding is that there is no dominant pattern of coping for these women.

Futa et al. (2003) compared the coping strategies used by women with four types of childhood histories – no child abuse, sexual abuse, physical abuse, and sexual and physical abuse – in order to examine how adults with and without an abuse history were currently coping with memories associated with abuse or other childhood stressors. The researchers also wanted to examine whether a history of abuse affects the ways women cope with current stressors. They revealed that there was no single profile of an abused child. The extent and nature of the impact varies from person to person. A variety of factors may affect whether and how abuse has an impact on women survivors, including the gender(s) of the victim and the perpetrator, the type and severity of abuse, the duration of and time since the abuse, and the family's reaction following identification of the abuse. It is because of this variety that sexual abuse is addressed as a specific rather than generalized phenomenon.

Emotional Effects of CSA

The experience of sexual abuse may cause negative psychological effects, which often persist into adulthood (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996; Roberts, O'Connor, Dunn, Golding, & ALSPAC Study Team, 2004; Sigmon, Greene, Rohan, & Nichols, 1996). Working through the trauma of sexual abuse often requires a reexamination of self and beliefs, which "may result in an untenable view of the world or oneself" (Roth & Newman, 1991, p. 281). Ginzburg et al. (2006) evaluated the psychometric properties of the Abuse-Related Beliefs Questionnaire. Internal attributions of blame mediated the relationship between CSA and shame. Attribution theory was applied based on the results of the survey and posits that individuals have a need to explain events in terms of their own roles in them, especially in the

case of negative events (Ginzburg et al., 2006). In the process of finding an explanation for the abuse, many victims blame themselves. This results in the development of guilt and shame and sexual trauma survivors may internalize the implicit and explicit communications of their attacker, such as the victim is an object made to meet his needs and her needs are irrelevant and that she deserves the abuse (Roth & Newman, 1991). This can contribute to deeper feelings of guilt and shame.

Guilt and shame often are referred to as a part of the notion of stigma. Briere (1989) linked stigmatization and self-blame noting the process of stigmatization is associated with the secrecy surrounding sexual abuse that often conveys to the abuse victim the notion that she or he was involved in a shameful act and was, in fact, a guilty co-conspirator. The concept of stigma appears to encompass negative self-evaluation and feeling deserving of condemnation of the abuse itself as well as a sense of being different and inferior to others. According to this model, internal attribution mediates the association between CSA and a sense of shame, which leads to adjustment difficulties. A pattern of correlations suggests that guilt is associated with depression (Ginzburg et al., 2006; Weierich & Nock, 2008).

Depression and anxiety can be overwhelming to survivors of CSA, resulting in the development of other maladaptive strategies such as disordered eating and alexithymia, which is defined by Nemiah and Sifneos (1970, as cited in Hund & Espelage, 2005) as a cognitive deficit involving difficulty identifying and verbalizing emotions, as well as difficulty distinguishing between emotional and physical sensations. Alexithymia can begin very early in life, because attachment figures play a key role in the facilitation of the development of a child's capacity to display affective and physiological arousal (McLean, Toner, Jackson, Desrocher, & Stuckless,

2006). As a result of early abuse, many survivors struggle to verbalize their emotional responses to the abuse and sometimes are unable to identify how they feel about being abused.

Dysfunctional family dynamics contribute to maladjustment in adulthood and parental support is related to the psychosocial adjustment. Higher rates of parental conflict in the family of origin contribute to more psychological distress in women survivors of CSA (Edwards & Alexander, 1992). Also, women who have been sexually abused report problems in their relationships with males and females (Browne & Finkelhor, 1986). Women survivors report less satisfactory relationships with female friends than non-abused women and this was found to be associated with the attribution of negative family interactions to their mothers rather than fathers.

Intimacy problems that incest survivors struggle with (such as alienation, social nonconformity and emotional discomfort) may be displayed in various relationships (Liang, Williams, & Siegel, 2006). Some women even characterize their family relationships as being dominated by individualism and personal authority with less intimacy, greater fusion, triangulation, and intimidation than non-abused women (Banyard et al., 2000; Carson, Gertz, Donaldson, & Wonderlich, 1990). Based on their experiences with the non-abusive parent (usually the mother), these women may displace their frustration related to parental conflict on to their female friends as a means to maintain the relationship with their mother (Edwards & Alexander, 1992). For the most part, the reason for this projection may be related to memories the survivors have of their mothers' inability or unwillingness to protect them. Also, it is safer to take the anger and frustration directed at the non-abusive parent, (usually the mother) and displaces it on a friend. This way, the survivor does not take the risk of losing a relationship with the non-abusive parent.

Cognitive Effects of CSA

Mental health and relational issues such as depression, alienation, paranoia, interpersonal difficulty, and hostility are significantly elevated in women who experienced CSA from someone they knew and trusted. Also, in cases when the abuse was disclosed, there may not have been support from other family members, which is a hindrance to the cessation of the abuse.

"Unlike many negative life events, CSA is so traumatic and stigmatizing that even children with generally supportive parents are often afraid to reveal abuse" (Testa, Miller, Downs, & Panek, 1992, p. 174). Women who had been sexually abused by a known and trusted person experience greater distress than those who were abused by a stranger or acquaintance (Feinauer, 1989; Wilcox, Richards, & O'Keefe, 2004). Among CSA survivors, "characterological self-blame (i.e., blaming something stable within oneself) has been associated with poor outcomes, whereas behavioral self-blame (i.e., blaming one's actions) has been associated with positive outcomes in certain circumstances because one may be able to change future behavior" (Filipas & Ullman, 2006, p. 653).

Victims were able to identify as survivors with positive indicators of self-esteem if they placed blame for the abuse with the abuser and not themselves (Wilcox et al., 2004). This blame placement, along with support from family and friends, proved to be effective and helpful in the process of resilience because of the positive coping and healing experienced by survivors.

Relational Effects: Barriers to Sexuality and Relationship Development

Women who have been sexually abused may face certain barriers to developing healthy relationships, such as an inability to trust themselves and members of the offending gender (Browne & Finkelhor, 1986). Regarding sexuality, sexually abused participants may have a significantly shorter future time perspective, fewer sexual self-care behaviors, less social support,

and more sexual risk-taking than non-abused participants (Johnson, Rew, & Sternglanz, 2006). Participants who do not report a history of sexual abuse have significantly more sexual health resources and engage in fewer sex-risk taking behaviors than those who report a sexual abuse history (Johnson et al., 2006). These findings reveal that sexual abuse may cause a distorted view of the sexual self for a survivor of such abuse. There seem to be fewer protective measures taken in survivors of abuse than those who have not been abused.

Liem, James, O'Toole, and Boudewyn (1997) found that individuals with a history of CSA were less likely to display resilience when their abuse co-occurred with other family stress such as parent illness, loss of a family member, divorce, or physical and/or emotional abuse. The presence of family stress compounds or exacerbates the experience of trauma for the survivor, which in some cases decreases the likelihood of the display of resilience. Trauma is the experience of feeling afraid, objectified, and helpless in situations of human aggression or calamities (Wilcox et al., 2004).

Negative Effects on Sexuality

In some cases, achieving what is deemed healthy romantic intimacy is especially difficult for CSA survivors. For instance, as a result of the abuse experience, intimacy may become associated with shame and fear instead of warmth and caring, and with concerns about dominance and submission rather than mutuality. Stigmatization that is experienced during and after CSA may be carried into nonabusive relationships that involve sex or romantic intimacy (Feiring, Simon, & Cleland, 2009). Survivors also tend to have difficulties with emotional and sexual intimacy, especially in heterosexual relationships (Browne & Finkelhor, 1986). Because of these struggles, they may lack the desire to develop intimate relationships, because doing so requires them to face their fears of intimate relationships.

Survivors may be retraumatized in intimate couple relationships because of flashbacks and other symptoms that may arise when there is an initiation of sexual aspects of a relationship (Liang et al., 2006). Those intrusive memories may interfere with arousal, orgasm, and the survivor's own sexual fantasies and sexual feelings. This may lead to an aversion to sexual activity and various other problems related to sexual activity. In fact, one of the most frequently reported findings is that sexually abused women are at increased risk for sexual difficulties that range from avoidance of sex to compulsive sexual behavior (Browne & Finkelhor, 1986; Merrill, Guimond, Thomsen, & Milner, 2003).

CSA might produce seemingly opposing outcomes as in an aversion to sexual activity versus promiscuity, through the process of traumatic sexualization (Finkelhor & Browne, 1985). "Traumatic sexualization refers to the shaping of a child's sexuality in an interpersonally dysfunctional manner, leading to lasting inappropriate associations with sexual activity and arousal" (Merrill et al., 2003, p. 987). Essentially, survivors of sexual abuse may struggle with various barriers to sexual intimacy, including but not limited to emotional and sexual conflicts (Liang et al., 2006). These struggles often lead to mental health issues in many survivors.

In the process of the development of a self-concept, the sexual development is an important factor for survivors. The knowledge structures surrounding self-concept serve as important components of the self. Specifically, these components are referred to as schemata, which are said to contain memories of emotions, inferences, beliefs about self, and descriptive detail (Nurius, 1989). The references to a single self-concept were challenged and Nurius (1989) said that only a subset of a person's accumulation of self-conceptions could be retrieved or triggered at any given time. In essence, the sexual self as a component of the self-concept is an important aspect of the survivor that cannot be ignored.

Despite the overwhelming majority of the research literature focusing on the negative aspects of coping, including relational functioning and sexuality, many survivors display resilience. Many survivors who identify as resilient are leading relatively happy, satisfying lives. The literature on resilience and CSA will be discussed next.

Resilience

Research has shown that despite the challenges that CSA presents, many children become reasonably competent adults—thus, they are resilient (Hyman & Williams, 2001). Resilience has been defined as "manifested competence in the context of significant challenges to adaptation or development" (Masten & Coatsworth, 1998, p. 206). The term resilience often has been used interchangeably with words such as *hardy, invulnerable, stress-resistant,* and *invincible* (Liem et al., 1997; Masten, 2001). Liem et al. (1997) asserted that resilience could be interpreted as interpersonal competence (e.g., the ability to form safe, caring, or intimate relationships) or instrumental competence in the form of academic and occupational success

Hyman and Williams (2001) defined resilience for CSA survivors as competent functioning in several interrelated spheres despite adversity. When a survivor is seen as resilient, she or he is perceived as possessing a relatively stable set of characteristics that allow her or him to manage well in the face of risk factors that are known for causing developmental impairment (Liem et al., 1997).

Resilience for CSA survivors has been operationalized as well-being in five essential spheres including physical health, mental health, interpersonal relationships, adherence to community standards and economic well-being (Hyman & Williams, 2001). Also, resilience was defined as having high levels of well-being (McClure, Chavez, Agars, Peacock, & Matosian, 2008). These definitions seem to cause some difficulty in the process of conceptualization of

resilience because there are so many factors to consider. In the current study, resilience is viewed as both biological and environmental, especially manifesting itself in the context of relationships and the development of interpersonal skills.

Resilience: State or Trait?

"Resiliency and resilience have emerged as intriguing areas of inquiry that explore personal and interpersonal gifts and strengths that can be assessed to grow through adversity" (Richardson, 2002, p. 307). Bogar and Hulse-Killacky (2006) described resilience as a combination of innate personality traits and environmental influences that serve to protect individuals from the harmful psychological effects of trauma or severe stress, enabling them to lead satisfying and productive lives.

Wright, Fopma-Loy, and Fischer (2005) suggested that a majority of the existing literature on resilience has examined resilience as a developmental outcome in a single domain of functioning. With this in mind, the authors conducted a study that explored questions about resilience in the lives of women survivors of CSA, specifically survivors who have children, within a multidimensional framework by assessing resilience across intrapersonal, interpersonal, and intrafamilial domains. The risk and protective factors examined included the mother's age, socioeconomic status, severity of CSA, coping strategies employed (i.e., avoidance, seeking social support, and problem solving), child characteristics and spousal/partner support. When the multiple adaptational domains were examined, mothers in the study showed discrepancies in how adequately they functioned across domains. This means that as survivors of CSA they struggled in some domains of functioning more than others.

Masten (2001) asserted, "The great surprise of resilience research is the ordinariness of the phenomenon. Resilience appears to be a common phenomenon that results in most cases

from the operation of basic human adapational systems" (p. 227). Consequently, if these systems are in good working order, healthy development is possible even in the face of severe adversity. However, if the major systems are damaged, before or as a result of the adversity, then the risk for developmental problems is magnified, especially if the environmental hazards are prolonged (Masten, 2001). The components of resilience must be identified in order for the level of resilience in survivors to be determined. In other words, what components constitute resilience?

Resilience Components

In order to study resilience in survivors of CSA, researchers "must specify the threat to development, the criteria by which adaptation is judged to be successful, and the features of the individual or the environment that may help explain resilient outcomes" (Masten, Hubbard, Gest, Tellegen, Garmezy, & Ramirez, 1999, p. 144). Bogar and Hulse-Killacky (2006) identified five resiliency determinants and four resiliency processes for women survivors of CSA. The five determinants consisted of survivors being interpersonally skilled, competent, having high self-regard, some spiritual connection, and having helpful life circumstances.

The interpersonal skills emphasized the natural, innate ability for women survivors to interact positively and effectively with others, which allowed them to develop good social networks of support in their lives (Bogar & Hulse-Killacky, 2006), once again raising the question of whether resilience is a state of being or a trait. Being competent referred to the skills and talents that the women identified as contributing to their ability to be resilient in adulthood. Although most of the women in the study struggled with self-esteem and self-concept at some point in their lives, most of them were able to recall a specific moment when they were able to change their negative self-view. Having a spiritual connection to God was identified as a contributor to resilience as well (Bogar & Hulse-Killacky, 2006).

The four resiliency processes include coping strategies, refocusing and moving on, active healing, and achieving closure (Bogar & Hulse-Killacky, 2006). Participants in this study used a variety of coping strategies, particularly during childhood and adolescence. As a result, participants were able to emotionally self-soothe and/or self-protect. In order to refocus and move on, participants had to focus physical and emotional energy on something other than the abuse. Refocusing was very beneficial for participants and was a significant part of moving on. Active healing required participants to choose to intentionally deal with the effects of CSA. Participants "took responsibility for their healing and rejected the role of "victim"" (Bogar & Hulse-Killacky, 2006, p. 323). Finally, achieving closure meant participants were "able to integrate that aspect of their lives into their personal life stories without undue emotional pain" (Bogar & Hulse-Killacky, 2006, p. 323).

Additionally, resilience has been defined as the learned ability to cope with many stressful situations or events so that these situations are transformed to a positive outlook (Kobasa, 1979). This process does not occur in isolation but has three elements that are interactive in nature: commitment, challenge, and control (Maddi & Kobasa, 1991). Commitment is seen as a general sense of enthusiasm for a task, project, or relationship. Challenge is the expectation that life will bring frequent and stimulating changes. Control is the belief that one can influence surrounding events and accomplish tasks (Maddi & Kobasa, 1991).

Feinauer et al. (1996) found that hardiness in survivors also contributed to positive long-term adjustment. Survivors, who displayed high hardiness, or resilience, had fewer distressing symptoms than those who did not display resilience (Feinauer et al., 1996). Additionally, attributions of blame from the survivors' perspective contributed to the overall resilience of women survivors as well. The result of the study showed that survivors who blamed themselves

had more symptoms than those who were able to attribute blame to the perpetrator (Feinauer & Stuart, 1996).

Avoidant coping as a strategy of dealing with the abuse emerged as a significant risk factor and was strongly and consistently associated with negative outcomes across the domains. It also was found that spousal/partner support was a strong protective factor and buffered the relationship between depressive symptoms and parenting competence. The authors suggested that their findings indicate a need for a comprehensive process of assessment of resilience on multiple domains of functioning (Wright et al., 2005). This may be because there are many domains to consider when assessing resilience. Some research is limited because there is a focus on only a few of the domains of resilience. There is a need for a comprehensive view of resilience in women survivors, including what the survivors themselves consider resilience to be and how social support before, during and after the abuse impacts the display of resilience.

Social Support and Resilience

According to Asberg and Renk (2012), support from family and other interpersonal relationships plays a role in the resilience of women survivors of CSA. Perceived social support from family and friends accounted for over half of the variance in the functioning of women survivors of physical or sexual abuse. Familial support was found to be important for successful recovery in women survivors of CSA (Stroud, 1999). For example, having a mother who was competent and sensitive to the needs of her child, affectionate bonds with other caregivers and an external support system in their neighborhood, church or youth group or school are other protective factors that have been identified among survivors (Werner, 2005). Wyatt and Mickey (1987), in their study of women survivors of CSA and the support from family and others, found

that family support leads to positive coping and negative coping usually comes from lack of familial support.

Resilience is a very complex concept because there are many aspects to consider. Moreover, resilience can be assessed in a non-clinical population, even considering that many survivors of CSA may have participated in and received help from a clinical, mental health professional. Some questions that come from the study of resilience and the review of the literature include: can resilience only be broken down into categories based on traits, state of being, process of development, outcomes, and antecedents or determinants?

The literature on resilience does not include a singular, clear definition. Understanding sexuality as a context for resilience and CSA is important because it can provide a greater appreciation for what survivors experience on their journey to healthy functioning. Additionally, resilience can be seen as a catalyst for survivors' development of themselves as a sexual being—the sexual self-concept.

Resilience and Sexuality

Nurius (1989) asserted that self-concept is "an interlocking system of knowledge structures about the self that is the basis of how we store and retrieve information from memory" (p. 286). Additionally, Nurius (1989) challenged references to a single self-concept and instead said that only a subset of one's total range of self-conceptions can be triggered or activated at any given time. Holmes (2002) explored the idea that "there are multiple self-concepts and they can be in conflict with one another and that conflicting self-concepts have been shown to have negative effects on mental health" (p. 348). Moreover, the extent to which those self-concepts conflict individuals may feel either positively or negatively about themselves (Markus & Nurius, 1986).

Sexuality, or sexual self-concept for women survivors of CSA is an important component of the self-concept that has received little attention (Vickberg & Deaux, 2005). Sexual self-concept includes aspects of the self-concept that center on sexuality. Breakwell and Millward (1997) used the term "sexual self-concept" to describe those aspects of sexuality that individuals endorse as descriptive of one's sexual self. Dimensions include the degree to which one is romantic, passive, willing to experiment, knowledgeable about eroticism, responsible for contraception, likely to exploit, and faithful in relationships (Holmes, 2002). As mentioned previously, knowledge structures that serve as the components of the self-concepts have been referred to as the schemata (Nurius, 1989) and they are believed to contain memories of emotions as well as inferences, beliefs, and descriptive detail of traumatic as well other self-defining events. These memories of CSA may be where survivors find their view of themselves as sexual beings, which is often skewed.

Most people treat their sexual lives as private and do not talk openly to others about the intimate details of their sexual attitudes and behaviors (Garcia, 1999). There also may be anxiety and emotions that accompany sexual experiences and relationships that make it difficult for many to develop a sense of their sexual selves. This includes thinking about their own sexuality and/or gaining knowledge during interpersonal communication about their sexual experiences (Garcia, 1999).

According to Garcia (1999), erotophilia and erotophobia are terms used to describe a person's orientation towards sexuality. Erotophilia is defined as a primarily positive affective orientation towards sexuality. On the contrary, erotophobia was defined as a primarily negative affective orientation towards sexuality. Erotophiles tend to approach sexual stimuli and seek to engage in sexual activity. Erotophobes tend to avoid sexual stimuli and situations where sexual

activity is a possibility. Most erotophobes are those who have experienced sexual violations of some type, namely sexual abuse (Garcia, 1999). These concepts may seem quite peculiar. However, they are related to sexual self-concept because they provide some professionals with a way to identify survivors' ways of responding to sexual stimulation. Individuals' responses to sexual stimulation are a large part of the sexual self-concept because it may also determine the confidence they have in themselves as a sexual being.

There is not much research on the healthy development of the sexuality with women survivors of CSA. Most of the research about sexuality and the sexual self-concept focuses on adolescent development (i.e., Breakwell & Millward, 1997; Johnson et al., 2006; Johnson, Rew, Fredland, & Bowman, 2010). Even so, sexual maturation occurs in the context of social and cognitive changes that influence an individual's ability to develop a healthy sexual self-concept and behaviors that affect sexual health. Often, the structure of the sexual self-concept is significantly shaped by dominant social representations of gender differences and relationships (Breakwell & Millward, 1997). It makes sense, therefore, that survivors' sexuality would be influenced by sexual abuse experiences (Johnson et al., 2006).

Johnson et al. (2006) explored gender differences in sexual self-concept, personal resources for sexual health, safe sex behaviors, and risky sexual behaviors among homeless adolescents with and without histories of sexual abuse. Female participants faired better than males on numerous measures of sexual health behaviors and attitudes. Also, female sexual self-concept revolved around concerns with assertiveness such as an unwillingness to have sex before marriage, controlling the frequency of sex, and pretending to enjoy sex.

Sexual assertion and the negotiations of different sexual limitations often run counter to behavioral possibilities of traditional female sexuality (Breakwell & Millward, 1997). Men's

scores on self-measures of sexual responsiveness, sexual deviance and sexual experience were higher than women's. Women's scores on sexual attractiveness and romanticism scales were higher than men's (Garcia, 1999; Garcia & Carrigan, 1998). These findings speak to the differences in perceptions of sexuality between men and women because they show that men tend to focus on sexual performance while women focus more on their ability to attract a mate.

In essence, healthy development of sexuality or the sexual self-concept needs to be examined explicitly as we seek to gain a better understanding of the experiences of women survivors of CSA and the aftermath of the abuse experiences. The focus on adolescents is a step in that direction in that the development of the sexual self-concept has been examined from a perspective that includes the social and cognitive aspects of development, which occur mostly in adolescence. For these reasons, the population that would be helpful to study is women survivors of CSA. Another reason for this assertion is that most of the literature and research with women survivors of CSA explained the negative effects of relationship functioning, sexuality and not much on resilience as an aptitude.

Gaps in the Literature

The current research regarding women survivors of CSA has focused mostly on the negative aspects of coping post-abuse, specifically the mental health and relational effects. However, some research has been done on resilience and a little attention has been given to understanding healthy sexual development. We know that there have been many negative effects of sexual abuse that manifest themselves in the lives of survivors. The resilience literature is not conclusive regarding a definition. We also know that the research that exists is also mostly quantitative and does not allow the women to elaborate on their experiences of CSA and the aftermath of disclosure. The gaps that I will attempt to fill are related to the healthy sexual

development as a context for resilience with women survivors' and their experiences of these concepts. The use of qualitative research methods will help with the process of allowing these women to speak explicitly about their experiences through the use of probes and follow up questions during interviews. These are aspects of the data collection process with women survivors that are not as prevalent in existing research.

In order to gain a better understanding of positive coping following CSA, it is necessary for the voices of the women survivors of CSA to be heard regarding their experiences with resilience and their view of themselves as sexual beings. The research that I have outlined in the literature review focuses on the experiences of the survivors but does not provide much of the personal voices of the women who have experienced mental health and relational effects, social support, and ultimately resilience. Allowing the women to speak about their own experiences with CSA, healthy sexual development, and resilience is important and will make the data gathered richer, thus, the research results more personal. It seems that a vast majority of the extant research focuses on literature that discusses the perceived maladaptive experiences of some women survivors and those who have utilized negative aspects of coping. The more research that allows women survivors of CSA to speak on her own behalf, the possibility of the field gaining an understanding of the lived experience of women survivors of CSA. For these reasons, it is imperative to take a different approach to studying women survivors of CSA because if understanding is what we seek as researchers. What better way to capture a more complete knowledge than by speaking with and gathering data from women who have live with the aftermath of sexual abuse everyday? By not doing so, I believe the interpretation of the meaning of these survivors' experiences will continue to be missing from the literature. Using

resilience theory and symbolic interaction theory as a lens through which to view resilience and the sexual self-concept allow a greater opportunity for the participants to tell their story.

I seek to add to the extant literature on healthy sexual development for women survivors of CSA. Most of literature on sexual self-concept development has been conducted with adolescents. This information is helpful to examine regarding the sexual self-concept. However, there are some physical circumstances that make the comparison to women survivors difficult.

Purpose of the Study

The overarching research question for this study is "How do women survivors of CSA experience resilience?" The purpose of this question is to discover how survivors define resilience, what the characteristics are of resilient survivors. Additionally, this study aims to gain insight into how survivors experience resilience in the context of relationships, including the development of healthy sexuality.

Chapter 3 - Research Methods

The majority of previous studies on CSA survivors included quantitative instruments to gather data on the negative consequences of CSA. Little is known about the positive coping strategies and resiliency of these women. Because this is such a sensitive topic, I believe that a qualitative approach is the best fit for this investigation. Qualitative methods allow the survivors to describe the full extent of their personal experiences, both positive and negative. Quantitative methods and measurements do not always capture the essence of those experiences. I aim to provide situations that allow survivors to feel comfortable speaking about their reality years after the abuse. The research questions that I seek to answer encourage the participants to think through and talk in depth about their experiences of CSA, specifically the lived experience of being a survivor of CSA, their views of themselves as sexual beings and how they have experienced resilience.

Qualitative methods are used to examine a phenomenon in depth (Patton, 2002). When gathering data on issues of sexuality (view of self as a sexual being) and resilience from survivors of CSA, it is important to capture the essence of their experience(s). Data should consist of direct quotes and personal definitions (i.e., resilience, healthy relationship functioning, and sexual self-concept). An assessment tool with a Likert-type scale to assess each survivor's experience would not provide the richness of data and the depth needed to relay each survivor's full story. Therefore, the research method used in this study is qualitative, with phenomenology as the approach.

A Phenomenological Approach

Phenomenology has a foundational question that asks "What is the meaning, structure and essence of the lived experience of this phenomenon for this person or group of people?" (Patton, 2002, p. 104) With this question as the baseline, I sought helpful information from the participants as they interpreted the meanings of their experiences of resilience and viewed themselves as sexual beings. When approaching the survivors and inquiring about their experiences of living with a history of sexual abuse, I was privileged to gain further insight into the positive functioning from their personal perspectives. The phenomenological approach assisted me in gaining those perspectives and the meaning that each survivor attached to them (Patton, 2002).

Phenomenology asks for the very nature of a phenomenon, for that which makes a something what it is. At the core of phenomenology is a systematic attempt to uncover and describe the structures, the internal meaning structures, of lived experience (van Manen, 1990). Phenomenology claims to be scientific in a broad sense, because it is a systematic, explicit, self-critical, and intersubjective study of its subject matter, which is the lived experience (van Manen, 1990). Data include quotes from participants who have experienced the phenomenon. Because women survivors are the experts on their experiences, specifically with resilience and sexuality, CSA survivors need an opportunity to share the lived, positive experience.

Theory

The theoretical lens through which to view a phenomenon is very important. Additionally, the reason for discussion the theoretical lens in the methods chapter is that it served as the guide for the project, including development of the research and interview questions as well as the identification of themes and categories during analyses. Symbolic interaction (SI)

theory was chosen because of the major assumptions. These major assumptions are "human behavior must be understood by the meanings of the actor, actors define the meaning of context and situation, individuals have minds, society precedes the individual" (White & Klein, 2008, pp. 98-99). The current study seeks to understand resilience in women survivors of CSA and how resilience is experienced in the context of relationships and sexuality. This theory fit with this study because of the emphasis on self and interactions and how those interactions contribute to the development of resilience. In essence, SI allows CSA and the participants' experiences with healthy sexuality and relationship functioning to be viewed through the lens of interpersonal interactions and the meaning that is made through those interactions.

Also, the concepts of SI are "self and mind, socialization, role, definition of the situation, and identity" (White & Klein, 2008, pp. 100-103). The data from the current study includes the aspects of healthy functioning in sexual relationships that are also seen in the assumptions of SI. For example, participants discussed how when CSA occurred in the relationship the perpetrator(s), the interaction influenced how they viewed men as well as the act of sex. Participants in this study will be asked to discuss how they view themselves in the context of relationships and sexuality. Additionally, their socialization, how they define the experience of abuse and their identity as a survivor will be discussed as well.

Symbolic Interaction Theory

Symbolic Interaction (SI) Theory, more than any other family theory, insists that attention is given to how events are interpreted by social actors (White & Klein, 2008). Therefore, in this study it emphasizes how women survivors of CSA interpret the experiences of CSA, resilience and the social and family support they received. Those relationships helped the survivors create meaning from the CSA event(s). This is also consistent with the

phenomenological approach because the meanings and representations of experiences are essential to the overall symbolism of survivors' lived experiences.

Definition of SI

One way SI has been defined is "the study of how social interaction creates and maintains the self, shared meanings and social structures" (Frey & Sunwolf, 2004, p. 279). When applied to the current study, the meanings shared by those affected by the CSA survivors' experience(s) of abuse and resilience is viewed as imperative. Some researchers believe that signs of resilience for survivors were interpersonal skills and stable relationships (Bogar & Hulse-Killacky, 2006). If a survivor was lacking those components, it may mean that those survivors are not as resilient (Wright et al., 2005). These findings indicated that resilience is an interpersonal, interactional process and is usually not developed in isolation. The emphasis is on social interaction.

Components of SI

The notion of "self" is another critical component of SI theory. "Socialization is the process by which we acquire the symbols, beliefs and attitudes of our culture" (White & Klein, 2008, p. 101). It is believed that the mind, the self and the symbol of a person develop concurrently (White & Klein, 2008). The participants in the current study had an earlier self that developed as a result of the CSA experience(s). The self the participants currently interact with and live with has developed as a result of the process of healing the view of self as a sexual being and what that means in the context of relationship functioning. SI theory was chosen because it focuses on the shared meaning of the people who are a part of the survivors' support group and/or those who helped to create the meaning of the survivors' experience of resilience.

Humans are motivated to make meaning from their experiences in order to make sense of them (White & Klein, 2008). SI calls for an examination of the personal symbolism of relationships to the survivor. These components, shared meaning and symbolism, are central to SI (Frey & Sunwolf, 2004; White & Klein, 2008). This leads to the development of the concept referred to the definition of the situation, which means, "what we define as real will have real consequences" (White & Klein, 2008, p. 102).

SI and Research Questions

Symbolic interactionism was a great match for this study because of the focus on meaning making (White & Klein, 2008). "People create shared meanings through their interactions, and those meanings become their reality" (Patton, 2002, p. 112). As I worked to develop the overarching research questions, I thought about what I wanted to know regarding the symbolism of the survivors' experience with resilience, including relationships and sexuality. "SI provided a unique perspective and viewpoints with which to frame my questions. Once I was able to pen the overarching questions, I was able to develop the more specific research questions.

Using SI as the guide, I then developed the specific interview questions that would help answer the research questions. SI theory allowed me to create questions that would accentuate the positive experiences, meanings and symbols that each survivor created through personal interactions and relationships. Because personal meaning and symbolism were important premises of SI, I had the space to ask participants to define resilience, healthy relationships, and sexual self-concept. All of the responses the survivors provided were based on their personal experiences and the meaning attached to those concepts.

Research Questions

Using the foundational question from phenomenology (Patton, 2002) and the assumptions and concepts of SI (White & Klein, 2008), the research questions were developed. As mentioned previously, the overarching research question is "How do women survivors of CSA experience resilience?" Listed below are the specific research questions that were used to inform this study.

1. How do women survivors of CSA experience resilience?
    a) How do women survivors define resilience?
    b) What factors contribute to resilience in women survivors of CSA?
2. How do women survivors of CSA experience sexuality?
    a) How do women survivors define healthy sexual self-concept?
    b) What factors contribute to the development of a healthy sexual self-concept?
3. How do women survivors of CSA experience relationships?
    a) How do women survivors define healthy relationship functioning?
    b) What factors contribute to healthy relationship functioning?

Unit of Analysis

The unit of analysis consists of women who experienced CSA as children. I chose the individual women as the unit of analysis because most of the negative, maladaptive functioning described in the literature is focused primarily on women survivors. Therefore, it is important to capture the positive, personal perspectives of each woman. The reason for the individual unit of analysis is for the women to be able to tell of their personal experience and not how others have interpreted their experiences. The negative aspects of coping with women survivors of CSA have

been discussed too frequently. Therefore, conducting a study where the focus is on the aptitude of survivors seems to be the best avenue for examining positive coping.

Sampling

Two types of sampling strategies were employed for this study: criterion and intensity sampling. Criterion sampling requires the participants to meet certain criteria before they can be included in a study (Patton, 2002). With intensity sampling, the participants were chosen based on their prior knowledge/experience of the phenomenon in question (Patton, 2002). The participants chosen for this study had to fit the following criteria: female, between 18 and 55 years of age, a history of CSA (i.e., those who were molested, raped or otherwise exposed to inappropriate sexual things as a child), those who self-identify as resilient, and women attempting to have an intimate sexual relationship with a partner.

Intensity sampling fit the phenomenological perspective because it allowed me to assess the intensity of the participants' lived experiences in the process of determining her eligibility for the study. Intensity was determined by the frequency of the survivors' experience with CSA as well as resilience following the abuse. Abuse needed to be experienced for at least a year and more than five times to qualify as intense. Criteria for intensity have not been outlined in the literature. Therefore, the criteria for intensity were created for this study based on my own therapeutic insight. The intensity of the experience was appropriate because it was used a way of narrowing the participant field to include survivors who are members of the group. Meaning, intensity was necessary so that the CSA experience(s) of participants was very similar regarding frequency and length of abuse.

Participant Recruitment and Selection

Letters of invitation (see Appendix B) were distributed in religious communities and through other participants in a Midwestern community to recruit participants for the study. There was no monetary incentive for participating. Potential participants were asked to tell their stories of the process of resilience. Once the potential participants expressed interest, I made contact with them via email and/or phone to screen them for the criteria outlined above (see Appendix C). When individuals were determined to fit the criteria, they were extended an invitation to participate in the study.

There were six participants in the study. Each participant self-identified as resilient and was in an intimate marriage/dating relationship. Racially, all participants identified as White Americans. The average age was 40 years and the average length of marriage/dating relationships was 13.6 years. The youngest participant was 22 years and the eldest was 53 years. Average length of CSA experiences was 6.75 years, with the longest being 16 years and the shortest one year. Participant demographic information can be found in table 3.1. For confidentiality purposes, participant names have been changed.

Table 3.1

Participant Demographic Information

Pseudonyms	Age	Relationship Status	Race/Ethnicity	Length of CSA
Lucy	22	Dating (1 yr.)	White American	1.5 years
Beth	48	Married (25 yrs.)	White American	~10 years
Suzy	51	Married (29 yrs.)	White American	8 years
Martina	28	Married (7 yrs.)	White American	4 years
Anna	38	Married (17 yrs.)	White American	1 year
Jessie	53	Married (2.5 yrs)	White American	~16 years

Data Collection

I used a standardized open-ended interview design to conduct one-on-one interviews. The standardized open-ended interview design required that I prepare each interview question word for word before the interview took place (Patton, 2002). This preparation fostered consistency in each interview. Standardized interviewing helped me to make sure that the time spent during the interview was used efficiently. Conducting and developing a standardized interview meant that all the respondents were asked the same questions, which reduced bias. However, there was some flexibility in exploring unanticipated topics that come up during the interview (See the Appendix A for a copy of the interview questions).

Data Analysis

In qualitative research, data analysis is "concerned with how we bring conceptual order to observed experience" (Daly, 2007, p. 209). Phenomenological analysis starts with the description of the lived experience provided by the participant. During the interview process, I

attempted to see the world through the participants' eyes (Daly, 2007). Along those lines, I took detailed field notes during each interview. The process of data analysis included transcription, developing themes, and coding. Bernard and Ryan (2010a) asserted that analyzing text involves five tasks that may prove to be complex: "discovering themes and subthemes; describing the core and peripheral elements of themes; building hierarchies of themes or codebooks; applying themes by attaching them to actual text; and linking themes into theoretical models" (p. 54). The "importance of any theme is related to how often it appears, how pervasive it is across different types of cultural ideas and practices, how people react when it is violated, and the degree to which the force and variety of a theme's expression is controlled by specific contexts" (Opler, 1945, as cited in Bernard & Ryan, 2010a, p. 55). For the purpose of a study examining the perspectives of women of survivors of CSA, themes were important to the outcome in that these women provided insight in the form of statements of ideas that recur regarding the adjustment they have experienced.

Transcription

I used a digital audio recording device when conducting the interviews. Each interview was stored in a separate folder on the device. Once the interviews were completed, I uploaded each file to ExpressDictate (NCH Software, 2001), dictation software that I used to transcribe each interview. As I listened to each recording, I compared the audio with my field notes and added thoughts from the audio that I may have missed during the actual interviews. Each interview was transcribed verbatim. After listening to recordings from each interview, I put the content in a textual form to facilitate further analysis. This provided me with an opportunity to re-experience the interview at a slower pace and maximize the attentiveness to what is being said

(Daly, 2007). Once the interviews were transcribed, the next step was to examine the transcripts for themes.

Themes

"Developing some manageable classification or coding scheme is the first step of analysis" (Patton, 2002, p. 463). One of the first steps in this process of identifying patterns, themes and/or categories is content analysis (Patton, 2002). The process of content analysis involves identifying, coding, categorizing, classifying, and labeling the primary patterns in the data (Patton, 2002). I read the transcripts of the interviews many times. As I read the transcripts, I made notes of and highlighted the patterns that emerged in each section by research question. As I performed the phenomenological analysis using the research questions as a guide, it was helpful to create topics and put information into categories as the patterns and themes emerged. Quotes from transcripts related to each research question were identified and put into a Word file. Once the main themes and codes were identified, coding took place. This step of the organization process allowed me to further organize the data and made it easier to identify the different ways of describing the information that I have collected (Patton, 2002). As themes and codes were identified based on the research questions, categories were identified. The categories consisted of themes and codes that were grouped together, again, guided by research questions.

Coding

Coding consists of organizing the lists of themes into codebooks and then applying those codes to parts of the text (Bernard & Ryan, 2010b). There are some initial coding practices that were of great value when working with the transcripts of the participant interviews. I started the coding process by using line-by-line to begin the search for codes that fit with the themes. "Line-by-line coding works particularly well with detailed data about fundamental empirical problems

or processes whether these data consist of interviews, observations, documents, or ethnographies" (Charmaz, 2006, p. 50). After the initial coding, I repeated the line-by-line coding process. This provided me with the opportunity to find new threads for analysis and view the data with fresh perspective (Charmaz, 2006).

I received assistance in the coding process from my major professor, who served as a co-analyst for this study. Having a co-analyst for data analysis with transcripts was very instrumental in the process. Searching for themes and codes and then creating categories based on those was made easier with the help of my co-analyst. Having a co-analyst is important because,

> It is in data analysis that the strategy of triangulation really pays off, not only in providing diverse ways of looking at the same phenomenon but in adding to credibility by strengthening confidence in whatever conclusions are drawn. (Patton, 2002, p. 556)

Self-Reflection

As the researcher, I bring my biases and values into the study. My interest in healthy sexuality and relationship functioning as a context for resilience in women survivors of CSA comes from my own personal experience of this phenomenon. I have found that the negative perceptions and stereotypes of women survivors have placed a dark cloud that makes it seem like CSA is an emotional death sentence. I noticed the plethora of literature on negative coping while working on my Master's project. Granted, that project was focused on the mental health and relational effects of CSA with women survivors, but there was not much about resilience. That was a problem to me. This seemed to add to the negative stereotype of our group. We are perceived as incompetent and fragile, as if we need to be put in a box on the shelf so that we don't hurt ourselves or anyone else. This is not the reality for all survivors. I am a survivor and

have worked very hard throughout my life to drop the victim role and mentality. I knew that if I had done this, surely there are others who have as well.

My co-analyst has not directly experienced CSA. She brought a unique perspective because she is not an "insider" who has directly experienced CSA. Her perspective and objectivity was very helpful for me. As a member of this group, I know that there are some things that I am not able to see because of subjective lenses I have. My major professor gave me a perspective and view of the data that I could not have otherwise. I am grateful for her input and contribution to the analysis process.

Summary of Methods

Because of the nature of the topic, it was appropriate to choose depth over breadth. Qualitative research provides an opportunity for depth because of the attention to detail and careful nuances that come with the experience of a phenomenon (Patton, 2002). Therefore, in order to understand the lived experience of this very intense issue, it is important to concentrate on depth with the fewer participants, rather than skim the surface of the phenomenon with many interviewees. There is not very much information in the literature regarding healthy sexuality and relationship functioning as a context for resilience in women survivors of CSA. These are the gaps that exist in the literature. Therefore, it was imperative that I capture the full experience and voices of the women participants. By using the phenomenological perspective, in addition to intensity and criterion sampling, I was equipped to do just that. The depth of the experience of CSA, resilience and the examination of the sexual self-concept is more of a necessity than breadth because the experience of the survivors was truly conveyed because depth was considered.

Chapter 4 - Results

The analysis of the transcripts revealed several important patterns related to participants' experiences of resilience and their sexuality. Themes were identified using the process identified in the previous chapter. Themes were then organized into categories based on the overarching research questions. This chapter is organized by research question. Each is "answered" with the emerging categories and specific themes. Direct quotes are provided as exemplars to allow the women's voices to be heard. For more insight into participants' background, a case synopsis for each of them is provided below. For confidentiality purposes, participants were given a pseudonym.

Lucy is a 22-year-old heterosexual White woman. She has never been married and is currently in a dating relationship that has lasted for 1 year. She has no children. Lucy was sexually abused at least one time a week for over a year. She started her process of resilience about a year ago. Lucy self-identifies as resilient because of her process of healing.

Martina is a 28-year-old heterosexual White woman. She has been previously married and divorced, but did not disclose the length of the first marriage. She has a child from that marriage who is 9 years old. She is currently married and has been for 7 years. They have 4 children together between the ages of 4 and 7. Martina was sexually abused at least weekly from ages 8 to 12. She started her process of resilience a few years ago and expressed that she believes it will be a lifelong process. Martina self-identifies as resilient because she feels the freedom to offer help to others who have experienced CSA.

Anna is a 38-year-old heterosexual White woman. She has been married for 17 years. They have 2 children, ages 13 and 11 respectively. Anna was sexually abused several times a month over the period of 1 year. She started her process of resilience when her second son was

born. Anna self-identifies as resilient because of the sexual freedom she has with her husband, as they participate in the swingers' lifestyle. She feels her voice is heard and respected in her sexual relationship.

Beth is a 48-year-old heterosexual White woman. She has been married for 25 years. They have 3 children ages 16, 14, and 11. Beth was sexually abused over the span of 10 years and lived in fear of being abused for several years after that. She started her process of resilience after her first child was born. Beth self-identifies as resilient because of the work she has done to process what happened to her.

Suzy is a 51-year-old heterosexual White woman. She has been married for 29 years. They have one child who is 15 years old. Suzy was sexually abused several times per week from the ages of 8 to 16. She started her process of resilience several years ago and predicts that she will continually be in that process. Regarding her view of self as a sexual being, it is important to note that Suzy *does* view herself as a sexual being but does not enjoy sex. Suzy self-identifies as resilient based on her experiences with healing and the growth in her relationship with her husband.

Jessie is a 53-year-old heterosexual White woman. She has been married to her current husband for 2 ½ years. Jessie was married previously but divorced after 15 years. She has two adult children from that marriage. Jessie was sexually abused from infancy until she was 18. She was involved in ritual sexual abuse between ages 2 and 4. Her process of resilience started when she divorced her first husband. Jessie self-identifies as resilient because of her journey and where she is now. Jessie chose to remain single for 18 years because she said "she did not want to bring someone else into her mess."

RQ 1: How Do Women Survivors Experience Resilience?

Resilience is a concept that has been difficult to define in the literature. Moreover, healthy sexuality and relationship functioning as a context of resilience in women survivors of CSA, specifically, has not been frequently studied. One of the main foci of the current study was to determine how women survivors experience resilience, specifically through the development of healthy sexuality. Participants talked about resilience as an outcome they have achieved. They consider themselves to be resilient. Additionally, they described the processes they experienced to become resilient. Therefore, the categories and themes within this research question are organized by the concepts process and outcome. The following categories emerged as describing the women's experiences of resilience from CSA: work through the pain (process), self-awareness (process and outcome) and caring for self (process). These themes, CSA is not an identity; internal strength; letting go of control, bitterness, shame and hatred, within these categories that seemed to be very powerful for participants in this study.

Work Through the Pain

When asked to define resilience, participants seemed to include a variety of paths that survivors take to reach their resilience destination. This category showed the outcomes that survivors in the current study received as a result of the process of working through the pain as they moved towards resilience. The definitions the participants gave indicated that those paths can be different, but the goal is the same—resilience and freedom from the effects of CSA on relational functioning and sexuality. In this category, CSA is not an identity/it does not define me was powerful among participants. Some words and phrases that were used frequently by all participants were as follows: *bouncing back, healthier, overcome adversity, fight back, emotional strength, not nearly as timid.*

CSA is Not an Identity

In response to the interview question, "How do you feel about your current functioning and why?" Lucy expressed, "*I feel good about it because I can separate myself from that [CSA]."* Anna added, "*You are able to acknowledge your own strength and decide that [CSA] will not define you."* When asked the interview question, "What are the characteristics of survivors who are resilient?" Jessie stated, *"Come hell or high water, this is not going to knock me down to the ground—even when I wanted to give up."* Jessie also said, "*It is something that happened to me and does not define who I am anymore."*

Self-Awareness

An outcome category that emerged from the data was self-awareness. The participants indicated that being aware of their internal s was a key component for resilience. Suzy had the mentality that the thought processes that she allowed herself to engage in internally determined how she reacted in situations that proved to be triggers for her: "*I am not a victim, I am a survivor."* This is a part of the positive self-talk that Suzy uses to encourage herself.

Regarding self-awareness, Beth said, "*I am not impacted the way I used to be; more boundaries and [being] more connected to needs and emotions"* than in previous years. This is how Lucy responded when asked how she would describe her current functioning related to resilience: "*I feel resilient because I understand resilience and seeing more clearly, which leads to resilience."* Anna responded to the same question with an indication of self-awareness: "*I pay attention to how I feel on a daily basis and how things are going."* She feels the need to do an emotional inventory daily and this helps her to maintain resilience and continue to move toward healing. The theme for this category was internal strength.

Internal Strength

Internal strength was another characteristics of resilient survivors. For Suzy, strength extended beyond taking power back after surviving the abuse. Suzy said, *"Don't give him any more power."* She felt it is necessary to have "*emotional strength"* to continue to walk the path of resilience. Martina stated, "*I am stronger because of the abuse. My mom was raped and she still maintains the victim mentality."* Martina no longer has the "*victim mentality"* that she believes is characteristic of survivors who are not resilient. Anna said, *"Being able to overcome adversity and fight back, you are able acknowledge your strength and decide that it will not define you."* Participants indicated that survivors who are resilient have the ability to see the internal strength it takes to live functional, resilient lives.

Care of Self

The last category for the first research question was described as care of self. This category was formed based on what participants indicated were factors that were included in the process that allowed them to reach out and find the help they needed to heal. These decisions to get support enabled participants to reach a place where they could self-identify as resilient. The themes in this category were work through, engage process, letting go of control, bitterness, shame and hatred, share story, and adapt to change. However, the theme letting go of control, bitterness, shame, and hatred seemed to consistently be the process that participants used as they moved towards resilience.

Letting Go of Control, Bitterness, Shame, and Hatred

In order to fully experience healing and forward movement in their lives, participants expressed the importance of letting go. Suzy talked about the characteristics of survivors who are

resilient: *"Feeling worthy to have a voice and give other survivors a voice, share story to help others, no shame."* They have gotten to a part of their journey where they are able to put the shame where it belongs. Beth said, "*Honesty, willing to press into the pain, seek the truth ruthlessly, letting go of control"* were characteristics that resilient survivors possessed. Additionally, of those who know her history of CSA, Beth said

> "*They would say that I am not impacted the way I used to be, more boundaries, more connected to needs and emotions, less bitter and less resentful."*

Anna said

> "*Strength, ability to let go, determination to be and do better, strong-willed, independent. I pay attention to how I feel on a daily basis and how things are going."*

Martina discussed the importance of letting go of hatred that she possessed:

> "*Once I was able to reconcile the hatred towards my mom for not believing me, the nightmares have stopped. The flashbacks have stopped."*

Each participant intimated the factors that contributed to the ability to let go of control, bitterness, and hatred. Those factors are what contributed to their resilience and will be discussed in the next section.

SRQ 1: What Factors Contribute to Resilience?

Participants provided a wealth of information regarding factors that contribute to resilience. Most of the responses included interactions over time in interpersonal relationships, which were a part of changing the perception of self as survivors. Categories that emerged were create a support network (process and outcome) and develop a spiritual connection (process). The themes that were identified will be discussed as well.

Create a Support Network

One of the factors that proved to be very instrumental in participants' resilience processes was creating a support network. There were many ways participants chose to build their support. For some of the women in the current study, friends were most significant. Others emphasized their relationships with their romantic partner. As a result, the theme that emerged from this category was friends, partner, and family.

Friends, Partner, and Family

The participants in this study attributed their ability to move towards and maintain resilience over time to the relationships they have with friends, their partner, and their family. Lucy said, *"The positives are finding out how supportive people are and are willing to be for broken people and deepening friendships* contributed to her ability to view herself as resilient and strong. Lucy added my friends and my *boyfriend provided support and challenges me* and *my boyfriend listens and I have freedom and security.* The combination of this support from her boyfriend and friends kept her from *feeling the need to run and hide* after disclosing the abuse.

Beth said, *"Family can be a place for survivors to find refuge."* Martina intimated, *"Not until I received acceptance from friends and family was she able to talk about [CSA]."* Jessie said,

> *"The German culture is hard-working, stoic, task-oriented it contributes to self-medication and healing. As an adult, people who spoke into my life, relationships with friends I can communicate with*, *people to come alongside and stuck around."*

Develop a Spiritual Connection

Another process theme that emerged was the importance of having a spiritual connection. For many of the participants, their Christian faith was a huge part of their ability to build a support network and contributed significantly to their resilience journey. They attributed their current functioning to their commitment to spiritual principles such as prayer, attending church services, and the view God has of them instead of what their perpetrator(s) *told them* they were. The theme that emerged in this category was church, God, and religion.

Church, God, and Religion

Jessie said, *"The church helped to meet needs and gave me a new filter for love."* Beth said, "*Churches can provide places to find comfort, compassion, empathy, a perspective that is helpful."* When I asked her to share ideas for my future research with CSA survivors, Beth asked me to

> *"Consider doing more work in the area of how the church can intervene and be a part of the solution and what strengthens the effectiveness of those interventions."*

Participants also were asked to give ideas they had regarding programs for survivors who are working toward resilience. Suzy said, "*Faith-based idea of validating what happened but not make that the identity of a victim, validate their identity as a child of God."* Lucy said of her process of healing,

> "*A lot better off and very blessed to be put in a place where I felt safe to talk about the hurts, weekly therapy and a good therapist, faith—I could not imagine going through childhood sexual abuse without God; I was able to view the support as an avenue of God*.

These spiritual and church connections were seen by the participants in the current study as important as they worked toward the development of healthy sexuality and relationship

functioning. Participants indicated the ability to view sex how God views it was a very helpful part of the journey. Healthy sexuality as a context for resilience was examined in the current study. It seemed that sexuality and relationship functioning played a large role in the processes and outcomes regarding resilience for participants. Categories and themes that emerged will be discussed in this section.

RQ 2: How Do Women Survivors Experience Sexuality?

One of the main foci of the current study was how survivors experience sexuality, how they feel about themselves as sexual beings, and the development of healthy sexuality. Categories that emerged included a healthy perception of sexuality (process and outcome) and being respected in a sexual relationship (process). The themes for these categories will be discussed in the next section.

Healthy Perception of Sexuality

This category was created based on participants' definitions of sexual self-concept. A healthy perception of sexuality seemed to be a process and an outcome for participants in the current study. Participants seemed to intimate that a healthy perception of sexuality started with a desire for sexual intimacy. This is the process aspect of this category. The outcome is the formation of a positive self-image. The theme derived from this category was sex is desirable and reframe/redefine sex and self.

Sex is Desirable and Reframe/Redefine Sex and Self

Regarding the her personal sexuality, Lucy stated that

"Sex is desirable in romantic relationships. It is healthy for the most part; there are parts that are still growing and healing and sometimes sex is still scary; the vulnerability, putting my body out there with the potential that it could be hurt."

When asked to define a healthy sexual self-concept, Lucy said, "*How you perceive yourself as sexually desirable, oriented, and ability."* Sometimes it is necessary for survivors to reframe their thought processes about sex and themselves, as well as redefine old definitions of self. Participants found it important as they sought healthy views of themselves sexually to reframe/redefine the old messages they learned as a result of CSA. Beth said,

> *"It has changed. Prior to working through the pain related to abuse, I viewed sex as pain…I struggled with touch and had to reprogram that part of myself.*"

Jessie said

> *"Seeing self as more than an object and/or sexual victim. Acceptance of self as a sexual being, not just a sliced off part of me that was taken, being able to see things in a new filter."*

This adjustment helped her to redefine her sexuality.

Beth intimated, "*Now I see sex as a gift from God. It created by God and is a good gift from God; exists in the marriage relationship. Faith defines it for me*." Suzy's response was very similar to what Beth said. Suzy said, *"Faith that God created sex and that He blesses intimacy. It's okay to enjoy and participate. God provided it and it's beautiful in God's plan."* Lucy felt it was important to "*Continue to seek out what God says I am instead of what the abuse says I am."*

Respect in Sexual Relationship

The other category that emerged was a part of the process of developing a healthy sexuality. It focused specifically on how participants' sexuality was respected in their relationships, which was very important to the development of healthy view of self as a sexual being. The theme safe, loving relationship seemed to resonate consistently with participants in

this study. Participants also talked about how it was difficult to develop healthy sexuality when they feel helpless, out of control and that their voice does not matter. As a result, I have provided and example of the mindset of a participant before and after the development of healthy sexuality. Regarding unhealthy sexuality, Lucy said,

> *"A lack of balance, thinking of self as a sexual being only versus being a social, thinking being, gets worth from sexual encounters, someone who is taught that their sexuality is not their own, someone who doesn't see sex as valuable, something they aren't choosing for themselves—not motivated out of love or self-sacrifice."*

Safe, Loving Relationship

Feeling safe and loved in a relationship was important for participants to feel emotionally and physically safe with their intimate partner. This helps survivors to feel safe and develop healthy sexuality and view of self as a sexual being. Once safety and respect had been established, Lucy said of her partner,

> *"The way he approaches my body is much different than the abuse; He is more gentle. Both my abuser and my boyfriend want the same thing, but my boyfriend hears my voice and is willing to sacrifice his desires for my comfort and health."*

Because of the safety she has in her relationship, Beth said, *"I have given myself permission to be sexual, enjoy the gift, the beauty of the commitment and demonstration of love."* Suzy intimated, *"I value sex less than the average person; I have to be on guard, very seldom relaxed."* Even with those feelings, Suzy views herself as a sexual being. Suzy said of her partner,

"*His patience over time, him not feeling rejected and that I didn't want him, being loving and not selfish; awareness of my husband's needs and that he feels desired; sometimes I initiate sex, work to meet his needs so that my needs are met as well."*

In order to continue practicing healthy sexuality, Lucy said, *"I need my boyfriend to continue to support and be an understanding friend."* Martina said, "*When I began to feel safe, my husband started to affirm my experience [of CSA] and my sex drive increased."*

Anna said, "*Communication [about sex] was the best because I have a voice that is respected and heard."*

Beth expressed confidence and said,

"I have given myself permission to be sexual and as issues come up, I stay in tune to what has surfaced in my heart and a commitment to reexamining past issues if necessary."

Confidence for Jessie was to *"believe that I have value and deserve to apply those healthy aspects; that it can work for me and I am not so damaged that it doesn't work."* Regarding what would be important as she continued to practice of healthy sexuality, Jessie indicated, *"honesty with myself, my friends [and] my husband, not isolating from loved ones, [and] continuing in my walk with the Lord."*

I realize that in this section I list a lot of quotes from participants and that can be overwhelming. However, I feel that I was important to show that every participant had something to say regarding their experience of sexuality in safe relationships. Next the factors that contribute to the development of a healthy sexual self-concept will be discussed.

SRQ 2: What Factors Contribute to Healthy Sexual Self-Concept?

Participants in this study believed their healthy view of themselves as sexual beings was due largely to learning self-acceptance. Based on this observation, one category was derived for

this specific research question: acceptance of self as sexual being. This is a process as well as an outcome for participants as they moved towards resilience. Themes that emerged from this category also will be presented.

Acceptance of Self as Sexual Being

The women overwhelmingly talked about the importance of accepting themselves in order to develop a healthy sexual self-concept. Regarding the implementation of the healthy sexual self-concept, Lucy indicated, *"I self indulge. It allows my body to feel good sensations instead of fighting it."* As she worked to accept herself as a sexual being, she had to learn to be comfortable with her body. They not only discussed acceptance of self as a sexual being, but also the necessity of creating a positive self-image emerged as a theme as well.

Participants discussed acceptance of self as a sexual being as a process that they have experienced as survivors. Beth said the ability to see herself as a sexual being *"gives value to that part of the self [and] helps to understand the original intent [of sex]."* Anna said *"being comfortable within myself"* was instrumental in the healthy view of self as a sexual being. Lucy said, *"It has made it difficult to enter in with my boyfriend without assumptions that he will desire me sexually after the disclosure and whether he would be the same as These past experiences…have made me more sure of speaking into our sexual relationship—it's the silver lining of childhood sexual abuse."*

View of self is a very important part of the development of one's sexuality. A positive self-image usually leads to a healthy view of self as a sexual being. Martina intimated, "*The ability to view self as I would view a friend; keep reiterating beauty and worth"* were instrumental in the development of her sexual self-concept. For Anna, the development of her

positive self-image came full circle because of the change in her sexual image: *"Once my mentality changed, my sexual image changed."*

At the beginning of her relationship with her partner, Jessie said,

> *"We were very slow and deliberate. I discussed with my [partner] beforehand that I desired an intimate, emotional relationship before a sexual relationship*; *talk about needs and wants away from the bedroom so it's subjective."*

The theme in this category was finding forgiveness and survivor mentality.

Forgiveness and Survivor Mentality

Forgiveness can be an important factor in healing of survivors of CSA. Sometimes that forgiveness is given to those who abused or did not prevent the abuse. It can also include forgiveness of oneself for negative choices made as a result of the abuse experiences. For Beth, she felt she needed to forgive herself because,

> *"Promiscuity wasn't consistent to my worldview. I was giving too much of myself. My husband was sad because of the sexual encounters prior to our marriage relationship and I felt shame and regret because of the choices. Hard to forgive myself but it's a non-issue now because I have forgiven myself.*

Suzy indicated,

> *"Lots of reminders; faith in God had gotten me through, reading Scriptures, viewing it as any sin when my mind brings it up and allow forgiveness [of myself] to be real. I am attacked by the enemy in this area but when I am committed to study and prayer it works better."*

Beth said, "*An honest look at the impact of the experience, placing blame and responsibility where it belongs, physiological response does not indicate consent."*

The impact of CSA on Suzy's intimate relationship is ironic. She said,

"The pain and fear cause problems as an adult, but the pain and fear protected me as a child [from being raped by abuser]. Empowered me to make the choice to give the gift [and not have it taken away]. The survivor mentality to take the power back."

The ability to forgive themselves for decisions made as a result of the abuse and to forgive their perpetrator(s) also was significant part of participants' ability to develop healthy sexuality. Additionally, as healthy sexuality developed, healthy relationship functioning developed as well.

RQ 3: How Do Women Survivors Experience Relationships?

Relationship functioning is an important part of women survivors' healing experiences. It seems that most healing and movement toward resilience takes place in relationships. There were several categories that emerged from these research questions. However, definition of healthy relationship functioning was where participants were able to describe the processes and outcomes in as they journeyed towards resilience.

Definition of Healthy Relationship Functioning

Participants in this study provided great insight regarding the topic of healthy relationship functioning. In order for a relationship to be defined as healthy, participants indicated that each person in the relationship must possess certain characteristics. Participants were asked to respond to questions related to their experiences in friendships, family, and romantic relationships, specifically in reference to what is necessary for them to feel secure in those relationships.

All of the women in the study acknowledged that they needed to have a tremendous amount of trust in a person no matter the type of relationship (friendship, family, or romantic). Each person the survivors chose to enter into a relationship with had to prove his or her

trustworthiness in some way, overtly or covertly. Based on their responses, one category was dominant: Characteristics of partner. This is a process and outcome category. Process because participants had to learn and identify what they needed in relationships. Outcome because the characteristics of the partner that the participants have identified are a direct result of the processes they have gone through to maintain the healthy relationship functioning. Within this category, honest and trust emerged as the theme that seemed to be the most needed characteristic of partners.

Characteristics of Partner

Participants in the study intimated that the positive qualities of their partner are integral in the definition of a healthy relationship. All participants indicated that there are certain aspects of a relationship as survivors of CSA that cannot be compromised if they are to continue on their journey toward resilience. For example, Lucy said she needs *"someone who accepts where I come from with my background of abuse, non-judgmental."* The journey to trust was also very difficult for participants as well. However, they did not allow that to be an excuse for developing relationships with intimate partners. I have provided examples of participants who struggled with trust but have been able to overcome the struggle as an outcome of the process of developing healthy relationships.

Honest and Trust

Martina said,

"Caused negativity in friendships and intimate relationships. I struggled with trust, disclosed and was not believed, which leads to mistrust."

Her family proved to be a dangerous place for her emotionally. Anna said, *"I looked for someone to take care of me, but they would take advantage of and control me."* Jessie admits,

> *"Trust issues--they are better but my radar still go up at times*; *hold people at a distance until they have proven themselves trustworthy."*

Despite the trust issues that have been prevalent with participants during their processes, they have ultimately been able to develop trust in relationships. Beth described her partner as someone who has a *"willingness to be authentic/real"* in interactions. For Suzy, a partner who is "*Trustworthy, not sarcastic about people; honesty, being real, being willing to share themselves"* When entering a new relationship, Anna asks herself, *"Can I trust them with my safety, a place of safety emotionally?"* Jessie said they have to be "*Trustworthy—early on I am able to sense this in people."* I believe this next quote from Jessie sums up what each participant expressed they need from a partner. Jessie said she needs "*Someone who is comfortable with me when I am uncomfortable with me."*

SRQ 3: What Factors Contribute to Healthy Relationship Functioning?

I felt it was important to allow participants to share what contributes to healthy relationship functioning. Specific research question 3c asked what factors contribute to healthy relationship functioning. There was one category that seemed to resonate strongly for all participants. That category is feeling empowered. There were some similarities in the themes from this category that were derived from previous categories. With that said, the unique theme that was identified based on this category was healing, sharing experience with others. This category and theme are definitely outcome oriented because they are usually a direct result of the processes encountered on the path to resilience.

Feeling Empowered: Healing, Sharing Experience with Others

Martina also expressed an understanding of what communication can bring about in relationships. When asked what has enabled her to develop close intimate relationships, she said, *"Once I could disclose, people sought out my strength, I understood my own strength."* Her honesty with herself and others around her allowed her to value her own voice and see that those close to her value her voice. The need for emotional safety also was expressed by most participants in response to what has enabled the development of close, intimate relationships.

Once this portion of the interview was complete, it became apparent that some participants' responses intimated that the elements they need to feel safe in and throughout their respective relationships were very similar. For example, Lucy's response to elements necessary for safety in romantic relationships was *"same as the things I said about friendships and they must love and have a personal relationship with God."* Also, in response to a question regarding the elements of safety in her romantic relationship, Beth agreed that what she indicated in the previous question about her friendships was the same for her romantic relationship. Beth also added *"mutual respect."* Both of these women acknowledged that there are additional aspects of romantic relationships that are necessary for their partners to prove themselves trustworthy.

Overall, the participants were able to verbalize the processes and outcomes that were significant to the development of healthy sexuality and relationship functioning as a context of resilience. These processes and outcomes are discussed further in the next chapter. Next is the summary of the findings.

Summary of Results

The results revealed the thoughts and focus the participants have regarding resilience and sexual self-concept. It was interesting to see how similar response patterns continued to emerge

as the interview questions became increasingly personal. The participants describe similar thought patterns as process and outcome, which lends to the idea that women survivors who self-identify as resilient have very similar experiences when it comes to resilience, relationship functioning and the view of themselves as sexual beings. Although each woman's experience is not exactly the same, it was very interesting to find that the mental, emotional, and physical experiences as survivors of CSA were quite similar. The significant processes and subsequent outcomes regarding the development of healthy sexuality and resilience were the same. The process and outcome components will be discussed further in the next chapter.

Chapter 5 - Discussion

The purpose of this study was to explore how women survivors of CSA experienced healthy sexuality and relationship functioning as a context for resilience. The overarching research question was "How do women survivors of CSA experience resilience?" Participants were asked to discuss aspects of resilience regarding relationships and sexuality. Using the qualitative research lens of phenomenology, I was able to capture the essence of the survivors' experiences of resilience. In this chapter I will address the knowledge gained from this study and the meaning of the findings through the theoretical perspective of Symbolic Interactionism, as well as implications for research and practice.

Knowledge Gained From Current Study

One of the main reasons for conducting this study of resilience in survivors of CSA was to gain insight regarding the process of resilience. The shared symbolism of these processes of healthy sexual and relationship development was a very significant finding. Participants in this study self-identified as resilient and were able to provide definitions of resilience. In addition to defining resilience, participants identified factors that contributed to this outcome, such as supportive people (including family, friends and significant others). In order to gain insight into the process of resilience for these women, they were asked to talk openly about the development of healthy sexuality, their view of resilience overall, characteristics of survivors who are not resilient, as well as characteristics of those who are resilient.

Participants, Shared Symbolism and SI

According to Symbolic Interactionism (SI), socialization is the process by which symbols and meanings are acquired (White & Klein, 2008). SI theory holds that the physical world, as

well as the social world, takes on meaning through the process of symbolic interaction (Waltner, 1986). It was very interesting to find that, although the participants in this study came from different age groups and experiences, their journeys of socialization and movement towards healthy sexuality and resilience were very similar. They provided shared symbolic meanings, even though they had no contact with each other. For example, the participants described several images that served as symbols of resilience throughout the process of reflection during the interviews. This was illustrated when they discussed resilience as a journey, a new identity as a symbol of resilience, and freedom in sexuality as resilience.

Focusing on symbols as the basis for creating shared meaning and collective action assists in the process of meaning making for members of a group (Frey & Sunwolf, 2004). The participants made it clear that resilience required determination and commitment. They explicitly described this as a journey. For example, they emphasized the importance of working through the pain, taking care of self, letting go negative mindsets, developing interpersonal and spiritual connections, and forgiveness of self and others. Participants described resilience as a process of cleansing the soul. Ridding themselves of the poison left behind after CSA was the task survivors were charged with; and when successful, they emphasized the symbols of strength and endurance. In essence, survivors indicated that they must be committed to healing and moving toward freedom. This symbol of a journey also was very important to the development of healthy relationships, which leads to healthy sexuality.

In the process of defining resilience, it became apparent that their journey led them to a new identity. This new self-image included seeing themselves as women who have the strength to press on, will not let themselves be defined by CSA, can adapt to change, will fight for

themselves emotionally and sometimes physically, and as women who can keep working to move forward despite their CSA experience(s).

In 1978, Whitehurst asserted that sexual relations were starting to become a symbol of the female identity. He argued that sex is related to the search for the self, a way of making meaning, explaining in more depth the meaning of relationships with others, and a means for focusing on what symbolizes personhood. As participants in the current study discussed aspects of the development of their sexuality, it became very apparent that sex had similar meaning and symbolism in their lives to what Whitehurst described. Sexual freedom seemed to symbolize power and control for these participants. This freedom was marked by what participants referred to as feeling safe and being able to use their voices regarding their sexual wants, needs and limits. Moreover, acceptance of self as a sexual being and a positive self-imag*e* seemed to be a very important component of freedom, strength and power for participants.

Resilience as State, Trait, and Process

In the literature review chapter, resilience as a state or trait was introduced as a methodological challenge. Some studies have considered resilience to be a personal characteristic or trait (e.g., Bogar & Hulse-Killacky, 2006), whereas others have viewed it as a state or outcome (e.g., Masten, 2001). An interesting finding in this study was that the participants emphasized both state and trait aspects of their journey to resilience. However, there also was a strong emphasis by these women on the process of resilience. In other words, for the participants in this study, resilience and the development of healthy sexuality was a journey that was facilitated by traits and resulted in a state of being. For example, the trait internal strength led to the process of working through the pain, which lead to the outcome of acceptance of one's sexual power. According to the women, all three of these components were integral to resilience.

This was very helpful as I worked to recognize the similarities of the participants' descriptions of resilience, even though they came from different age generations. There are a few possible explanations for this. First, all the women were White and heterosexual. Second, each woman identified Christianity and the role it played in their journey of resilience. Finally, all the women were from the same region geographically. These commonalities may contribute to similarities in thought processes, shared symbolism, as well as action taken toward healing. The findings may have been different if the participant sample was less homogenous. Implications for research and practice are offered next.

Implications for Research and Practice

There is much to be learned across fields from this type of research with CSA survivors. The current study has many implications for research and practice in the fields of family studies, mental health and the medical fields.

Research

Healthy sexuality as a context for resilience as an aptitude for women survivors of CSA has not been widely studied. The current study has provided the view of resilience from survivors who live it. Participants were very open about their experiences of resilience. Moreover, they did not deny that there was a struggle to get to where they are on the journey towards healing. In fact, they answered interview questions about the past hurdles and were willing to admit to some current hurdles they face. These aspects were a strength of the current study because survivors provided their personal perspectives as about their struggles and victories on the journey to resilience. While this begins to build our understanding in this area, we need to continue examining the process of resilience specifically in women survivors of CSA. This study merely began the discussion.

I would suspect resilience for men who are survivors of CSA has been studied even less than women's. It would be valuable to uncover the positive interpersonal relationship functioning and sexuality in the context of resilience for men and compare that to women survivors of CSA. Additionally, an examination of healthy sexuality as context for resilience in women and men survivors of CSA who identify as lesbian, bisexual, gay, transgender, and questioning (LBGTQ) would be helpful in understanding the process of resilience.

Although the current study provided rich data from participants, there were some things that I would have done differently. First, I would have interviewed more participants. Qualitative research does not usually require a large sample, but I believe that more participants would have provided a broader view of survivors' experiences of resilience, healthy relationships and healthy sexuality. Secondly, I would have worked to increase the diversity of the sample. Survivors from different racial and/or ethnic groups, religious affiliations, and socioeconomic statuses could potentially increase the transferability of findings of the current study.

Additionally, this study has been a catalyst for a desire to conduct further research in women survivors of CSA and resilience in the context of high stress work environments. Some extant literature has examined employment status as a means to measure resilience (i.e., Bogar & Hulse-Killacky, 2006; McClure et al., 2008; Wright et al., 2005). Survivors who have had success in the professional world may reveal other elements of functioning that have facilitated the development of resilience.

Comparisons between men and women survivors may contribute a more complete picture of CSA and resilience across gender. Comparisons between and/or within race and/or ethnic groups would contribute as well. This is a limitation of the current study. Demographics of participants were limited. The only race represented in the current study was White Americans.

A study comparing survivors, both men and women, across race and/or ethnic groups would potentially reduce the bias that exists when there is only one race represented.

Post-traumatic growth is another area that would benefit from our understanding of survivors as well. Studies that focused on resilience specifically focused on factors that excluded survivors from being categorized as resilient (e.g., Hyman & Williams, 2001; Wright et al., 2005). Most of those results were based on pen and paper measures of resilience, not on the voices, opinions, and/or perspectives of survivors. With that said, it may be helpful to develop a measurement tool for sexuality that could be used for a mixed methods study regarding the development of healthy sexuality as a context of resilience.

Participants in this study contributed what they felt would be a good direction to pursue for future research as well. It was very clear that participants felt society contributes to negative perceptions of functioning in CSA survivors. Overall, participants expressed that society, as a whole, has not been a safe place for the development of resilience, healthy relationship and sexual functioning. A study examining ways survivors of both genders perceive societal views on CSA survivors and what can be done to enhance society's contribution to healing could be valuable as well.

Overall, implications for research from this study are important because there has not been much discussion related to the positive aspects of coping in survivors. The focus has been primarily on the negative aspects of coping and not the resilience that many women who have experienced CSA display. Another reason these implications are important is because the voices and personal perspectives and experiences of women survivors are the source of the information. Their ideas and perspectives are such a priceless part of research with CSA survivors and resilience. Survivors in this study were encouraged to tell their stories of resilience and healthy

relationship and sexuality development. These aspects of the study will provide an understanding of intimate and interpersonal relationships among survivors that would not be revealed otherwise.

Practice

Regarding implications for practitioners, it will be crucial that survivors have input related to programming for CSA survivors. Survivors are able to advocate for themselves and identify what their needs are as they work to establish and maintain resilience. Certified Family Life Educators (CFLE) providing sexuality education would benefit from gathering data via focus groups and/or panel discussions with survivors of CSA regarding curriculum development. Specifically, CFLEs would gain insight into the reality of the aftercare needs as well as the long-term education needed. Survivors not only need to know how to cope, they need help in the areas of relationship development and healthy sexuality.

A connection with survivors who are resilient will be useful for CFLEs because of the life experience they can share. It will be helpful for those stuck in the victim role to hear from those who have had CSA experience(s) and see the progress they have made. Also, those charged with being providers of sex education could benefit from the results of the current study as well. Most participants expressed that the sex education they received as children was not thorough enough and/or not soon enough. This is knowledge that would act as a buffer to prevent children of survivors of CSA from being victimized and those children who are being victimized from being further victimized.

Medical practitioners will benefit from the findings in the current study through knowledge of how to encourage patients who are currently (and/or in the past have been) victims of CSA to seek out help in the journey towards healing. This study provides hope that positive

coping is real, attainable, and realistic. Survivors in the current study were not in denial of the struggles that ensued as a result of CSA, but they were proud of their current functioning and the work they have done to maintain resilience.

Conclusion

The current study focused specifically on resilience in the context of relationships with others. As discussed previously, most studies on women survivors of CSA have focused on the negative aspects of coping. It is important that the process of resilience in relationships is examined as it provides hope for others who are journeying toward resilience. By using qualitative methodology, the survivors were able to personally describe their process of resilience and experiences with sexuality development. The voices of survivors were valued and their competence regarding their needs was respected and celebrated. We must be willing to advocate for survivors of CSA, adult or otherwise, and put time and effort into helping them experience the freedom of resilience.

In the introductory chapter, I provided a story of a woman who had been sexually victimized by her grandfather. She was in a seemingly hopeless situation as she was left to deal with the effects of her experience of CSA. She called her friend, desperate for her to give her something, anything, that would help ease the pain. Her friend assured her that she was doing the right thing by dealing with the CSA directly. She also helped the desperate survivor realize that the only way out was through the pain; the only way to heal was to deal and that she was strong enough to make it to the other side—alive.

This study provides that same hope for victims as in that story. Survivors need to know that there are others who have been through what they are experiencing. They need to know that other women have been through it, but that they, despite the CSA, are functioning well and

living happy lives. This is what the current study provides for survivors; hope for the future, hope for healing, hope for freedom.

The current study can be used as a catalyst for others who are interested in resilience and post-traumatic growth in survivors of CSA to pursue further avenues of research. My hope is that this is just the beginning of allowing people who have experienced CSA to be the experts on their lives and healing. In order to empower these women, I have concluded with the voices of the participants and their wisdom about their personal journey towards healing.

Lucy: *"The positives are finding out how supportive people are and are willing to be for broken people…[I'm] a lot more gentle now than when I started therapy, better at empathizing with others who are broken, able to share CSA with others; more willing to be seen as broken for others. These past experiences and going through therapy have made me more sure of speaking into our sexual relationship—It's the silver lining of childhood sexual abuse."*

Beth: *"Exploring the impact and coming to terms with the betrayal, violation; taking an honest look at the experience; developing the ability to say no. Before, I would put people a "catch-22" situation. I had to learn that my voice was important."*

Anna: *"Speaking openly about what I want or don't want, being comfortable within myself has empowered me in my ability to stand up for myself."*

Jessie: *"I have value and deserve to apply those healthy aspects, that it can work for me, and I am not so damaged that it doesn't work."*

Martina: *"Once I could disclose, people sought out my strength, [and] I understood my own strength."*

Suzy: *"I am not a victim, I am a survivor."*

REFERENCES

Asberg, K., & Renk, K. (2012). Comparing incarcerated and college student women with histories of childhood sexual abuse: The roles of abuse severity, support, and substance use. *Psychological Trauma: Theory, Research, Practice, and Policy.* Advance online publication. doi: 10.1037/a0027162

Banyard, V. L., Arnold, S., & Smith, J. (2000). Childhood sexual abuse and dating experiences of undergraduate women. *Child Maltreatment, 5(1),* 39-48.

Banyard, V.L., Williams, L.M., Siegel, J.A., & West, C.M. (2002). Childhood sexual abuse in the lives of Black women. *Women and Therapy, 25(3-4),* 45-58.

Bass, E., & Davis, L. (2008). *The courage to heal: A guide for women survivors of child sexual abuse, 4th ed.* New York: Harper.

Batten, S. V., Follette, V. M., & Aban, I. B. (2001). Experiential avoidance and high-risk sexual behavior in survivors of child sexual abuse. *Journal of Child Sexual Abuse, 10(2),* 101-120.

Bernard, H. R. & Ryan, G. W. (2010a). Finding themes. In H. R. Bernard & G. W. Ryan, *Analyzing qualitative data: Systematic approaches,* (pp. 53-73). Thousand Oaks, CA: Sage.

Bernard, H. R. & Ryan, G. W. (2010b). Codebooks and coding. In H. R. Bernard & G. W. Ryan, *Analyzing Qualitative Data: Systematic Approaches,* (pp. 75-105). Thousand Oaks, CA: Sage.

Bogar, C. B. & Hulse-Killacky, D. (2006). Resiliency determinants and resiliency process among female adult survivors of childhood sexual abuse. *Journal of Counseling and Development, 84(3),* 318-327.

Breakwell, G. M. & Millward, L. J. (1997). Sexual self-concept and sexual risk taking. *Journal of Adolescence, 20,* 29-41.

Briere, J. (1989). The long term clinical correlates of childhood sexual victimization. *Annals of the New York Academy of Sciences,* 528, 327–334.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin, 99,* 66-77.

Bryant-Davis, T., Chung, H., & Tillman, S. (2009). From the margins to the center: Ethnic minority women and the mental health effects of sexual assault. *Trauma, Violence, and Abuse, 10(4),* 330-357.

Carson, D., Gertz, L., Donaldson, M., & Wonderlich, S. (1990). Family-of-origin characteristics and current family relationships of female adult incest victims. *Journal of Family Violence, 5,* 153-171.

Charmaz, K. (2006). Coding in grounded theory practice. In *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis,* (pp. 42-71). Thousand Oaks, CA: Sage.

Coffey, P., Leitenberg, H., Henning, K., Turner, T., & Bennett, R. T. (1996). The relation between methods of coping during adulthood with a history of childhood sexual abuse and current psychological adjustment. *Journal of Consulting and Clinical Psychology, 64(5),* 1090-1093.

Daly, K. J. (2007). Analytical strategies. In *Qualitative methods for family studies and human development,* (pp. 209-241). Los Angeles: Sage.

Edwards, J. J., & Alexander, P. C. (1992). The contribution of family background to the

long-term adjustment of women sexually abused as children. *Journal of Interpersonal Violence, 7(3),* 306-320.

Feinauer, L. L. (1989). Comparison of long-term effects of child abuse by type of abuse and by relationship of the offender to the victim. *The American Journal of Family Therapy, 17(1),* 48-56.

Feinauer, L. L., Mitchell, J., Harper, J. M., & Dane, S. (1996). The impact of hardiness and severity of childhood sexual abuse on adult adjustment. *The American Journal of Family Therapy, 24(3),* 206-214.

Feinauer, L.L. & Stuart, D. A. (1996). Blame and resilience in women sexually abused as children. *The American Journal of Family Therapy, 24(1),* 31-40.

Feiring, C., Simon, V. A., & Cleland, C. M. (2009). Childhood sexual abuse, stigmatization, internalizing symptoms, and development of sexual difficulties and dating aggression. *Journal of Consulting and Clinical Psychology, 77(1),* 127-137.

Filipas, H. H. & Ullman, S. E. (2006). Child sexual abuse, coping responses, self-blame, posttraumatic stress disorder, and adult sexual revictimization. *Journal of Interpersonal Violence, 21(5),* 652-672.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry, 55,* 530-541

Finkelhor, D., Hotaling, G., Lewis, I. A., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics and risk factors. *Child Abuse and Neglect, 14,* 19-28.

Folkman, S. & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior, 21,* 219-239.

Folkman, S., & Lazarus, R. S. (1988). Coping as a mediator of emotion. *Journal of Personality and Social Psychology, 54(3),* 466-475.

Frey, L. R. & Sunwolf. (2004). The symbolic-interpretive perspective on group dynamics. *Small Group Research, 35(3),* 277-306.

Futa, K. T., Nash, C. L., Hansen, D. J., & Garbin, C. P. (2003). Adult survivors of childhood abuse: An analysis of coping mechanisms used for stressful childhood memories and current stressors. *Journal of Family Violence, 18(4),* 227-239.

Garcia, L. (1999). The certainty of the sexual self-concept. *The Canadian Journal of Human Sexuality, 8(4),* 263-270.

Garcia, L. T. & Carrigan, D. (1998). Individual and gender differences in sexual self perceptions. *Journal of Psychology and Human Sexuality, 10(2),* 59-70.

Ginzburg, K., Arnow, B., Hart, S., Gardner, W., Koopman, C., Classen, C. C., Giese Davis, J., & Spiegel, D. (2006). The abuse-related beliefs questionnaire for survivors of childhood sexual abuse. *Child Abuse & Neglect, 30,* 929-943.

Harrison, P. A., Fulkerson, J. A., & Beebe, T. J. (1997). Multiple substance use among adolescent physical and sexual abuse victims. *Child Abuse and Neglect, 21,* 529-539.

Holmes, M. C. (2002). Mental health and sexual self-concept discrepancies in a sample of young Black women. *Journal of Black Psychology, 28,* 347-370.

Hund, A. R. & Espelage, D. L. (2005). Childhood sexual abuse, disordered eating,alexithymia, and general distress: A mediation model. *Journal of Counseling Psychology, 52(4),* 559 573.

Hyman, B., & Williams, L. (2001). Resilience among women survivors of child sexual abuse. *Afflia, 16,* 198-219.

Johnson, R. J., Rew, L., Fredland, N., & Bowman, K. (2010). Sexual self-concept in sexually abused homeless adolescents. *Vulnerable Children and Youth Studies, 5(1),* 44-51.

Johnson, R. J., Rew, L., & Sternglanz, R. W. (2006). The relationship between childhood sexual abuse and sexual health practices of homeless adolescents. *Adolescence, 41(162),* 221 234.

Kobasa, S. C. (1979). Stressful events, personality, and health: An inquiry into hardiness. *Journal of Personality and Social Psychology, 37,* 1-11.

Liang, B., Williams, L. M., & Siegel, J. A. (2006). Relational outcomes of child sexual trauma in female survivors: A longitudinal study. *Journal of Interpersonal Violence, 21(1),* 42-57.

Liem, J. H., James, J. B., O'Toole, J. G., & Boudewyn, A. C. (1997). Assessing resilienceIn adults with histories of childhood sexual abuse. *American Journal of Orthopsychiatry, 67(4),* 594-606.

MacMillan, H. L., Fleming, J. E., Trocme, N., Boyle, M. H., Wong, R., Racine, Y. A.,…Offord, D. R. (1997). Prevalence of child physical and sexual abuse in the community. *The Journal of the American Medical Association, 278,(2),* 131-135.

Maddi, S. R., & Kobasa, S. C. (1991). The development of hardiness. In A. Monat & R. S. Lazarus (Eds.), *Stress and coping: An anthology* (3rd ed., pp. 245-257). New York: Columbia University Press.

Markus, H., & Nurius, P. (1986). Possible selves. *American Psychologist, 41,* 954-969.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist, 56(3),* 227-238.

Masten, A. S., & Coatsworth, J. D. (1998). The development of competence in favorable and unfavorable environments. *American Psychologist, 53(2),* 205-220.

Masten, A. S., Hubbard, J. J., Gest, S. D., Tellegen, A., Garmezy, N., & Ramirez, M. (1999). Competence in the context of adversity: Pathways to resilience and maladaptation from childhood to late adolescence. *Development and Psychopathology, 11,* 143-169.

McClure, F. H., Chavez, D. V., Agars, M. D., Peacock, M. J., & Matosian, A. (2008). Resilience in sexually abused women: Risk and protective factors. *Journal of Family Violence, 23,* 81-88.

McLean, L. M., Toner, B., Jackson, J., Desrocher, M., & Stuckless, N. (2006). The relationship between childhood sexual abuse, complex post-traumatic stress disorder, and alexithymia in two outpatient samples: Examination of women treated in community and institutional clinics. *Journal of Child Sexual Abuse, 15(3),* 1-17.

Merrill, L. L., Guimond, J. M., Thomsen, C. J., & Milner, J. S. (2003). Child sexual abuse and number of sexual partners in young women: The role of abuse severity, coping style, and sexual functioning. *Journal of Consulting and Clinical Psychology, 71(6),* 987-996.

Molnar, B. E., Buka, S. L., & Kessler, R. C. (2001). Child sexual abuse and subsequent psychopathology: Results from National Comorbidity Survey. *American Journal of Public Health, 91,* 743-760.

Murthi, M., & Espelage, D. L. (2005). Childhood sexual abuse, social support, and psychological outcomes: A loss framework. *Child Abuse & Neglect, 29,* 1215 1231.

NCH Software. (2001). Expressdictate. Menno Bakker.

Nemiah, J. C., & Sifneos, P. E. (1970). Affect and fantasy in patients with psychosomatic

disorders. In O. W. Hill (Ed.), *Modern trends in psychosomatic medicine (Vol. 2,* pp. 26-34). London: Butterworth.

Nurius, P. S. (1989). The self-concept: A social cognitive-update. *Social Case Work: The Journal of Contemporary Social Work, 70,* 285-294.

Oaksford, K. & Frude, N. (2003). The process of coping following child sexual abuse: A qualitative study. *Journal of Child Sexual Abuse, 12(2),* 41-72.

Patton, M. Q. (2002). *Qualitative research and evaluation methods.* Thousand Oaks: Sage.

Peters, S. D., Wyatt, G. E., & Finkelhor, D. (1986). Prevalence. In Finkelhor, D. (ed). *A sourcebook on child sexual abuse* (pp. 15-59). Beverly Hills, CA: Sage.

Richardson, G. E. (2002). The metatheory of resilience and resiliency. *Journal of Clinical Psychology, 58(3),* 307-321.

Roberts, R., O'Connor, T., Dunn, J., Golding, J., & ALSPAC Study Team. (2004). The effects of child sexual abuse in later family life: Mental health, parenting, and adjustment of offspring. *Child Abuse & Neglect, 28,* 525-545.

Roth, S. & Newman, E. (1991). The process of coping with sexual trauma. *Journal of Traumatic Stress, 4,* 279-297.

Schuetze, P., & Eiden, R. D. (2005). The relationship between sexual abuse during childhood and parenting outcomes: Modeling direct and indirect pathways. *Child Abuse and Neglect, 29,* 645-659.

Sigmon, S. T., Greene, M. P., Rohan, K. J., & Nichols, J. E. (1996). Coping and adjustment in male and female survivors of childhood sexual abuse. *Journal of Child Sexual Abuse, 5,* 57-75.

Stroud, D. D. (1999). Familial support as perceived by adult victims of childhood sexual abuse.

Sex Abuse: A Journal of Research and Treatment, 11(2), 159-175.

Testa, M., Miller, B. A., Downs, W. R., & Panek, D. (1992). The moderating impact of social support following childhood sexual abuse. *Violence and Victims, 7(2),* 173 186.

van Manen, M. (1990). Human Science. *Researching lived experience: Human science for an action sensitive pedagogy,* pp. 1-34. London: SUNY Press.

Vickberg, S. M. J. & Deaux, K. (2005). Measuring the dimensions of women's sexuality: The Women's Sexual Self-Concept Scale. *Sex Roles, 53(5/6),* 361-369.

Walker, J. L., Carey, P. D., Mohr, N., Stein, D. J., & Seedat, S. (2004). Gender differences in prevalence of childhood sexual abuse and in development of pediatric PTSD. *Archives of Women's Mental Health, 7,* 111-121.

Walsh, K., Fortier, M. A., & DiLillo, D. (2010). Adult coping with childhood sexual abuse: A theoretical and empirical review. *Aggression and Violent Behavior, 15,* 1-13.

Waltner, R. (1986). Genital identity: A core component of sexual- and self-identity. *Adversaria, 22(3),* 399-408.

Webster, R. E. (2001). Symptoms and long-term outcomes for children who have been sexually assaulted. *Psychology in Schools, 38(6),* 533-547.

Weierich, M. R., & Nock, M. K. (2008). Posttraumatic stress symptoms mediate relation between childhood sexual abuse non-suicidal self-injury. *Journal of Consulting and Clinical Psychology, 76(1),* 39-44.

Werner, E. E. (2000). Protective factors and individual resilience. In J. P. Shonkoff & S. J. Meissels, (Eds.), *Handbook of early childhood intervention (2nd ed.),* pp. 115-132. New York: Cambridge University Press.

Werner, E. (2005). Resilience research: Past, present, and future. In R. D. Peters, B. Leadbeater, and R. J. McMahon, eds, *Resilience in children, families, and communities: Linking context to practice and Policy,* (pp.3-9). New York: Kluwer Academic/Plenum Publishers.

White, J. M. & Klein, D. M. (2008). *Family Theories, 3rd Ed.* Los Angeles: Sage Publications.

Whitehurst, R. N. (1978, November). Loss of virginity in college women. *Medical Aspects of Human Sexuality,* 7-23.

Wilcox, D. T., Richards, F., & O'Keefe, Z. (2004). Resilience and risk factors associated with experiencing childhood sexual abuse. *Child Abuse Review, 13,* 338-352.

Wright, M. O., Fopma-Loy, J., & Fischer, S. (2005). Multidimensional assessment of resilience in mothers who are child sexual abuse survivors. *Child Abuse & Neglect, 29,* 1173-1193.

Wyatt, G. E., & Mickey, M. R. (1987). Ameliorating the effects of child sexual abuse: An exploratory study of support by parents and others. *Journal of Interpersonal Violence, 2(4),* 403-414.

Zinzow, H., Seth, P., Jackson, J., Niehaus, A., & Fitzgerald, M. (2010). Abuse and parental characteristics, attributions of blame, and psychological adjustment in adult survivors of child sexual abuse. *Journal of Child Sexual Abuse, 19(1),* 79-98.

Appendix A-Interview Questions

"Today I would like to talk with you about your experience related to resilience and your sexual self-concept. I will ask you information about your experiences and behaviors related to childhood sexual abuse (CSA), your feelings about how you view yourself and your values and opinions. Before we start, I would like to talk with you about the informed consent form. This form gives me your permission to ask you questions and provides you with information about the study. Please take a few minutes to read the form and we will continue accordingly. Thank you. I would like to start by having you complete a questionnaire related to your background."

"I would like to shift the topic to relationships that you have had in the past and/or those that you have presently. These questions will be related to the elements of safety in relationships in reference to what is necessary for you to feel secure with friends and/or intimate partners."

1. When entering a relationship, past or present, what aspects are most important for the person(s) to have in order to have a perception safety in the relationship, specifically a friendship? Romantic relationship? Family relationship?
2. How has your experience with CSA affected your view of romantic relationships?
3. As you remember what the CSA experience was like for you, what has enabled you to develop close, intimate relationships?
4. What has been the impact on your relationships regarding your experience of CSA?

"During this next series of questions I will ask you to give your opinion about your view of yourself as a sexual being and how those views are demonstrated in relationships. Additionally, I will ask questions about how survivors of CSA can learn to have a healthy view of themselves as sexual beings."

1. In your opinion, what is sexual self-concept?

2. What is necessary for a healthy sexual self-concept (view of self as a sexual being)?
3. How would you define an unhealthy sexual self-concept?
4. What about your personal sexual self-concept? How would you define it (i.e., healthy or unhealthy)? Why?
5. How has your relationship with your partner been a part of developing your sexual self-concept?
6. How have you implemented your view of yourself as a sexual being into your sex life?
7. How have your past experiences and sexual encounters affected your ability to apply a healthy view of yourself as a sexual being to your relationships?
8. The experience of CSA often has lasting affects on those who experience it in reference to their ability to consider sex education in their sexual encounters. What has your experience with sex education in school?
9. What are some external factors that hinder the ability to apply the healthy aspects of sex education in your intimate romantic relationships?
10. What are some internal factors that hinder the ability to apply the healthy view of sex education in your intimate romantic relationships?
11. What helps you in implement a healthy sex education practices into your intimate relationships?
12. A healthy view of self as a sexual being is difficult for some CSA survivors to implement in their lives. If there were programs that helped survivors in the process of developing a healthier view, what components do you feel you would need to be present for those programs to be effective? What about for others?

13. What do you think has been/will continue to be helpful for as you practice healthy sexuality?

“These questions will be directly related to how you feel about the CSA experience, how you feel about being a survivor, and resilience what factors have helped you in the process of resilience.”

1. What emotions do you associate with the experience of CSA?
2. How are your feelings similar or different from those of other survivors?
3. Sometimes survivors of CSA have a difficult time expressing feelings and others have no difficulty. How would you describe your ability to express you feelings about sex in your intimate relationships?
4. How would you define resilience? What are the characteristics of survivors who are resilient? Not resilient?
5. What do you feel are the biggest hindrances to leading a functional life as a survivor of CSA (Resilience)?
6. How do you feel others who know your history of CSA would describe your resilience? How do you describe your current functioning as it relates to resilience? How do you feel about your current functioning? Why?
7. What do you feel society can do to help survivors learn how to function after their abuse experience(s) and lead functional lives?
8. How do you feel society, your community, has contributed to your ability to lead a functional life as a survivor of CSA?
9. How do you feel your needs are being met as a survivor living in today’s society?

“As we conclude our interview: “

1. What do you think I should have asked about that I did not ask about?
2. What questions do you have about the current study?
3. What advice do you have for my future research with survivors of CSA?

"This concludes our interview. Thank you very much for your time and efforts. I appreciate your contribution to education on CSA and survivors."

Appendix B-Invitation to Participate

Resilience in Women Survivors of Childhood Sexual Abuse: Examining the Sexual Self-Concept

Invitation to Participate

We are asking for your help with a research study about resilience in women survivors of childhood sexual abuse (CSA) and their experience of sexuality. Women between the ages of 18 and 55 are invited to participate.

- *What is the topic of the research?* This study is being done because I would like to focus on the positive aspects of recovery for women who have experienced childhood sexual abuse. I would like to provide women with an opportunity for their voices to be heard regarding their process of creating a successful life after the abuse experience.

- *Who will be included?* This study includes females between 18 and 55 years of age who have a history of CSA, who self-identify as resilient, who have an abuse experience that lasted at least a year and happened more than five times, and who are involved in an intimate sexual relationship with a partner.

- *What are participants asked to do?* You will be asked to discuss the process of resilience that you have experienced. The focus of the questions in the interview will be the positive aspects of the aftermath of abuse.

- *Why should I do this*? This study will allow me to understand your personal perspectives and will provide a wealth of insight and knowledge to be given to the to professionals who work with women survivors, other women, as well as scholars who study resilience. The information that is based on your lived experience as a survivor provides a wonderful opportunity to explore implications for future research as well. Not only will you provide information regarding your experience of resilience and sexuality, you also can identify topics related to issues with survivors for researchers to explore further.

- *What will happen to the information*? The things we learn from the study will be reported to participants in the study, to other general audiences, and to professionals like therapists, counselors and medical personnel who are interested in this topic. No names or information that would identify you will be included in the reports.

Questions? Contact Kimmery Newsom, MS, Researcher, School of Family Studies and Human Services, Kansas State University, (785) 532-5510, kcn5555@k-state.edu or Dr. Karen Myers-Bowman, project director, School of Family Studies and Human Services, Kansas State University, Manhattan, KS, (785) 532-1491, karensm@k-state.edu.

Appendix C-Screening Questions

1. What is your age?
2. Were you been sexually abused as a child?
3. How often did you experience sexual abuse as a child and over what time period?
4. Do you consider yourself to be resilient?

Appendix D-Informed Consent

Resilience in Women Survivors of Childhood Sexual Abuse:

Examining the Sexual Self-Concept

Researcher: Kimmery Newsom, MS, PhD Candidate

Project Director: Dr. Karen Myers-Bowman

You are being invited to participate in a research study. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

Explanation of Study

This study is being done because I would like to focus on the positive aspects of recovery for women who have experienced childhood sexual abuse. I would like to provide women an opportunity to have their voices to be heard regarding their process of creating a successful and functional life after the abuse experience.

If you agree to participate, you will talk to an interviewer about your experiences with resilience. The interview will be audio recorded. The interview will last about an hour to one-and-a-hours.

To participate in this study, you must:

- be a female between 18 and 55 years of age,
- have a history of child sexual abuse,
- identify yourself as resilient,
- have had an abuse experience that lasted at least a year and happened more than five times,
- be involved in an intimate sexual relationship with a partner.

Risks and Discomforts

You might feel discomfort with one or more topics brought up in this discussion. But you may refuse to answer any questions and are free to withdraw from the study at any time. A list of providers for additional follow-up care will be provided for future reference.

Benefits

This study will allow me to understand your personal perspectives and will provide a wealth of insight and knowledge to professionals who work with women survivors, other women, as well as scholars who study resilience. The information that is based on your lived experience as a survivor provides a wonderful avenue to explore implications for future research as well. Not only will you provide information regarding your experience of resilience and sexuality, you also can identify topics related to issues with survivors to explore further.

Individually, you may benefit because you will have the opportunity to speak as freely as you would like about the impact of the abuse experience and how you have come to be resilient.

Confidentiality and Records

The information you provide for this study will be kept confidential. Audiotapes of the discussion will be locked in a cabinet in the researcher's office. When the audiotapes are transcribed, no information that identifies you will be included in the transcripts. Pseudonyms (made-up names) will be used to identify individual participants in the transcripts. After the audiotapes are transcribed, the tapes will be destroyed.

Contact Information

If you have any questions regarding this study, please contact Kimmery Newsom, MS, researcher, Kansas State University, kcn5555@k-state.edu, (785) 532-5510 or Dr. Karen Myers-Bowman, project director, Kansas State University, karensm@k-state.edu, (785) 532-1491.

If you have any questions regarding your rights as a research participant, please contact Dr. Rick Scheidt, Chair, Committee on Research Involving Human Subjects, Kansas State University, (785) 532-3224.

By signing below, you are agreeing that:

- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered,
- you have been informed of potential risks and they have been explained to your satisfaction,
- you are 18 years of age or older,
- your participation in this research is completely voluntary,
- you may leave the study at any time. If you decide to stop participating in the study, there will be no penalty to you and you will not lose any benefits to which you are otherwise entitled.

Signature_____ Date_____

Researcher's Signature_____ Date_____

Appendix E-Debriefing Statement

Thank you for your participation in this study. Researchers have shown more interest in understanding the positive aspects of coping with the trauma of sexual abuse in women survivors. Some studies have shown that there are certain characteristics of women survivors who display resilience that enable them to continue to demonstrate those traits throughout their lives and in their relationships. However, most studies on the topic of sexual abuse in women focus on the negative mental and relational effects of the trauma. This particular study was designed to highlight the positive aspects of the aftermath of sexual abuse.

All of the data collected today will be kept confidential and there will no way of identifying your responses in the archive. I am not only interested in one individual's response but seek to examine patterns and themes that emerge when all the data is analyzed together.

If you have any questions about the study, or would like to receive a report of this research when it is completed, please feel free to contact Karen Myers-Bowman, PhD at (785) 532-1491 or Kimmery Newsom, MS, at (785) 532-5510.

Thank you for your time and effort concerning this project. Your participation will help expand knowledge of women survivors' experiences with resilience. If your participation in the study has caused you any emotional distress or if you would like to explore your experience further, you may contact The Family Center at (785) 532-6497, Andrews and Associates at (785) 539-5455, or Pawnee Mental Health at (785) 587-4310.

Appendix F-Demographic Questionnaire

1. What is your current age?
2. What is your highest level of education?
3. How do you earn your income?
4. What is your sexual orientation?
5. What is your relationship status?
6. How long have you been in the current relationship?
7. Do you have any children?
8. If so, how many? What are their ages?
9. If not, would you like to have children?