

**COPING BEHAVIOUR, POSTTRAUMATIC GROWTH
AND PSYCHOLOGICAL WELL-BEING IN WOMEN WHO
EXPERIENCED CHILDHOOD SEXUAL ABUSE**

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**VAAL TRIANGLE CAMPUS
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PSYCHOLOGICAL WELL-BEING IN WOMEN WHO EXPERIENCED
CHILDHOOD SEXUAL ABUSE**

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THIS STUDY IS DEDICATED TO MY PARENTS

MY FATHER, NEIL HARLEY WALKER, A REMARKABLE GENTLEMAN AND EVER-PRESENT LOVING FATHER, ALWAYS TRUE TO HIS FAMILY, A POSITIVE INSPIRATION, MENTOR AND ROLE MODEL WHO TAUGHT ME (AND STILL DOES) TO TOLERATE IMPERFECTIONS AND WORK TOWARD MY DREAMS.

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PREFACE AND DECLARATION

The article format was chosen for this study. The researcher, Hayley Janay Walker-Williams conducted the research and wrote the manuscripts. Prof C. van Eeden and Dr E. K. van der Merwe acted as promoter and co-promoter respectively. Three manuscripts have been written, and will be submitted for publication in the *Journal of Traumatic Stress* and *Journal of Child Sexual Abuse*.

MANUSCRIPT ONE: The prevalence of coping behaviour, posttraumatic growth and psychological well-being in women who experienced childhood sexual abuse
(*Journal of Traumatic Stress*)

MANUSCRIPT TWO: A qualitative understanding of the coping behaviour, posttraumatic growth and psychological well-being in women who experienced childhood sexual abuse
(*Journal of Traumatic Stress*)

MANUSCRIPT THREE: Guidelines for an intervention to enhance constructive coping behaviour, posttraumatic growth and psychological well-being in women who experienced childhood sexual abuse
(*Journal of Child Sexual Abuse*)

I declare that **COPING BEHAVIOUR, POSTTRAUMATIC GROWTH AND PSYCHOLOGICAL WELL-BEING IN WOMEN WHO EXPERIENCED CHILDHOOD SEXUAL ABUSE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

H.J. Walker-Williams (Student Number: 10837965)

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Letter of permission.

Permission is hereby granted that the following three manuscripts:

1. Prevalence of coping behaviour, posttraumatic growth and psychological well-being in women who experienced childhood sexual abuse;
2. A qualitative understanding of the coping behaviour, posttraumatic growth and psychological well-being in women who experienced childhood sexual abuse;
3. Guidelines for an intervention to enhance constructive coping behaviour, posttraumatic growth and psychological well-being in women who experienced childhood sexual abuse,

may be submitted by Hayley Walker-Williams for the purpose of obtaining a PhD-degree in Psychology. This is in accordance with academic rule A.8, and specifically rule A.8.2.b of the North-West University.

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DECLARATION

I hereby certify that the PhD dissertation of **HAYLEY JANAY WALKER-WILLIAMS** was properly language edited.

Title of dissertation:

Coping Behaviour, Posttraumatic Growth and Psychological Well-Being in Women who Experienced Childhood Sexual Abuse



JACKIE VILJOEN
Strand
South Africa
03 May 2012

ABSTRACT

The high prevalence of sexual abuse suffered by women as children is well documented, both internationally and in South Africa. The life outcomes of women who had experienced childhood sexual abuse are generally reported as adverse, yet some of these survivors manage to overcome the abusive relationship and experience positive changes in themselves and their lives. Emerging trauma literature thus supports a philosophical shift from a pathogenic to a salutogenic paradigm in which the focus is on positive and adaptive post trauma outcomes. Previous trauma models, which were based on a pathogenic model, are now shifting to a positive psychology trend by incorporating a salutary component, which includes a spiritual and existential dimension as well as an area of potential emerging growth. Information on the constructive coping behaviours, posttraumatic growth and psychological well-being of women who had experienced childhood sexual abuse can lead to the formulation of guidelines with strategies for an intervention programme that can facilitate and enhance coping, posttraumatic growth and psychological well-being in survivors of childhood sexual abuse. This research investigated the coping behaviours, posttraumatic growth and psychological well-being of women who had experienced childhood sexual abuse. The research was carried out in South Africa in the greater Gauteng Province and surrounding areas, with women who had experienced sexual abuse in childhood. A mixed method research design was used in which: the first phase was quantitative research conducted with validated psychometric instruments measuring coping behaviour, posttraumatic growth and psychological well-being. These instruments were the COPE (Coping Self-efficacy Scale), the Posttraumatic Growth Inventory, the Mental Health Continuum, Rosenberg's Self-esteem Scale and the General Health Questionnaire. The second phase was of a qualitative nature, and explored the stories and experiences of women identified as coping constructively, manifesting posttraumatic growth and psychological well-being, by using semi-structured interviews. Lastly, the data obtained was used to formulate guidelines with specific strategies, which can be used by helping professionals in a group context to facilitate and enhance constructive coping, posttraumatic growth and psychological well-being in survivors of childhood sexual abuse.

The results of this research were as follows: prevalence of constructive coping, posttraumatic growth and psychological well-being was determined, and indicated that 58% of participants manifested constructive coping, 60% manifested posttraumatic growth and 42% manifested psychological well-being. Semi-structured interviews conducted with the women scoring in the upper range of coping constructively, growing after the trauma and emerging psychologically well were transcribed and analysed by means of interpretative phenomenological analysis, and the following broad themes emerged: psycho-socio spiritual resources, the healing process and positive strengths. These themes and sub-themes produced data which could be used in the formulation of guidelines with strategies for an intervention programme aimed at enhancing and facilitating constructive coping, posttraumatic growth and psychological well-being thereby improving the therapeutic services available to childhood sexual abuse survivors. Finally the study was evaluated and conclusions and recommendations were made.

Key words: Coping, posttraumatic growth, psychological well-being, positive psychology, intervention programme, guidelines, strategies

OPSOMMING

Die hoë voorkoms van seksuele misbruik van vroue en kinders is goed gedokumenteer in Suid-Afrika en wêreldwyd. Die lewensuitkomst van vroue wat seksuele misbruik as kind ervaar het, word oor die algemeen as negatief gerapporteer en tog slaag sommige vroue daarin om die seksuele misbruik te oorwin en om positiewe veranderinge in hulself en hul lewens te ervaar. Opkomende traumaliteratuur ondersteun dus 'n filosofiese verskuiwing van 'n patogeniese na 'n salutogeniese paradigma waarin gefokus word op positiewe en aanpassende uitkomst ná posttrauma uitkomst. Traumamodelle wat voorheen op 'n patogene model gebaseer was vertoon deesdae 'n positiewe sielkundetendens wat 'n salutogene komponent met geestelike en eksistensiële dimensies asook van potensiële groei insluit. Inligting met betrekking tot konstruktiewe coping-gedrag, posttraumatische groei en psigologiese welstand by vroue wat as kinders seksuele misbruik ervaar het, kan lei tot die formulering van riglyne en strategieë vir 'n intervensieprogram om die coping, posttraumatische groei en psigologiese welstand van die wat seksuele misbruik oorwin het, te verhoog. Hierdie navorsing het die coping-gedrag, posttraumatische groei en psigologiese welstand van vroue wat as kinders seksuele misbruik ervaar het, ondersoek. Die navorsing is in die Gauteng Provinsie en omliggende streke in Suid-Afrika gedoen, met vroue wat as kinders seksuele misbruik ervaar het. 'n Gemengdemetode-navorsingsontwerp is gebruik waarin die eerste fase as kwantitatiewe navorsing gedoen is met gevalideerde psigometriese instrumente vir coping, posttraumatische groei en psigologiese welstand, naamlik die COPE (Coping Self-efficacy-skaal), die Posttraumatic Growth Inventory, die Mental Health Continuum, Rosenberg se Self-esteem Scale en die General Health Questionnaire. Die tweede fase was kwalitatief, en het die stories en ervarings van vroue by wie konstruktiewe coping-gedrag, posttraumatische groei en psigologiese welstand geïdentifiseer is, deur middel van semigestruktureerde onderhoude verken. Laastens is die data wat verkry is, gebruik om riglyne en spesifieke strategieë te formuleer vir gebruik deur hulpverlenende professionele persone om in groepverband die konstruktiewe coping-gedrag, posttraumatische groei en psigologiese welstand van slagoffers van kinder- seksuele misbruik te verhoog. Die resultate van hierdie navorsing het sekere aspekte aan die lig

gebring. Dit het ingesluit: voorkoms van konstruktiewe coping-gedrag, posttraumatiese groei en psigologiese welstand is bepaal en het aangetoon dat 58% deelnemers konstruktiewe coping-gedrag vertoon het, 60% posttraumatiese groei en 42% psigologiese welstand. Semigestruktureerde onderhoude wat met vroue wat hoë tellings vir konstruktiewe coping-gedrag, groei ná die trauma en psigologiese welstand behaal het, gevoer is, is getranskribeer en deur middel van interpretatiewe fenomenologiese analise geanaliseer en die volgende breë temas het voorgekom: psigososiale spirituele hulpbronne, die helingsproses en positiewe sterktes. Die temas en subtemas het bruikbare data verskaf waarmee riglyne en strategieë geformuleer kon word vir 'n intervensieprogram met die doel om konstruktiewe coping-gedrag, posttraumatiese groei en psigologiese welstand te fasiliteer en sodoende die terapeutiese dienste aan vroue wat kinder- seksuele misbruik oorwin het, te verhoog. Ten slote is die studie geëvalueer en gevolgtrekkings en aanbevelings is gemaak.

Sleutelwoorde: coping, posttraumatiese groei, psigologiese welstand, positiewe sielkunde, intervensieprogram, riglyne, strategieë

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SECTION ONE

OVERVIEW OF THE STUDY

OVERVIEW OF THE STUDY

Character cannot be developed in ease and quiet, only through experience of trial and suffering can the soul be strengthened, vision cleared, ambition inspired and success achieved. It is in the most trying times that our real character is shaped and revealed.

Helen Keller
(Krieger, 2002, p. 13).

In this overview of the thesis on the coping behaviour, posttraumatic growth and psychological well-being of women who had experienced childhood sexual abuse, the background and rationale that inspired the study are discussed first, followed by the problem statement, paradigmatic perspective and the research methodology. Thereafter the two phases of the study and the emerging guidelines with strategies for an intervention programme aimed at the enhancement of coping, posttraumatic growth and psychological well-being in women who had experienced childhood sexual abuse, are presented in article format, according to the criteria of the journal of choice. The thesis is concluded with a reflection and evaluation as well as a discussion of the limitations, conclusions and recommendations pertaining to the study. The overview serves as a background document (proposal) for the research, and the manuscripts serve as the research reports. It is therefore acceptable that some duplication of content may occur between the overview and the manuscripts, with the latter containing the details of the empirical research.

1.1 Background and rationale for the study

The high prevalence of physical and sexual violence and abuse suffered by women as children is well documented, both internationally and in South Africa. According to the South African Police Service docket analysis on crimes against children (South African Police Service, 2005), rape and attempted rape are two of the most prominent types of crime in South Africa. South African statistics on crimes against children for the period 2010 to 2011 report the prevalence of incidents of rape and sexual assault at 56 272

(South African Police Service, 2011). According to Spies (2006a), approximately 16 to 25% of all adult women are sexually abused as children, and in South Africa the statistics point to the fact that this percentage may even be higher.

Glazer and Frosh (1993 in Spies, 2006a), indicate that there appears to be no universal definition of child sexual abuse (CSA), although there are many *ad hoc* formulations and operational guidelines. The American Psychological Association (2001) also supports this opinion.

According to the Children's Act 38 of 2005, legislated in South Africa (Bosman-Sadie & Corrie, 2010, p. 12), sexual abuse, in relation to a child, means –

- (a) sexually molesting or assaulting a child or allowing a child to be sexually molested or assaulted;
- (b) encouraging, inducing or forcing a child to be used for the sexual gratification of another person;
- (c) using a child in or deliberately exposing a child to sexual activities or pornography; or
- (d) producing or allowing a child to be procured for commercial sexual exploitation or in any way participating or assisting in the commercial sexual exploitation of a child.

A pertinent definition proposed by Newton (2001, p. 1), defines child sexual abuse as –

... contacts or interactions between a child and an adult when the child is being used for sexual stimulation of the perpetrator or another person when the perpetrator or another person is in a position of power and control over the victim.

According to Ryan and Blum (1994) in order to define sexually abusive behaviour, we must recognise that it is not the sexual behaviour which defines sexual abuse as the behaviours are usual normal human behaviour it is instead, the nature of the relationship and interaction between the two people which defines abuse. Bosman-Sadie and Corrie (2010, p. 12) conclude that sexually abusive behaviour includes the following elements: (a) the child involved is below the age of consent and not developmentally mature enough to understand the meaning of the sexual activity; (b) the perpetrator is in a position of power and control over the child; (c) the

sexual activity leads to the gratification of the sexually mature person; (d) contact sexual abuse involves touching of the sexual areas of either the child's body or the perpetrator's body; and (e) non-contact sexual abuse may include sexy talk and voyeurism. Thus, CSA not only involves the sexual misuse but also the abuse of power that an adult has over a child.

According to Hay (1997) and Mathews (1995), sexual abuse occurs in all communities, ethnic backgrounds, religions, cultures and social and economic classes, and is experienced by both males and females, while Spies (2006a) reports that sexual abuse is a worldwide problem. According to Futa, Nash, Hansen and Garbin (2003), the extent and nature of the CSA varies from child to child. The impact of the abuse depends on a variety of factors such as the age and gender of the victim and perpetrator, the type and severity of abuse, the duration of and time since the abuse, and the family reaction following disclosure of the abuse (Berliner & Elliot, 1996; Browne & Finkelhor, 1986a; Fouché, 2007; Malinosky-Rummell & Hansen, 1993).

It is reported that the long-term effects of CSA frequently include a range of symptoms such as depression, dissociation and self-destructive behaviour, anxiety, posttraumatic stress, stigmatisation, social isolation, interpersonal problems, poor self-esteem, difficulty in trusting others, a tendency toward revictimisation, substance abuse, physical complaints and sexual maladjustment (Allen, 2008; Beitchman, Zucker, Hood, daCosta, Akman & Cassavia, 1992; Bennett & Hughes, 2000; Elhai, Gold, Mateus & Astaphan, 2001; Finkelhor & Browne, 1986; Spies, 2006b; Van Rensburg & Barnard, 2005; Vigil & Geary, 2008). Taylor and Thomas (2003) indicate the significant problems in self-esteem due to CSA. Many studies have reported on the psychological impact of CSA and there is growing concern about the implications of this for women's health in general and specifically their mental health (Saywitz, Mannarino, Berliner & Cohen, 2000). It also appears as if CSA in women is not being adequately taken into account in the management and treatment of female psychiatric patients (Wilson & Strebel, 2004). The non-detection and non-integration of experiences of sexual abuse, such as CSA, in medical and mental health services have been indicated by authors such as Campbell and

Raja (1999), Warshaw (1993) and Wilson and Strebel (2004). According to Baker (2002), sexual abuse against females is a serious problem in society and there is a need for deeper understanding of the presented problems and treatment thereof in adult survivors of childhood sexual abuse.

The impact of CSA on adult adjustment has been reported by authors such as Beitchman et al. (1992), Fergusson, Boden and Horwood (2008), Louw and Louw (2007), and Springer, Sheridan, Kuo and Carnes (2007). Hobbins (2004) states that childhood sexual abuse has a lifelong impact on its survivors and all types of childhood abuse, including CSA, seem to be strongly associated with poor psychological adjustment in adulthood (Carlin & Ward, 1992; Lucenko, Gold & Cott, 2000; Saywitz et al., 2000; Silverman, Reinherz & Giaconia, 1996). Considerable evidence indicates that many children who are sexually abused will grow up to experience difficulties as adults (Saywitz et al., 2000). Mullen and Flemming (1998), further indicate that the long-term effects of CSA should be understood as an interaction between the developmental, psychological, social and interpersonal aspects of a person.

According to Carlson and Dalenberg (2000), researchers have now begun to focus on gaining a better understanding of risk and protective factors that affect psychological adjustment in the face of sexual assault. An apparent risk factor concerns some of the methods of coping that are used to deal with the stress of a sexual assault. Banyard (2003) suggests that one potential mediator of the CSA distress link that requires further exploration is that of coping behaviour, while Hitchcock (1987) asserts that adults who were abused as children are less likely to have adequate coping skills, especially when stress levels are high. Spaccarrelli (1994), is of the opinion that the impact of CSA on adult well-being could be mediated by the cognitive appraisal (e.g. self-blame) and coping behaviour (e.g. avoidance) used, therefore Newman, Kaloupek and Keane (1996) emphasise that when working with CSA trauma survivors it is important to assess an individual's symptoms, as well as life context, coping skills, beliefs, strengths and weaknesses.

It appears however, that relatively little research has been conducted on how victims who experienced CSA cope in adulthood. Much is documented on the potential long-term consequences of CSA, but relatively little is known about the coping strategies victims use to deal with the experience and memories of the abuse. Research has not specifically explored whether or not abuse influences a survivor's coping styles for unrelated current stressors, thus the identification of coping strategies used by abuse survivors may contribute to a better understanding of factors that facilitate or interfere with adaptive functioning (Futa et al., 2003).

Over the last few years, Linley and Joseph (2003, p. 135) began to turn their attention to the question "Why is it that some people are able to grow and thrive as a result of a traumatic experience, achieving a higher level of functioning and self-actualisation than they enjoyed before the trauma?" According to Linley (2003), such positive adjustments can underpin a whole new way of living that embraces the central tenets of positive psychology, namely that people may change their life philosophy; learn to appreciate each day to the full (i.e. positive subjective experience); realise that their life is finite, or believe themselves to be wiser or act more altruistically; have a greater sense of personal resilience and strength, linked with a greater acceptance of their vulnerabilities and limitations (i.e. positive individual characteristics); dedicate their energies to social renewal (i.e. positive communities) or report that their relationships are enhanced in some way (i.e. positive social relationships) (Tedeschi, Park,& Calhoun, 1998).

According to Harvey (2001), trauma survivors embrace this positive approach to life within a context of tragic hopefulness. They have experienced firsthand the limits of human life and this transforms into the awareness that the trauma can be seen as a valuable learning opportunity. Linley and Joseph (2003) further report that people who report more growth in the aftermath of trauma, later manifest better long-term adjustment. An awareness of the potential for positive change following trauma provides a potentially rich theme for therapists to consider in their work with traumatised people. The authors mentioned, further believe that post-traumatic growth harnesses the core principles of positive psychology such as strength, resilience, hope, gratitude and

forgiveness and that these principles can be put to effective use in the therapeutic service of trauma survivors (Linley & Joseph, 2003; Joseph & Linley, 2005).

Previous research appears to have focused primarily on the adverse effects that occur as a result of sexual traumatisation (Sher, 2002). The relevant literature available on survivors of CSA is primarily from a pathogenic perspective and reports on the adverse effects that a trauma may have had on an individual (Bennett & Hughes, 2000). However, according to Tedeschi and Calhoun (1995), suffering can often yield strengthening and growth. These authors have coined the term “posttraumatic growth” and refer to this concept when reporting positive changes in individuals that occur as the result of attempts to cope in the aftermath of traumatic life events. The empirical literature focused specifically on posttraumatic growth is rather recent and still relatively small (Tedeschi & Calhoun, 2004a).

This raises the question whether the life outcomes of CSA survivors are generally only adverse, or whether survivors have managed to overcome the abusive relationship experiences and through posttraumatic growth been able to “survive and prevail” (Tedeschi & Calhoun, 2004a, p. 406) and even experience health, well-being and overall satisfaction with life. In other words, can women who have had CSA experiences, cope positively and experience psychological well-being in adulthood? Seen from a psychopathogenic perspective, victims of CSA experience numerous interpersonal problems and maladaptive behaviours that could impede their productivity and quality of life (Putnam & Trickett, 1993). Sexual trauma in childhood seems predictive of poorer psychosocial functioning in adulthood, including poorer role functioning, fewer psychological resources to sustain intimacy, higher levels of emotional instability and turmoil. All of this eventually compromises the ability of these individuals to have the quality of life they desire (Lysaker, Meyer, Evans, Clements & Marks, 2001). However, the positive psychology framework that is currently winning favour in the research and practice domains of psychology would question the assumed adverse outcome of CSA and allow for open strengths and growth-related outcomes such as the experience of

psychological well-being, with manifestations of self-esteem, coping self-efficacy, flourishing and general health.

1.2 Problem statement

The purpose of this study was therefore to investigate the coping behaviour, posttraumatic growth and psychological well-being of adult women who have experienced CSA, and to explore these constructs with the aim of developing an intervention programme aimed at enhancing positive coping, posttraumatic growth and psychological well-being in women who have had such experiences. The intention of the study was to build on existing psychological perspectives related to the effects of CSA, in order to provide developmental recommendations and strategies for an in-depth and thorough positive psychological intervention programme for therapeutic use.

Prompted by the above problem statement, the researcher formulated the following research questions:

- What are the coping behaviours of women who experienced CSA, do they experience posttraumatic growth and how do these factors influence their psychological well-being in adulthood?
- What enabled these women to cope optimally or positively, grow through this experience, and to function in a psychologically healthy manner?
- What should be included in an intervention programme aimed at enhancing female survivors of CSA's positive coping behaviour, their posttraumatic growth and their overall psychological well-being in adulthood?

1.3 Research objectives

Based on the above-mentioned research questions, the following objectives are identified:

- to determine what the coping behaviours of adult women survivors of CSA are, whether they manifest posttraumatic growth and what their levels of psychological well-being are – quantitative study;

- to explore what the coping behaviours of adult women survivors of CSA are, whether they have grown after the trauma and what their psychological well-being experiences are – a narrative to explore what enabled these women to survive and thrive – qualitative study; and
- to construct an intervention programme aimed at enhancing the positive coping behaviour, posttraumatic growth and psychological well-being of female survivors of CSA in adulthood.

1.4 Central theoretical argument

The investigation of the coping behaviour, posttraumatic growth and psychological well-being of women who had experienced CSA lead to the identification of women who, despite having been sexually abused as children, displayed positive coping, posttraumatic growth and overall psychological well-being in adulthood. After analysing the stories of such women, characteristics, strengths and other contributing protective factors were identified, to facilitate a thorough understanding of the nature of overcoming CSA and the resultant sound functioning in adulthood. From these findings, guidelines with strategies for interventions were deducted to facilitate and enhance coping, posttraumatic growth and psychological well-being of women who had experienced CSA.

1.5 Paradigmatic perspective

The researcher agrees that no research can be seen as free of values and therefore in this section, the paradigms which guided this study are discussed.

According to Nieuwenhuis (2009, p. 47), “a paradigm is a set of assumptions or beliefs about fundamental aspects of reality which gives rise to a particular world-view” – it addresses fundamental assumptions of faith, such as beliefs about the nature of reality (ontology), the relationships between the knower and the known (epistemology) and assumptions about methodologies. Therefore Lincoln and Guba (1985, p. 15 in Nieuwenhuis, 2009, p. 48) point out that “paradigms represent what we think about the

world (but cannot prove)” and thus the actions that we take as inquirers cannot occur without mention of these paradigms. In this study, the researcher focused on dynamic, holistic and individual aspects of phenomena, using multi-method research as the choice for the study. Therefore, different methods were seen as compatible and the paradigm was determined by the researcher and the research problem rather than the method (Tashakkori & Teddlie, 2003).

The paradigmatic framework of this study is based on the assumptions of positive psychology. Positive psychology no longer views human beings as passive victims of fate but instead as “individuals capable of choices, thoughts and decisions that promote the potential for mastery and resilience despite having experienced adversity” (Seligman, 2005, p. 5). My personal paradigm is important to the study as I am the primary gatherer and interpreter of the data and my assumptions, preconceived notions and values may influence the research. As the researcher, I therefore need to become aware of how these may colour the findings (Creswell, 1994). Covey (1998) states that a paradigm is an indication of how the researcher perceives, understands and interprets the world; thus, my own paradigm is aligned with the salutogenic or strengths-based approach grounded in positive psychology. I assume that individuals are capable of overcoming adversity and recognise the strength and virtue that this would entail. A paradigmatic perspective includes ontological and epistemological dimensions (meta-theoretical assumptions) and the methodological dimension, which are discussed below.

1.5.1 Ontological, epistemological and methodological dimensions

Ontology refers to the study of the nature and form of reality (that which is or can be known) (Nieuwenhuis, 2009, p. 53). According to Mouton and Marais (1996), in the context of research, the ontological dimension refers to the researcher’s beliefs about the nature, form, structure and status of phenomena and reality. Discovering “truth” as a verified and tested entity will ensure correspondence between the research account and the real-life account. The external world then becomes “real” because of how the researcher “constructs” and “experiences” it (Nieuwenhuis, 2009, p. 54). The researcher

who believes that a real, external and objective world exists that functions independently and objectively from our knowledge, works in a positivist paradigm. The positivist or modernist stance taken in the quantitative component of this research thus works from the assumption that reality is measurable, controllable and predictable, while accepting that objective and observable facts provide valuable perspectives on reality. However, a view of reality as fluid and dependent on the perspectives of the viewer is fundamental to a post-modern paradigm. Such a post-positivist or post-modern stance taken in the qualitative component of this research views reality as created, subjective and uncontrollable and it assigns value to multiple meanings rather than only one “correct” objective view of reality (Jansen, 2009, p. 22).

Epistemology refers to the view of truth and knowledge and the methods through which such knowledge can be found or created. Epistemology therefore looks at how one knows reality, the method for knowing the nature of reality, or how one comes to know reality. It assumes a relationship between the “knower and the known” (Nieuwenhuis, 2009, p. 55). Within the positivist paradigm, quantitative research celebrates the world of science (scientific approach) and measurable data and depicts the researcher as an “expert” seeking singularity of meaning and objectivity as truth (Jansen, 2009, p. 22). The researcher positions him- or herself outside the phenomenon. In contrast, qualitative research in the post-modernist paradigm acknowledges an interactive relationship between the researcher and the participants, as well as between the participants and their own experiences and the way they have construed reality based on these experiences (Nieuwenhuis, 2009). In qualitative research, the researcher aims to understand and construct knowledge through individual or group re-constructions centred on consensus (Guba & Lincoln, 2005). Thus, the stories, experiences and voices of the respondents are the mediums through which the researcher explores and understands (knows) reality. The emphasis is on the post-modern interpretivist approach, which is concerned with meaning and seeks to understand society’s meanings and understandings of situations. The interpretivist approach seeks to “produce research that emphasizes deep, interpretive understanding of social phenomena” (Henning, Van Rensburg & Smit, 2005, p. 20).

The ontological perspective of the researcher informed her epistemological perspectives in this multi-methods study. The researcher positioned herself within post-modernism where she accepted a “both ... and” synthesis. Thus, the so-called objective quantitative data was sought and combined with qualitative data to create a rich and deep description of the experiences of women who had experienced CSA. The researcher saw the participants as the experts of the phenomenon under investigation, namely coping with and after CSA, posttraumatic growth and psychological well-being (Hofer & Pintrich, 2002).

A visual picture or design map of the philosophical framework is presented in Figure 1.1.

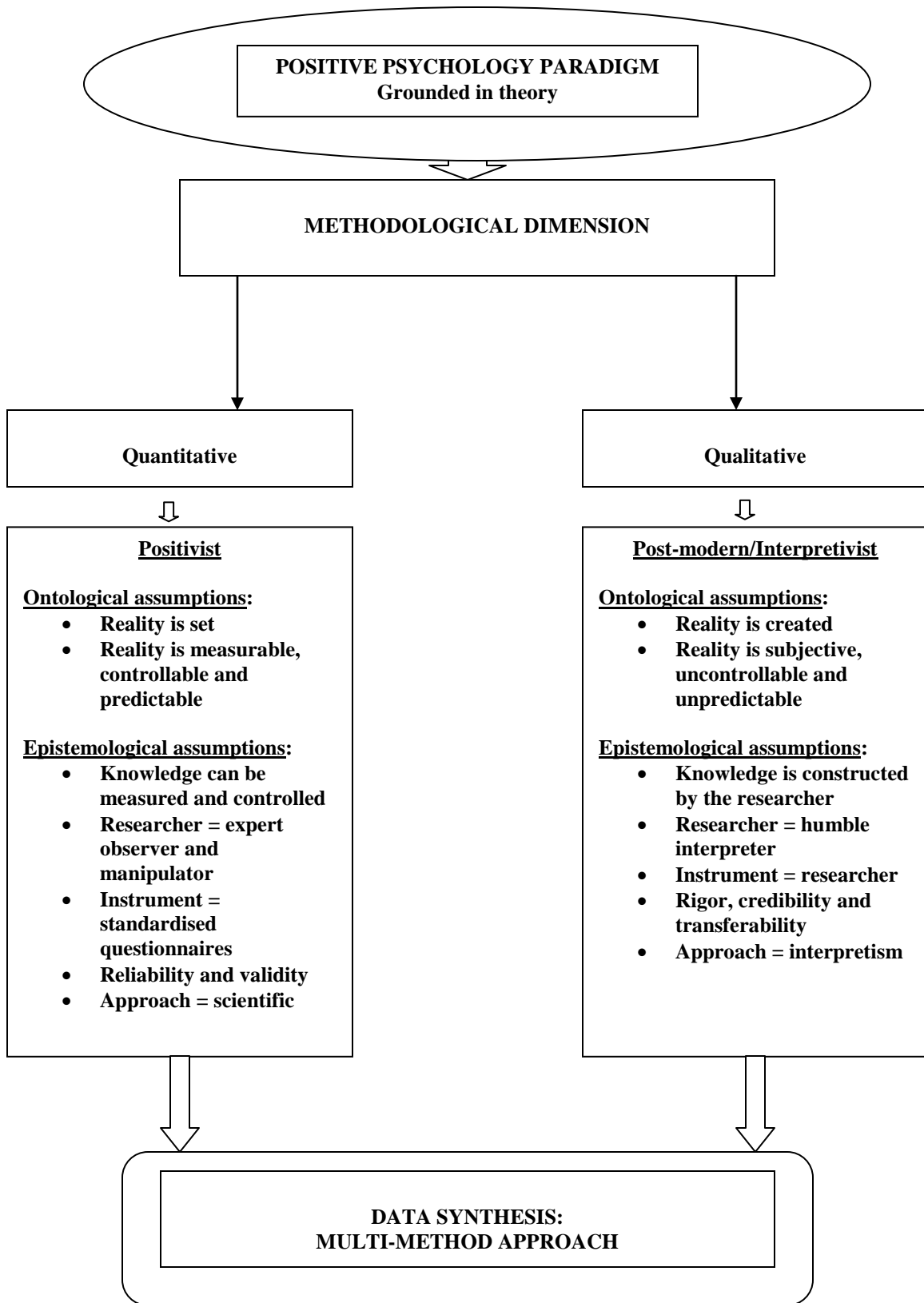


Figure 1.1: Philosophical paradigm

1.6 Literature review

A literature review was conducted to ground the research. The following themes were investigated: childhood sexual abuse (CSA), coping with childhood sexual abuse, posttraumatic growth and psychological well-being, and these will be discussed extensively in what follows. These themes are illustrated in Figure 1.2 below:

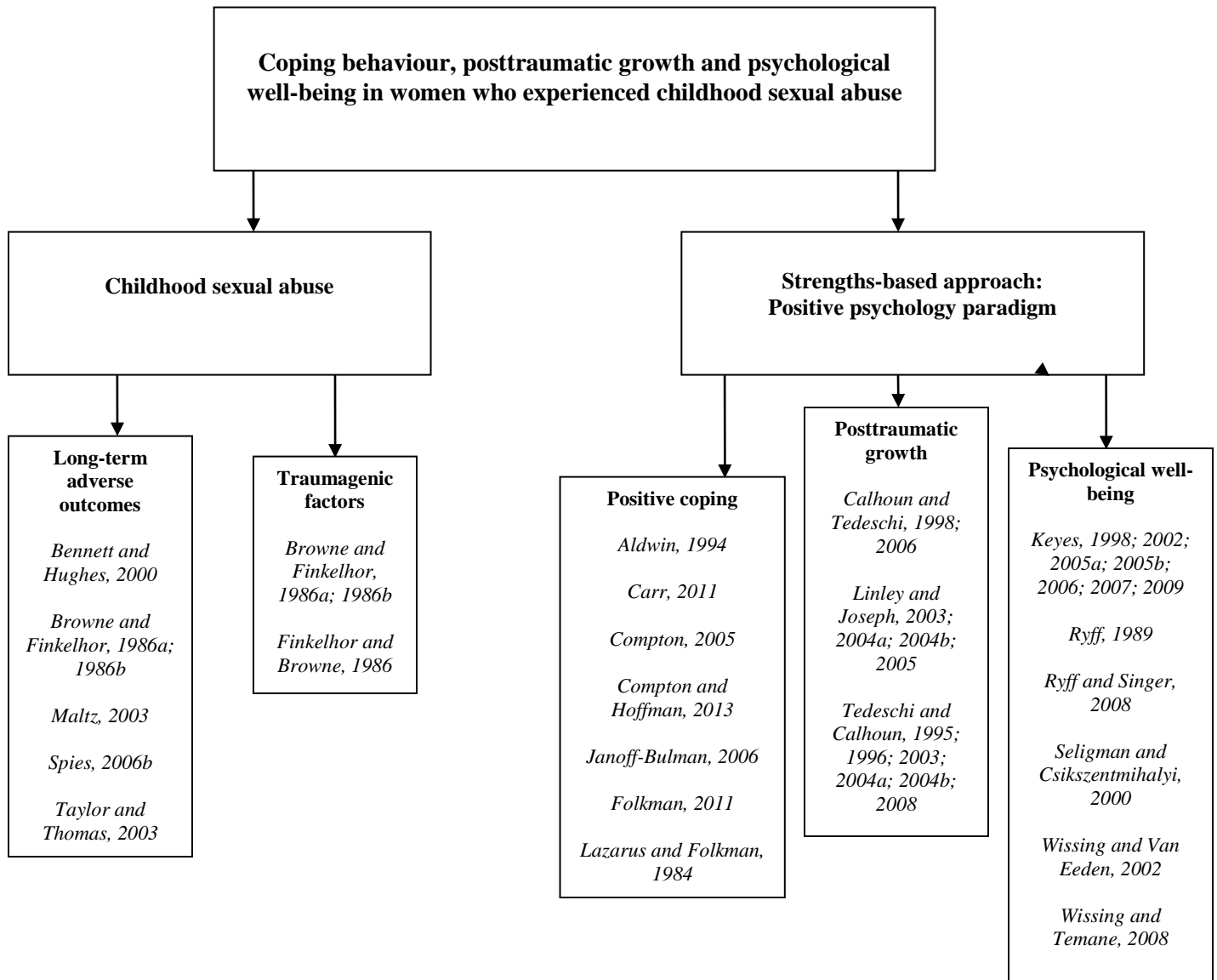


Figure 1.2: Literature review

1.6.1 Childhood sexual abuse

The sexual abuse of children is sadly as universal and as old as the human race itself, and the majority of which appears to occur within the family setting, the very environment in which a child should expect to be protected, nurtured, loved and most importantly, able to feel safe (Taylor & Thomas, 2003). Louw and Louw (2007, p. 363) define such sexual abuse as “any illegal sexual act which is committed against a child”. It can include rape, fondling of the genitals or breasts, sodomy, exhibitionism, exposing the child to indecent acts and using a child in the production of pornography. Spies (2006a) explains that childhood sexual abuse is the betrayal of trust by someone who has power over the child. South African children are victims of all types of sexual abuse (Richter & Higson-Smith, 2004) and of particular concern is the numbers of children who are raped in South Africa each year of which more than 15% involve children under 11 years while approximately 40% involve children under the age of 17 years (ISPCAN, 2004 in Louw & Louw, 2007). While girls are sexually abused more often, boys also become victims and in more than 80% of all cases, the perpetrators are known to the child (Louw & Louw, 2007). For the purpose of this research, CSA was considered to be the use of a child for any form of sexual activity or behaviour by an adult or adolescent. The focus in this study was on females who had been sexually abused as children. Restricting this study to females, in no way implies that the sexual abuse of males is any less significant nor deserves any less focus or attention.

Types of sexual behaviour can refer to non-contact abuse, which for the most part refers to two types of experiences. Firstly, it refers to encounters with exhibitionists, and secondly, to the solicitation to engage in sexual activity, where no physical contact occurs, for example pornography. The term “contact abuse” refers to all behaviours that do involve sexual contact, including fondling of breasts and genitals, intercourse and oral or anal sex (Peters, Wyatt & Finkelhor, 1986, p. 23). The impact of sexual abuse varies according to several factors, for example the nature, frequency and duration of the abuse and the relationship with the abuser. The reaction of significant others, especially the mother, may also have an influence, and the more distressed the reaction, the worse the

symptoms of the child tend to be (Louw & Louw, 2007). Despite the factors involved, the long-term effects on female survivors of CSA are mostly vast and devastating.

1.6.1.1 Long-term effects of childhood sexual abuse

According to Spies (2006a), the long-term effects of CSA can be so pervasive that it is sometimes hard to pinpoint exactly how the abuse affects a person. It permeates everything, including the sense of self, intimate relationships, sexuality, parenting, work life and even a person's sanity. Bass and Davis (1988, p. 37) explain that when children are sexually abused, their natural capacity of psychosexual development is stolen.

You were introduced to sex on an adult's timetable, according to an adult's needs. You never had a chance to explore naturally, to experience your own desires from the inside. Sexual arousal became linked to feelings of shame, disgust, pain and humiliation.

The long-lasting and often permanent damaging effects of sexual abuse on the affective, cognitive, behavioural, and physiological development of victims are well documented in research literature (Taylor & Thomas, 2003). Depending on the specific nature of the sexual abuse, the duration, the frequency and the time during the child's development, a host of dysfunctional symptoms can result, and incestuous sexual abuse is often seen as the most destructive in this regard. Distortions in attachment that result from childhood sexual abuse (CSA) can have toxic effects in all future relationships and especially so in the areas of self-esteem and the ability to form intimate relationships, to trust and to bond (Taylor & Thomas, 2003). CSA is associated with an increased risk for a myriad of dysfunctional psychological consequences in adulthood:

Emotional reactions and self-perceptions

The depressive and self-destructive tendencies among victims of sexual abuse appear well established. Depression is the symptom most commonly reported among adults molested as children and empirical findings seem to confirm this. Heim, Newport, Heit, Graham, Wilcox, Bonsall, Miller, and Nemeroff (2000), in a community study in the

United States, concluded that women who were abused as children were more likely to have been hospitalised for depression than were non-victims. Heim et al. (2000) further state that CSA leads to more reactive endocrine and autonomic nervous systems and that a combination of abuse and depression makes the body hyper-reactive to all stress. These chronic stress reactions exhaust the body and thus women who were abused as children are apparently carrying a historic burden of stress reactions that make all current burdens more unbearable. Furthermore, both clinical and non-clinical samples have shown victims of CSA to be more self-destructive. A high incidence of suicide attempts among victims of CSA can be found in the literature as well as an association between CSA and suicidal ideation or deliberate attempts at self-harm (Spies, 2006b).

Somatic disturbances and dissociation

Children initially learn about themselves and the world through their bodies. It is therefore ironic but not surprising that symptoms of the adverse consequences of CSA would also be manifested in bodily experiences. Briere (1984 in Browne & Finkelhor, 1986b) reports that 54% of the CSA victims in his adult clinical sample experienced anxiety attacks, 54% had nightmares and 72% had difficulty sleeping. Another somatic outcome connected with sexual abuse in the literature is the development of eating disorders (Spies, 2006a; Swanston, Plunkett, O'Toole, Shrimpton, Parkinson & Oates, 2003). Sexual abuse victims also disproportionately report symptoms of dissociation, as well as out-of-body experiences and feelings that things are unreal. Spies (2006b) hypothesised that dissociation could be a strategy that victims use to escape from the unpleasant sensations of the abuse experience and that this later becomes an autonomous symptom. All the problems survivors experience with their bodies, like splitting, numbing addiction and self-mutilation, begin as attempts to survive the CSA (Janikowski & Glover-Graf, 2003; Swanston et al., 2003).

Effects on self-esteem and personal power

When an adult has been sexually abused as a child their personal boundaries, right to say no, as well as their sense of control in the world, are all violated. As a result, adult survivors may experience the same sense of powerlessness in adulthood as in childhood,

believing that they have no right to make decisions about personal boundaries. Goodrich (2005) indicates that the effect of sexual abuse is so severe that survivors believe that their offender's power will last forever; hence, their ever-present fear of losing control and of a reoccurrence of the abuse. According to Spies (2006b), CSA victims continue to feel isolated and stigmatised as adults and often report feelings of isolation, and with incest even more so. Women with very poor self-esteem are nearly four times as likely to report a history of CSA, and Swanston et al. (2003) found that the effect of CSA can be less damaging to the self-esteem of adult survivors if the victim received effective therapy immediately after the disclosure of the sexual abuse, which very seldom happens.

Impact on interpersonal relating

Women who have been sexually abused as children report a variety of interpersonal problems such as difficulty in relating to both women and especially men, conflicts with their parents and discomfort responding to their own children. Incest victims seem especially likely to experience difficulty in close relationships and often display fear of their husbands or sex partners and of marital commitment (Spies, 2006b). CSA also affects later parenting where such mothers at times maintain emotional and physical distance from their children because closeness and affection are tainted with a sexual meaning. Another serious long-term effect is the apparent vulnerability of women who have been sexually abused as children to being revictimised later in life. Fromuth (1983) found that women who had been sexually abused before the age of 13 years were especially likely to become victims of non-consensual sexual experiences again. Sexual abuse victims are vulnerable to later sexual assault and in particular, rape victims of CSA seem more likely to be abused by husbands or other adult partners (Spies, 2006b).

Effects on sexuality

One of the areas of the long-term effect of CSA receiving most attention in literature concerns the impact of early sexual abuse on later sexual functioning. According to Spies (2006a), sexuality is the most intimate, private aspect of who we are and is strongly influenced by and subject to our self-esteem and capacity for intimacy with a partner. Almost all clinically based studies show later sexual problems among CSA victims and

particularly among the victims of incest (Maltz, 2003; Spies, 2006a). Maltz (2003) reports that CSA victims were sexually anxious, experienced sexual guilt and reported dissatisfaction with their sexual relationship. Women who had been sexually abused as children also reported difficulties with sexual adjustment as adults as well as a decreased sex drive, the inability to relax and enjoy sexual activity, an avoidance or abstention from sex or conversely a compulsive desire for sex. Spies (2006b) found that adult survivors may enter homosexual relationships as a way of experiencing the nurturing and acceptance that they did not receive as children, as it is sometimes safer for them to connect with people who do not represent the sex of the perpetrator.

Effects on social functioning

Some studies suggest a connection between CSA and substance abuse (Sartor, Duncan, McCutcheon & Argrawal, 2008). According to Simpson and Miller (2002), the rate of CSA among females seeking treatment for substance use problems is twice that of women in the general population. A history of CSA has also been associated with earlier age onset of alcohol use and greater alcohol-related problems among individuals using detoxification services (Sartor et al., 2008).

In the above paragraphs, CSA and its long-term effects were described: A framework for understanding the traumatic nature of CSA will be discussed next.

1.6.1.2 Traumagenic dynamics of childhood sexual abuse

As early as 1986, Finkelhor and Browne proposed a framework in order to systematically understand the effects of sexual abuse. To date, this model has not been substituted and it therefore continues to guide the literature and is incorporated in many recent sources for example, Alao and Molojwane (2008), Scheepers (2006) and Fouché (2007). In this conceptual model, Finkelhor and Browne (1986, p. 180) propose that the experience of CSA can be analysed in terms of four trauma-causing factors, called “traumagenic dynamics”. These dynamics include traumatic sexualisation, stigmatisation, betrayal and powerlessness. These traumagenic dynamics are generalised dynamics, but the

conjunction of the four dynamics in one set of circumstances are what makes the trauma of child sexual abuse unique and different from other childhood traumas. “These dynamics, when present, alter the child’s cognitive and emotional orientation to the world, and create trauma by distorting a child’s self-concept, world view, and affective capacities” (Finkelhor & Browne, 1986, p.180). For example, the dynamic of stigmatisation distorts a child’s sense of their own value and worth, while the dynamic of powerlessness distorts the child’s sense of their ability to control their lives. When victims attempt to cope with the world through these distorted lenses (in childhood and later as adults), it results in a myriad of dysfunctional symptoms and problems on a cognitive, affective, behavioural, physical, sexual and interpersonal or social level (Finkelhor & Browne, 1986; Taylor & Thomas, 2003). The four dynamics are described in more detail in the paragraphs that follow.

Traumatic sexualisation

Traumatic sexualisation refers to a process in which a child’s sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse. This can happen in a variety of ways in the course of the abuse: it can occur while a child is repeatedly rewarded for sexual behaviour; through the exchange of affection, attention, privileges and gifts for sexual behaviour, so that the child then learns that sexual behaviour can be used as a strategy for manipulating others; and it can occur when very frightening memories and events become associated in the child’s mind with sexual activity. Sexual abuse activities can vary dramatically in terms of the amount and kind of traumatic sexualisation they provoke, as well as the degree of understanding the child forms regarding sexual activity (Fouché, 2007; Scheepers, 2006). Finkelhor and Browne (1986, p. 182) explain, “children who have been traumatically sexualised emerge from their experiences with inappropriate repertoires of sexual behaviour, with confusions and misconceptions about their sexual self-concepts, and with unusual emotional associations to sexual activities.”

Betrayal

Betrayal refers to the dynamic by which children discover that someone on whom they are vitally dependent or whom they trusted, has caused them harm. This may occur in a variety of ways in a molestation experience. For example, children may come to the realisation that a trusted person has manipulated them through lies or misrepresentations about moral standards, or that someone whom they loved or whose affection was important to them treated them with cruel disregard. Children can experience betrayal not only at the hands of the abusers, but also by family members who are not abusing them. They can, for example, experience betrayal by a family member whom they trusted but who was unable or unwilling to protect or believe them, or who has a changed attitude toward them after disclosure of the abuse. Sexual abuse experiences that are perpetrated by family members or other known and trusted persons obviously involve more potential for betrayal than those involving strangers, and this also implies how “tricked” the child feels by the perpetrator (Finkelhor & Browne, 1986, p. 183). The family’s response to the child’s disclosure will determine the degree of betrayal experienced by the child and children who are disbelieved and blamed will experience a greater sense of betrayal than those who are supported by their families (Finkelhor & Browne, 1986).

Powerlessness

Powerlessness or what is also called disempowerment is the “dynamic of rendering the victim powerless”. This refers to the process in which the child’s willpower, needs and sense of efficacy are continually disregarded (Finkelhor & Browne, 1986, p. 183). Powerlessness occurs in sexual abuse when a child’s boundaries and body space are repeatedly invaded against the child’s will through coercion and manipulation. Any kind of situation in which a child feels trapped, even if only by the realisation of the consequences of disclosure (being punished or not believed), can create a sense of powerlessness (Finkelhor & Browne, 1986).

Stigmatisation

Stigmatisation, the final dynamic, refers to the negative connotations and associations (for example, being bad, shame and guilt) that are communicated to the child about the

experiences and that then become internalised into the child's self-image. These negative meanings are communicated in many ways. They can come directly from the abuser, who may blame the victim for the activity, belittle the victim or convey a sense of shame about the behaviour. When there is pressure for secrecy from the offender this can also convey powerful messages of shame and guilt (Scheepers, 2006). Stigmatisation is mostly reinforced by attitudes that the victim infers or hears about from other persons in the family or community, and it is most certainly reinforced if, after disclosure, people react with shock or disbelief or blame the child for what has transpired. The child may be additionally stigmatised by people in their environment who now label them with other negative characteristics as a result of the sexual abuse. Stigmatisation occurs in various degrees in different abusive situations. Most children have to deal with powerful religious and cultural taboos. Keeping the secret of having been a sexual abuse victim appears to increase this sense of stigma as it reinforces the sense of being different (Finkelhor & Browne, 1986).

According to Finkelhor and Browne (1986), these four traumagenic dynamics account for the main sources of trauma in CSA. Most of the outcomes with regard to the behavioural and emotional problems which relate to a history of sexual abuse, as cited in the literature and confirmed by empirical studies, appear to be conveniently categorised according to one or two of these dynamics as illustrated in Figure 1.3.

<p>(1) TRAUMATIC SEXUALISATION</p> <p>Psychological impact</p> <ul style="list-style-type: none"> • Increased salience of sexual issues • Confusion about sexual identity and sexual norms • Confusion of sex with love and care-giving • Negative associations with sexual activities and arousal sensations • Aversion to sex or intimacy <p>Behavioural manifestations</p> <ul style="list-style-type: none"> • Sexual preoccupation • Promiscuity • Sexual dysfunctions • Phobic reactions to sexual intimacy 	<p>(2) STIGMATISATION</p> <p>Psychological impact</p> <ul style="list-style-type: none"> • Guilt and shame • Lowered self-esteem • Sense of being different from others <p>Behavioural manifestations</p> <ul style="list-style-type: none"> • Isolation • Drug or alcohol abuse • Criminal involvement • Self-mutilation and suicide
<p>(3) BETRAYAL</p> <p>Psychological impact</p> <ul style="list-style-type: none"> • Grief and depression • Extreme dependency • Mistrust especially of men • Anger and hostility <p>Behavioural manifestations</p> <ul style="list-style-type: none"> • Isolation • Clinging • Vulnerability to further abuse and exploitation • Allowing own children to be victimised • Discomfort in intimate relationships • Marital problems • Aggressive behaviour 	<p>(4) POWERLESSNESS</p> <p>Psychological impact</p> <ul style="list-style-type: none"> • Anxiety and fear • Lowered sense of self-efficacy • Perception of self as a victim • Need to control <p>Behavioural manifestations</p> <ul style="list-style-type: none"> • Nightmares • Phobias • Somatic complaints • Depression • Dissociation • Employment problems • Vulnerability to further abuse and exploitation • Becoming an abuser

Figure 1.3: Traumagenic dynamics in the impact of childhood sexual abuse
 (Adapted from Finkelhor & Browne, 1986, p. 186).

The model of the four traumagenic dynamics outlined above can be specifically used to assess the impact of sexual abuse. These dynamics are thus seen as the four links between the experience of sexual abuse and the sequelae of long-term effects that have been widely published. This concludes the discussion of CSA and the theoretical concepts and pertinent research findings related to CSA.

In Figure 1.2 above it is shown that this study departs from the positive psychological framework that studies strengths-based behaviour in women who had experienced CSA. Below, the strengths-based theoretical constructs of coping, posttraumatic growth and psychological well-being, are clarified.

1.6.2 Coping

The classic definition of coping by Lazarus and Folkman (1984) is that coping refers to a range of diverse cognitions and behaviours used to manage the internal and external demands of a stressful or threatening situation. Coping is also described as a stabilising factor, which can help individuals maintain psychosocial adaptation during stressful periods and which encompasses cognitive and behavioural efforts to reduce or eliminate stressful conditions and associated emotional distress (Zeidner & Endler, 1996). Kleinke (1998) words it differently by stating that coping can be defined as continuously changing cognitive and behavioural efforts aimed at managing specific external and internal demands, perceived as threatening or exceeding the individual's resources.

According to Holahan, Moos and Schaefer (1996), factors within the individual's environmental system (important social supports and stresses) and their personal system (such as psychological, temperamental and neurobiological traits and demographic attributes) all of which are relatively stable, influence changes in life circumstances such as life crises and transitions. All of the above factors affect health and well-being, both directly and indirectly, through cognitive appraisal and coping plus related neurobiological stress and coping processes. Stress and coping processes are sub-served by activity in the amygdala, prefrontal cortex, sympathetic nervous system and the

hypothalamic pituitary adrenal axis (Carr, 2011). Coping thus serves the central function as is seen by its position in the framework (Figure 1.4), and the bi-directional pathways indicate the possibility of reciprocal feedback occurring at any stage of the stress and coping process. This framework of coping includes dispositional and contextual models. Dispositional models put emphasis on the role of relatively stable personal factors determining the choice and effectiveness of coping strategies. In contextual models, the choice and effectiveness of coping strategies is viewed as being largely determined by the nature of the stresses with which the person has to cope and the way these are appraised (Carr, 2011).

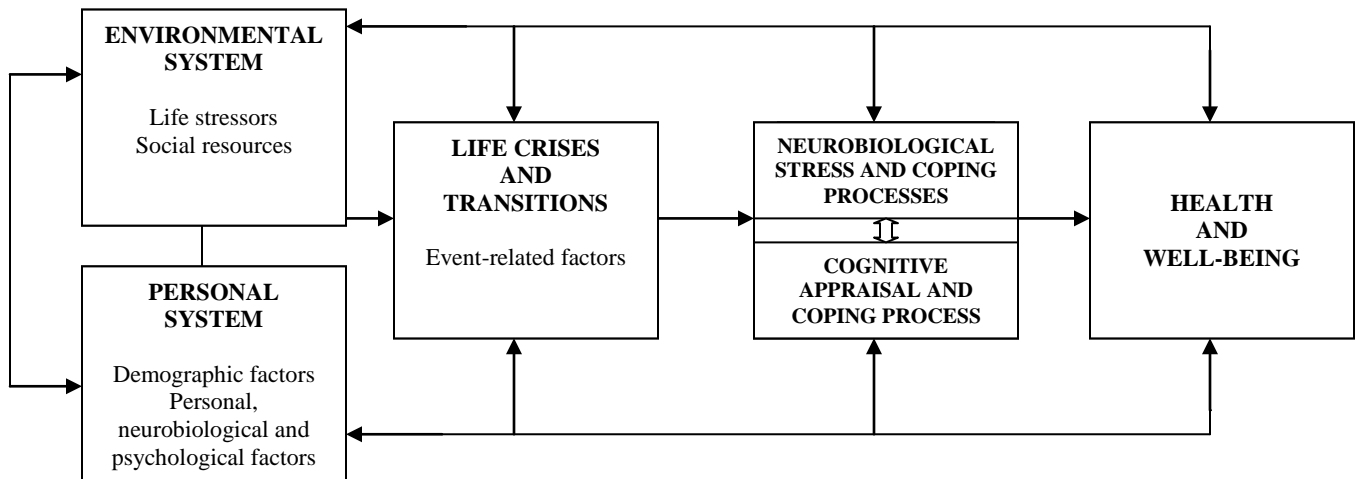


Figure 1.4: The coping process

(Adapted from Holahan et al., 1996, p. 27)

1.6.2.1 Coping strategies

Coping strategies are constructs that were developed within the cognitive-behavioural tradition to explain how we consciously manage situations in which external demands outstrip personal resources (Carr, 2011). Carr (2011) further points out that, within the stress and coping literature, many typologies of coping processes have been developed. According to Holahan and Moos (1987) coping is classified as consisting of either cognitive or behavioural responses to a specific stressor or situation. Cognitive coping strategies include attempts to change one’s perception of a situation, whereas behavioural

coping includes actions taken to reduce the effects of the stressor. For example, focusing on positive aspects of a situation would be considered a form of cognitive coping, while engaging in substance abuse or physically distancing oneself from the source of stress would be conceptualised as behavioural coping. Another common approach involves distinguishing between approach and avoidance coping (Holahan & Moos, 1987). This model suggests that coping alternates between approach (active coping), which involves attempts to integrate painful material, and avoidance (passive coping), which involves attempts to protect oneself from a threatening event. Thus, to approach allows for direct action in attempts to regulate stress whereas to avoid serves to prevent negative emotions from becoming overwhelming, by allowing distance from the trauma and so reducing stress (Roth & Cohen, 1986). Moos (1995) suggests that cognitive/behavioural and approach/avoidance coping dimensions can be considered in combination when assessing and analysing coping strategies. He proposes that the cognitive/behavioural construct reflects the “method” of coping and the approach/avoidance distinction the “focus” of coping (Moos, 1995, p. 2).

The Lazarus and Folkman (1984) transactional model of stress appraisal mentioned before, is a widely known and used model within coping research. During stress, two types of appraisal take place: primary appraisal as the extent to which the individual perceives the situation to be threatening, and then secondary appraisal, as the individual’s perception of whether or not they have the resources to deal with the stressor. This is done by using problem-focused coping, emotion-focused coping, or both (Bala, Rohloff & Van Waning, 2005). Lazarus and Folkman (1984) as well as Zeidner and Endler (1996) propose a prominent typology, which distinguishes between three main coping strategies that individuals use when faced with a stressful situation: problem-focused strategies (those in which a person attempts to change the situation that caused the stress); emotion-focused strategies (those in which a person attempts to change the negative emotions involved); and avoidant strategies (those in which a person attempts to avoid the problem).

According to Lazarus and Folkman (1984, p. 150), problem-focused coping “involves the use of realistic strategies that could make a tangible difference in the situation that causes the stress”. Problem-focused coping styles can be divided into those directed at changing the situation, also called surround-focused coping, and those directed at changing the self. Problem-focused coping directed at the self, also called inner-focused coping, often involves cognitive reappraisals. For controllable stresses, such as academic examinations or job interviews, problem-focused coping strategies, which aim to modify the source of stress directly, are more appropriate. Emotion-focused coping is directed at regulating emotional responses to problems. The goal here is to release the tension, eliminate the worry and release the anger. Emotion-focused strategies are appropriate for managing effective states associated with uncontrollable stresses, such as bereavement (Lazarus & Folkman, 1984). These authors further subdivide emotion-focused coping into cognitive and behavioural aspects. Cognitive emotion-focused coping is often involved with defensive reappraisals or ways of thinking that attempt to draw attention away from the painful elements of a situation by reinterpreting the situation. Behavioural emotion-focused coping involves doing something to regulate one’s emotions, such as exercise or meditation, etc.

Another way of dealing with stressors is to simply use avoidance and, in some situations where time-out from active coping is required to assemble personal resources before returning to active coping, avoidant coping may be appropriate. For all three coping styles described above, a distinction may be made between functional and dysfunctional strategies as depicted in Figure 1.5.

Type	Aim	Functional	Dysfunctional
Problem-focused	Problem-solving	<ul style="list-style-type: none"> • Accepting responsibility for solving the problem • Seeking accurate information • Seeking dependable advice and help • Developing a realistic action plan • Following through on the plan • Postponing competing activities • Maintaining an optimistic view of one's capacity to solve the problem 	<ul style="list-style-type: none"> • Taking little responsibility for solving the problem • Seeking inaccurate information • Seeking questionable advice • Developing unrealistic plans • Not following through on plans • Procrastination • Holding a pessimistic view of one's capacity to solve the problem
Emotion-focused	Mood regulation	<ul style="list-style-type: none"> • Making and maintaining socially supportive and empathic friendships • Seeking meaningful spiritual support • Catharsis and emotional processing • Reframing and cognitive restructuring • Seeing the stress in a humorous way • Relaxation routines • Physical exercise 	<ul style="list-style-type: none"> • Making and maintaining destructive relationships • Seeking meaningless spiritual support • Unproductive wishful thinking • Long-term denial • Taking the stress too seriously • Drug and alcohol misuse • Aggression
Avoidance-focused	Avoiding source of stress	<ul style="list-style-type: none"> • Temporarily mentally disengaging from the problem • Temporarily engaging in distracting activities • Temporarily engaging in distracting relationships • Reassemble resources to cope 	<ul style="list-style-type: none"> • Mentally disengaging from the problem • Long-term engagement in distracting activities • Long-term engagement in distracting relationships • Distancing from resources to cope

Figure 1.5: Functional and dysfunctional coping strategies

(Adapted from Zeidner & Endler, 1996 in Carr, 2011, p. 255)

Carr (2011) points out that the character strengths of creativity and wisdom, which are personal attributes, are important for problem-focused coping, and people with the personality traits of extraversion and conscientiousness tend to use problem-focused coping strategies. Where stresses are uncontrollable, emotion-focused coping strategies such as making and maintaining socially supportive friendships, particularly those in which it is possible to confide deeply felt emotions and beliefs, are appropriate. Key requirements for developing this coping strategy are internal working models of relationships based on secure attachment and the capacity to empathise with others. An emotion-focused coping strategy related to seeking social support is catharsis (Carr, 2011). Catharsis is defined as the “process of verbally expressing in detail intense emotional experiences and engaging in processing of emotionally charged thoughts and memories within the context of a confiding relationship” (Carr, 2011, p. 256). Emotion-focused coping strategies do little to alter the source of stress but rather they permit the regulation of negative mood states that arise from exposure to stress (Carr, 2011). Dysfunctional coping strategies may lead to short-term relief but in the long term they tend to maintain rather than resolve stress-related problems (Carr, 2011). Psychologically disengaging from a stressful situation and the judicious short-term involvement in distracting activities and relationships are functional avoidant coping strategies, but avoidant coping strategies become dysfunctional when they are used as long-term solutions to stress management (Carr, 2011).

Earlier research hypothesised that problem-focused coping was the better form of coping; however, more recent research showed that emotion-focused coping can indeed have positive consequences. For example, avoidance was once seen as a negative coping strategy although literature dictates that in the short term, engaging in healthy distractions can be a good thing for people who have experienced significant trauma (Reynolds & Kee Hean, 2007). Stanton, Kirk, Cameron and Danoff-Burg (2000) refer to the process as coping through emotional approach, and they have developed a scale to assess this construct. Research using this measure found that emotional approach coping enhances adjustment to stressors including infertility, sexual assault and breast cancer. In many

instances, people combine emotion- and problem-focused coping with good results (Compton, 2005).

1.6.2.2 Coping with childhood sexual abuse

Hitchcock (1987) emphasises that adults who were abused as children are less likely to have adequate coping skills, especially when stress levels are high. Heim et al. (2000) further state that the trauma of child abuse leaves the person more vulnerable to stress and destructive coping, and Janoff-Bulman (2006) concurs that any traumatic experience provides a dramatic test of human coping abilities.

The experience of CSA may prompt the use of particular coping strategies across general domains of functioning as well as in specific stressful situations (Walsh, Fortier & DiLillo, 2010). Consistent with this notion is the traumagenic dynamics model of CSA that was discussed earlier (Finkelhor & Browne, 1986), which accounts in part for the manner in which CSA may influence the development of coping strategies. The model puts forward four dynamics which explains the symptoms observed in sexual abuse victims: traumatic sexualisation, betrayal, stigmatisation and powerlessness. Finkelhor (1987, p. 355) suggests that victims may develop abuse-related schemas and coping strategies that are adaptive and reflect integration, but which may be “dysfunctional coping in a world where abuse is not the norm”.

Walsh et al. (2010) extensively investigated the literature on the relationship between CSA and coping, and reported that collectively studies indicate that CSA victims use a wide array of coping strategies both in the immediate aftermath of abuse and over the long term, while the specific strategies used may differ substantially with time. Strategies include cognitive (e.g. cognitive reappraisal, reframing, minimisation, memory repression, distraction) and behavioural (e.g. avoidance, addictive behaviours) efforts to deal with the abuse experiences. Coping responses used in the immediate aftermath of abuse generally appear to reflect avoidance behaviours, and long-term coping strategies appear to reflect cognitive efforts to integrate the traumatic material (Walsh et al., 2010).

Morrow and Smith (1995) identified two core coping strategies used by victims of CSA: keeping from being overwhelmed by threatening emotions and managing feelings of helplessness, powerlessness and lack of control. Perrott, Morris, Martins and Romans (1998) proposed six main coping styles, namely deliberately suppressing, reframing, working through the abuse, seeking support, talking about the abuse as adults, and coping on their own. Processes that enabled women to manage their negative emotions effectively and display positive coping strategies were refocusing and moving on, active healing, and achieving closure (Bogar & Hulse-Killacky, 2006). Himelein and McElrath (1996) attempted to clarify adaptive coping strategies in sexually abused women and found four coping strategies emerging in resilient women: disclosure, minimisation, positively reframing the abuse, and refusing to dwell on the past. According to DiPalma (1994), coping strategies used during childhood included attempts to stop the abuse, avoidance, psychological escape and compensation, while strategies used in adulthood involved breaking way from the past, cognitive coping, self-discovery and revisiting the past. Long-term coping efforts in women who endured CSA appear to include rumination, normalising the abuse and acquiring a sense of psychological control (Oaksford & Frude, 2003). Coping strategies which appear to be prevalent include wishful thinking, cognitive appraisal, downward comparison and minimisation.

Disengagement methods of coping are often employed by CSA victims to deal with painful thoughts and feelings associated with their childhood experiences (Coffey, Leitenberg, Henning, Turner & Bennett, 1996; Runtz & Schallow, 1997). Several studies indicate that disengagement or avoidant methods of coping often used by survivors of CSA lead to increased psychological distress (Burt & Katz, 1987; Frazier & Burnett, 1994; Meyer & Taylor, 1986; Santello & Leitenberg, 1993; Valentiner, Foa, Riggs & Gershuny, 1996). Widom (2000) states that childhood victimisation and violence result in the development of maladaptive styles of coping, possibly functional at the time (e.g. avoidance of feelings), but which may later create problems for adjustment and dealing with stress. Active coping strategies (e.g. confrontation, fight, escape) are usually elicited if the stressor or threat is controllable or escapable, while passive coping strategies (e.g.

immobility, disengagement) are evoked if the stressor is uncontrollable or inescapable (Olf, Langeland & Gersons, 2005).

It thus becomes clear from the literature that women who endured CSA predominantly engage in emotion-focused coping and that they use more cognitive strategies (such as cognitive re-structuring) than behavioural coping strategies. It further appears as though an adaptive outcome could emerge with the evolution of these strategies over time, i.e. survivors report coping predominantly by engaging in psychological escape methods initially, and then adopting cognitive appraisal and positive reframing strategies in the long term. This could suggest that the coping process can affect the eventual psychological outcome following CSA (Oaksford & Frude, 2003).

1.6.2.3 Positive coping

There are individuals who cope with life challenges more successfully than others who deal with the same type of events but with less success. This is not just coping, but “positive coping” and in support of a posttraumatic growth and positive psychology orientation (Compton, 2005, p. 117). O’Learly and Ickovics (1995 in Compton, 2005, p. 117) term such a process “psychological thriving” which includes both enhanced psychological and physical functioning after successful adaptations. People seem to be engaged in thriving when they resiliently adapt to stress and challenge. As a result of such adaptive processes they acquire more refined coping skills. Therefore, some ways of dealing with stress may actually help to build more effective coping resources for the future. In this regard Folkman (2011, p. 76) has refined the definition of coping as “the cognitive and behavioural efforts used to regulate distress, manage the problem causing the distress and sustain positive well-being during stressful situations”.

According to Compton (2005), the dimensions of positive coping are: coping styles, coping resources and coping strategies. Coping styles include the previously discussed emotion-focused and problem-focused styles as well as avoidance as a style. Aspinwall and Taylor (1997) have suggested a third category of coping called proactive coping,

which involves efforts to prevent stress from occurring in the first place. Coping resources are those resources we can draw upon as we meet various challenges. These resources may be external such as available social support, or internal resources that include positive emotionality, the cognitive reappraisal of events, optimism, perceived control, self-efficacy, hardy personality styles and a sense of coherence. Coping strategies can include behavioural strategies such as maintaining positive social contacts, keeping a sense of humour and optimism or physiological strategies such as meditation, exercise and a good massage (Compton, 2005). The coping task confronting the trauma victim is nothing short of overwhelming; yet, in the face of their profound coping challenges, trauma survivors often discover new personal strengths and possibilities (Janoff-Bulman, 2006). Aldwin (1994) refers to this as transformational coping, which Tedeschi and Calhoun (2004a, p. 1) have expanded and conceptualised as posttraumatic growth.

1.6.3 Posttraumatic growth

Posttraumatic growth, also referred to as “adversarial growth and benefit-finding” (Park, 2010, p. 257), is defined as the “positive psychological change experienced as a result of the struggle with highly challenging life crises” (Tedeschi & Calhoun, 2004a, p. 1). The words trauma, crisis or stressful events are used as synonymous expressions by the authors, and with these expressions they describe sets of circumstances which represent significant challenges to the adaptive resources of the individual, and that in turn represent significant challenges to the individual’s ways of understanding the world and their place in it (Janoff-Bulman, 1992 in Tedeschi & Calhoun, 2004a, p. 1). Tedeschi and Calhoun (2004a) recognise that traumatic events are not to be viewed simply as precursors to growth and that they are profoundly disturbing, but also that the processes involved in managing these disturbances are the same processes which can produce positive changes. Thus posttraumatic growth occurs in tandem with attempts to adapt to highly negative sets of circumstances that can engender high levels of psychological distress and thus, continuing personal distress and growth can often co-exist (Tedeschi & Calhoun, 2004a). Posttraumatic growth describes the experiences of individuals whose development, at least in some areas, has surpassed what was present before the struggle

with the crisis occurred. The individual has not only survived, but has experienced changes that are viewed as important and that go beyond what was previously the status quo thus, posttraumatic growth is not simply a return to baseline; it is instead an experience of improvement that for some persons is deeply profound (Tedeschi & Calhoun, 2004a, p. 4). Posttraumatic growth can therefore be differentiated from concepts such as resilience, hardiness, optimism and a sense of coherence in that it refers to a change in people that goes beyond an ability to resist and not be damaged by highly stressful circumstances. It involves a movement beyond pre-trauma levels of adaptation. Posttraumatic growth has a quality of “transformation” or a qualitative change in functioning unlike the similar concepts of resilience, sense of coherence, optimism and hardiness (Tedeschi & Calhoun, 2004a, p. 4). Posttraumatic growth, according to these authors, implies an established set of schemas that are changed in the wake of trauma.

In the process of posttraumatic growth, growth does not occur as a direct result of trauma; it is instead the individual’s struggle with the new reality in the aftermath of trauma that is crucial in determining the extent to which posttraumatic growth occurs. Calhoun and Tedeschi (1998) illustrate this process with a metaphor of an earthquake. A psychologically seismic event can severely threaten or destroy many of the schematic structures that have guided a person’s understanding, decision-making and meaningfulness regarding their assumptive, predictable world, and this threat is accompanied by significant levels of psychological distress. Extending this seismic metaphor, the cognitive processing and restructuring which a person must engage in order to overcome the distress may be comparable to the physical rebuilding that occurs after an earthquake. The physical structures can be redesigned to be more resistant to shocks in the future, as the community learns from the earthquake in terms of what has withstood the shaking and what has not. Cognitive rebuilding that takes into account the changed reality of one’s life after trauma, produces schemas that incorporate the trauma and possible similar threats in the future and that are more resistant to being shattered. These cognitive changes are experienced as growth (Calhoun & Tedeschi, 1998). Furthermore, such psychological processing of a crisis event has a highly emotional

element connected to it and what makes these experiences transformative seems to be this affective component (Tedeschi & Calhoun, 2004a).

It appears that the phenomenon of posttraumatic growth occurs in a wide range of people facing a wide variety of traumatic circumstances and it is manifested in a variety of ways, including an increased appreciation for life in general, more meaningful interpersonal relationships, an increased sense of personal strength, changed priorities and a richer existential and spiritual life (Tedeschi & Calhoun, 2004a). Although the term is new, the idea that great good can come from great suffering is ancient (Tedeschi & Calhoun, 2004a). According to Linley and Joseph (2003, p. 135), “various philosophies, literatures and religions throughout history have conveyed the idea that there is personal gain to be found in suffering”. Although much evidence has been accumulated on the presence of post-traumatic stress in survivors of various traumatic events, there also appears to be growing empirical evidence which reflects that trauma can provide the impetus for personal and social transformation (Linley & Joseph, 2003). Thus the frightening and confusing aftermath of trauma, where fundamental assumptions are severely challenged, can be fertile ground for unexpected outcomes that can be observed in the growth of survivors.

Tedeschi and Calhoun (2004b, p. 406) report that there appears to be a basic paradox that is realised by trauma survivors who report aspects of posttraumatic growth: “Their losses have produced something of value” and there appears to be “an increased sense of their own capacities to survive and prevail”. The general explanation for posttraumatic growth is that challenged beliefs and assumptions about life can provide a basis and an opportunity for personal growth. Initially, traumatic experiences are disorientating and frightening but over time however, people may learn deeper lessons about themselves and about life. These insights have the potential to enhance individuals’ understanding of themselves, their relationships, what is most important in life, and it may also contribute to more effective coping and adjustment. Figure 1.6 shows some of the positive changes reported in the posttraumatic growth literature.

Positive changes reported in the posttraumatic growth literature

Changes in perception

- An increased feeling of personal strength, confidence and self-reliance
- Greater appreciation of the fragility of life, including one's own
- Perceptions of self as survivor rather than victim

Changes in relationships

- Closer ties to family
- Greater emotional disclosure and feelings of closeness to others
- More compassion for others and more willingness to give to others

Changes in life priorities

- Increased clarity about what is most important in life
- A deeper and often spiritual sense of meaning in life
- A new commitment to take life easier
- Less concern with acquiring material possessions, money and social status

Figure 1.6: Positive changes reported in the posttraumatic growth literature

(Adapted from Baumgardner & Crothers, 2009, p. 68)

The positive changes individuals experience in their struggle with trauma, as reflected in a measure of posttraumatic growth developed by the authors based on interviews with many trauma survivors (Tedeschi & Calhoun, 1996), are divided into the three general domains described in Figure 1.6, namely changes in the perception of self, changes in the experience of relationships with others and changes in one's general philosophy of life. Five further domains were extrapolated from these, which will be discussed below.

Personal strength

A general sense of increased personal strength or the recognition of possessing personal strength is another domain of posttraumatic growth (Tedeschi & Calhoun, 2004a). This encompasses the changed perception of self and is manifested in trauma survivors reporting becoming stronger, deeper, more authentic, confident, open, empathic, creative, more alive, mature, humanitarian, special and humble. Many survivors describe themselves as a “better person” now that they have undergone this “seismic” event (Hefferon & Boniwell, 2011, p. 121). The identification of strength is often correlated, almost paradoxically, with an increased sense of being vulnerable. Growth in this domain is experienced as a combination of the clear knowledge that bad things can and do happen and the discovery that “if I handled this then I can handle just about anything” (Tedeschi & Calhoun, 2004a, p. 6).

Relating to others

More intimate and more meaningful relationships with other people are also reported (Tedeschi & Calhoun, 2004a). This stems from changes in the experience of relationships with others and is evident in trauma survivors reporting becoming closer with their immediate and extended families. People report that friendships bind tighter and that people who were acquaintances before the event may become prominent positive figures in their daily lives. Camaraderie and friendship among survivors of the same trauma is common (Hefferon & Boniwell, 2011). However, this experience can also occur along with the loss or disappearance of other relationships (Tedeschi & Calhoun, 2004a). In this regard, also see the work of Helgeson and Lopez (2010) on social support and growth following adversity.

Appreciation for life

Many trauma survivors undergo a change in life philosophy which includes an increased appreciation for life in general along with a changed sense of what is important. Individuals typically report that this is a major shift in how they approach and experience their daily lives or an existential awareness (Tedeschi & Calhoun, 2004a). When trauma highlights the individual’s vulnerability and the fact that humans are not invincible, such

person starts to reflect on deeper issues such as mortality, spirituality and the meaning and purpose of life. Many survivors report that the trauma allowed them to understand what matters in life and to make changes to their priorities (Hefferon & Boniwell, 2011). A typical change in priorities is an increase in the importance of what before might have been considered the “little things”, and the recognition of the importance of things formerly taken for granted (Tedeschi & Calhoun, 2004a, p. 6).

New possibilities

Posttraumatic growth can also be seen in the individual’s identification of new possibilities for one’s life or of the possibility of taking a new and different path in life (Tedeschi & Calhoun, 2004b), for example where the survivor would consider becoming involved in providing care and comfort to other persons facing suffering and loss. These new possibilities stem from changes in one’s general philosophy of life and involve the aspiration of individuals to change their life goals. Many trauma survivors begin to focus on the here and now, with a new appreciation of life (Hefferon & Boniwell, 2011).

Spiritual domain

Growth in the domain of spiritual and existential matters is another way in which some persons experience positive change in their struggles with stress and loss. Individuals who are not religious, or who are actively atheistic, can also experience growth in this domain. There can be a greater engagement with fundamental existential questions and that engagement in itself may be experienced as growth (Tedeschi & Calhoun, 2004a). After enduring a change in one’s general philosophy of life, the trauma survivor may begin to participate actively and to engage in the belief in a higher being (Hefferon & Boniwell, 2011).

The Posttraumatic Growth model

Each of the five domains of posttraumatic growth described above tends to have a paradoxical element to it that represents a special feature of the general paradox of the concept “out of loss there is gain” (Tedeschi & Calhoun, 2004a, p. 6). At a time when one is vulnerable as never before, there is a sense of strength and out of spiritual doubt

there can emerge a deeper faith. Recognition of these paradoxes engages trauma survivors in dialectical thinking that is similar to that described in the literature of wisdom (Tedeschi & Calhoun, 2004b).

The transformational model (Tedeschi & Calhoun, 1995) as seen in Figure 1.7 is the most complete and widely used model of growth. It hypothesises that posttraumatic growth is the result of excessive rumination (or cognitive processing) following a personal seismic event (Tedeschi & Calhoun, 2003). Following such a seismic event, the person is presented with various challenges (for example the management of emotional distress). A person must engage in managing the excessive rumination in three stages. Firstly, the person experiences automatic and intrusive thoughts which the individual will learn to manage over time until they engage in what is called “deliberate rumination” (Hefferon & Boniwell, 2011, p. 126). Secondly, while the person is grappling with these thoughts, they are engaged in self-disclosure as they attempt to reduce emotional distress. Thirdly, by doing so, they commence their disengaging from previous goals, resulting in changed schemas and narrative development. Once these processes have been completed, the person is able to achieve posttraumatic growth in addition to wisdom or preparedness. Importantly, this model acknowledges that distress can co-exist alongside posttraumatic growth (Tedeschi & Calhoun, 2008). It is interesting to note that Park (2011) approaches posttraumatic growth as the outcome or product of meaning making or of creating a sense of purpose for an adversity experienced.

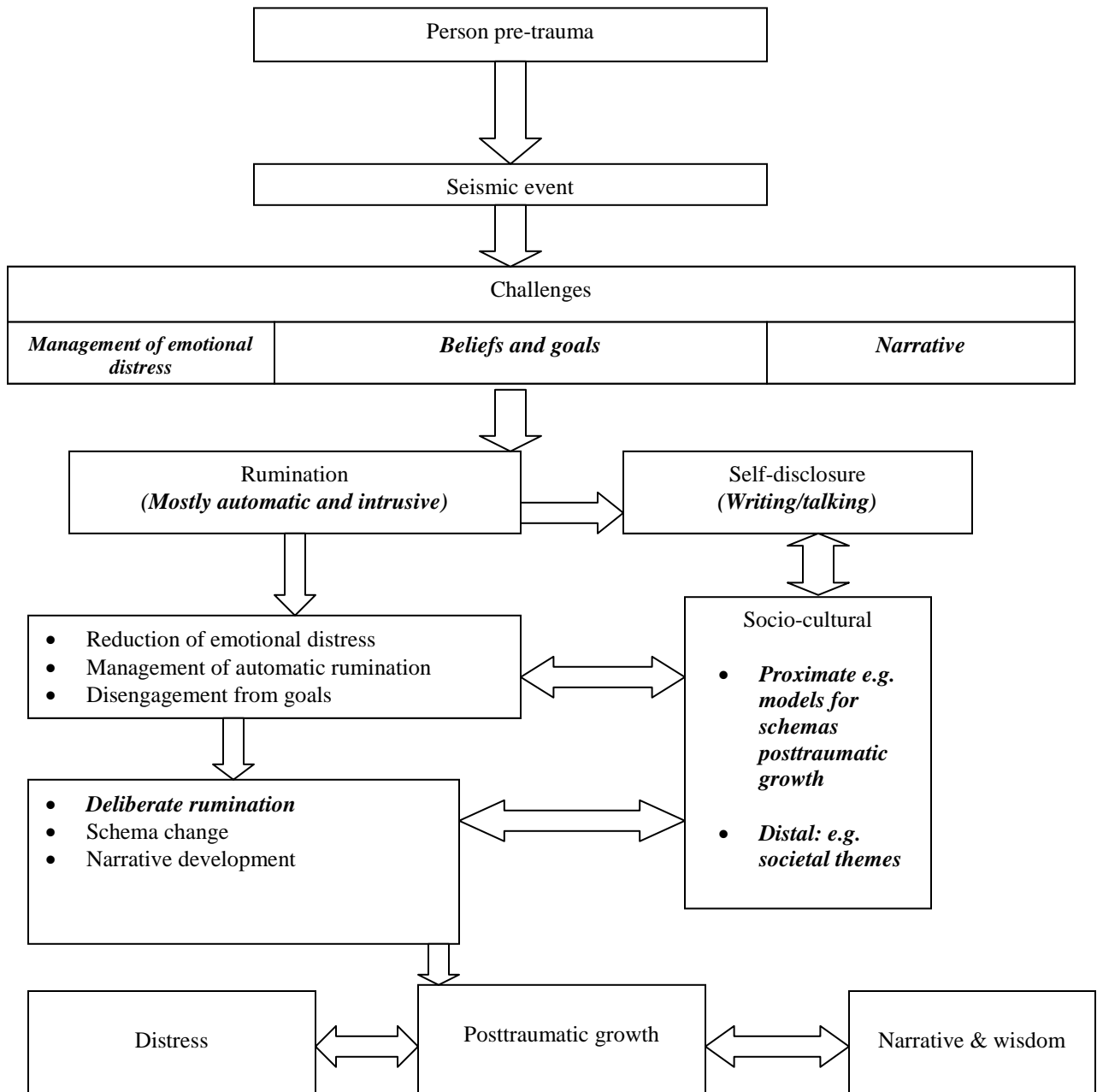


Figure 1.7: A comprehensive model of posttraumatic growth

(Adapted from Calhoun & Tedeschi, 2006, p. 8)

In the aftermath of traumatic victimisation, survivors recognise that they have gone through agony and are stronger for it. In the course of their challenges and sufferings they also learn about new possibilities in their own lives. They recognise new paths, develop new interests and believe they are more likely to change things that need changing. Newly recognised coping skills and resources become the basis for new choices in the way survivors live their lives (Janoff-Bulman, 2006, p. 88). For many survivors, new possibilities follow from a newfound sense of confidence and courage derived from hard-won coping successes. Any person is capable of experiencing the posttraumatic growth phenomenon; however, researchers have suggested that people who experience self-esteem and positive emotions will be better equipped to cope with adversity, to broaden and build their cognitive and behavioural repertoires, as well as experience posttraumatic growth (Linley & Joseph, 2004b).

According to Sher (2002), previous research has mostly focused on the adverse effects that occur because of sexual traumatisation. The relevant literature available on survivors of CSA is primarily from a pathogenic perspective and reports on the adverse effects that a trauma may have on an individual (Bennett & Hughes, 2000). However, the posttraumatic growth construct of Tedeschi and Calhoun (1995) convincingly shows that suffering can often yield strengthening and growth. Applying the posttraumatic growth concept to women who live in the aftermath of traumatic life events such as CSA emphasises the paradox that is experienced by these trauma survivors who report that their losses of trust, security, self-esteem etc. have “produced something of value” and they experience “an increased sense of their own capacities to survive and prevail” (Tedeschi and Calhoun, 2004b, p. 406). The question arises as to what enabled these women to deal with the CSA adversity and to resile or overcome in order to manifest posttraumatic growth.

1.6.4 Enabling factors

Positive emotions and a sense of self as enabling factors are discussed below.

Positive emotions

The beneficial effects of positive emotions on a wide range of human behaviours and experiences have been indicated by, amongst others, Ong, Bergeman and Chow (2010). These authors cite both theoretical and empirical findings that positive emotions promote flexibility in thinking and problem solving, counteract the physiological effects of negative emotional experiences, facilitate adaptive coping, build psychological and social resources and spark enduring well-being. A theoretical model which explains the salutary dynamics of positive emotions in individuals is the broaden-and-build theory of Fredrickson (2002), that describes how positive emotions open up our thinking and actions to new possibilities and how this expansion can help build physical, psychological and social resources that promote resilience and lead to well-being (Baumgardner & Crothers, 2009).

According to Hefferon and Boniwell (2011), positive emotions do not only open our minds to alternative action strategies; instead, research has shown that the experience of positive emotions coupled with the broadening effect thereof has the ability to build personal resources, which we are able to dip into when needed. These resources include intellectual resources (problem solving, being open to learning), physical resources (health and coordination), social resources (we can maintain relationships and create new ones) and psychological resources (resilience, optimism, sense of identity and goal orientation). As these develop, they induce more positive emotions that continue building the resources in an upward spiral (as seen in Figure 1.8).

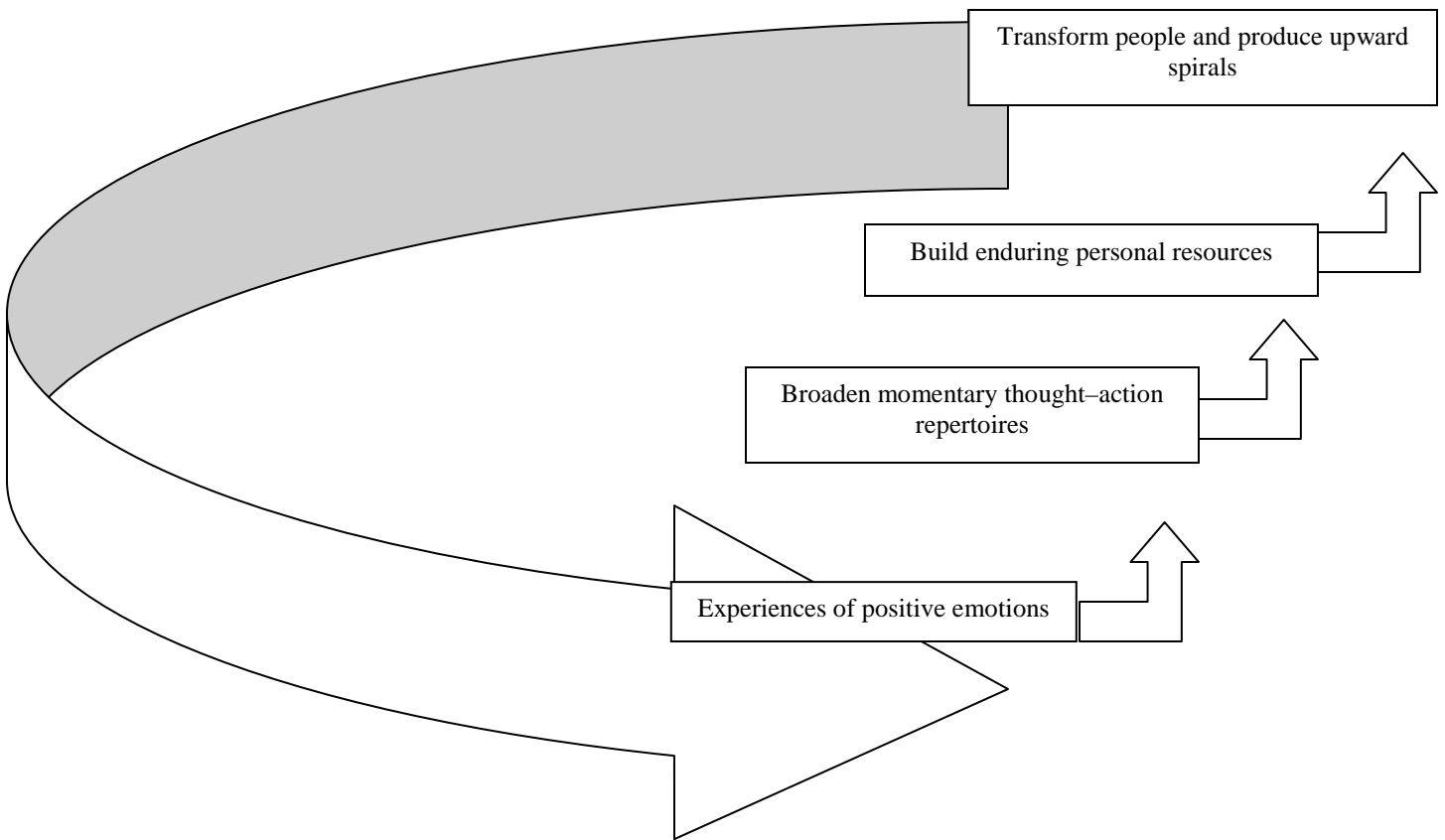


Figure 1.8: The broaden-and-build theory of positive emotion

(Adapted from Fredrickson, 2002, p. 124)

Positive emotions may contribute to our physical resources by enhancing immune-system functioning. Such resources may contribute to psychological resources by buffering or offsetting the detrimental effects of stress, and finally positive emotions may enhance people’s social resources by facilitating the development and maintenance of supportive social relationships (Baumgardner & Crothers, 2009). Ong et al. (2010, p. 86) come to the conclusion that “positive emotions appear to be an active ingredient in what it means to be resilient”. This statement is of particular importance in a study aimed to understand what enables posttraumatic growth in women who had experienced CSA.

Sense of self

A strong sense of self is characterised by features of the self, also known as self-esteem, self-confidence or self-efficacy and self-understanding. A sense of self is associated with strengths such as hope and optimism, positive emotions and the ability to manage negative behaviours and emotions (Compton & Hoffman, 2013; Skodol, 2010). Hefferon and Boniwell (2011) report that coping effectively with life challenges is governed by a positive view of the self, while high self-esteem and strong self-efficacy beliefs contribute to personal strength and resilience (Bandura, 1997; Maddux, 2009). According to Carr (2011), we have better health and well-being when we evaluate ourselves positively (high self-esteem) and believe that we will succeed at tasks we attempt (high self-efficacy).

Rosenberg (1965, p. 30) conceptualised self-esteem as the “totality of the individual’s thoughts and feelings with reference to himself as an object”, while authors Hefferon and Boniwell (2011, p. 106), describe self-esteem as the disposition to experience oneself as competent to cope with the basic challenges of life and as worthy of happiness. High levels of self-esteem including self-worth, self-respect and self-acceptance are correlated with subjective well-being, low neuroticism and optimism as well as higher levels of intelligence and happiness. Furthermore, self-esteem generally correlates strongly with whether one believes that one is included or excluded by other people. Children and adolescents who feel more accepted by their parents have higher levels of self-esteem. Similarly, low self-esteem and depression often follow social exclusion. Low levels of self-esteem are linked to several negative outcomes such as depression in times of low stress, body dissatisfaction, perfectionism, substance use and abuse and aggression (Hefferon & Boniwell, 2011). Huang (2010) found that self-esteem remains relatively stable over time and the stability of self-esteem is partly ascribed to the ways in which people process information about the self.

As was previously discussed, the long-term effects of CSA are vast and devastating. The literature reports that self-esteem is a predominant factor affected by such a sexual trauma with very often a ripple effect of negativity and significance onto other important

areas of the survivor's functioning. However, a strong sense of self, especially self-esteem, may be a resilience-promoting strength that enables positive outcomes or posttraumatic growth in CSA victims.

Both positive emotional experiences and a sound sense of self are associated with psychological well-being (Linley & Joseph, 2004a; Ryff & Keyes, 1995). In this study, psychological well-being is the third construct under investigation in women who had experienced CSA, and this will be discussed forthwith.

1.6.5 Psychological well-being

The issue of the nature and structure of well-being is increasingly becoming one of interest and focus in positive psychology (Linley, Maltby, Wood, Osborne & Hurling, 2009). When introducing the positive psychology approach to the scientific world of psychology, Seligman and Csikszentmihalyi (2000) claimed that psychology is not just the study of pathology, weakness and damage, but also of strength and virtue. It is considered as a science in which the human being should be conceptualised and understood as possessing inherent potentials for developing positive character traits and virtues and overcoming adversity with resilience and strength (Linley & Joseph, 2004a). The World Health Organization's (1948, p. 28) definition of optimal health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" provides a clear starting point for defining wellness in people. This definition refers to both the pathogenic and the salutogenic paradigms of human functioning and has added the concept of well-being to the definition of health. Furthermore, this definition provides strong clues about which domains should be considered in the measurement of health and wellness, as well as the broader concept of psychological well-being (Power, 2003).

An understanding of the well-being component of this concept (psychological well-being) starts with the construct subjective well-being introduced by Diener in 1984. Subjective well-being is conceptualised as people's levels of happiness, satisfaction with

life and neuroticism, in other words people's feeling of being happy, their judgement of being satisfied with life and their experience of low neuroticism or distress (Diener, 1984; Diener & Lucas, 1999). This component of psychological well-being is often seen as the hedonic or pleasurable part of human functioning, which has to be complemented by a eudaimonic or deeper sense of wellness that includes meaning, a true sense of self, living one's potential and lasting relatedness with others (Ryan & Deci, 2001; Tamir & Gross, 2011).

Psychological well-being is defined and operationalised in the form of various constructs, models and measures (Diener, 2009; Lopez & Gallagher, 2009). It is a complex and holistic construct which covers a variety of domains and is seen as multidimensional, where different aspects of the self are involved, such as affect, cognition and behaviour (Wissing & Van Eeden, 2002). Keyes (2009) describes psychological well-being as the culmination of emotional, mental and social well-being into a state known as flourishing or optimal functioning.

The General Psychological Well-being (Wissing & Van Eeden, 2002) and Mental Health Continuum models (Keyes, 2002), are two contemporary conceptualisations that consider psychological well-being from a holistic perspective. The two models recognise the overlap between the eudaimonic and hedonic dimensions at both conceptual and psychometric levels (Keyes, 2002; Keyes, 2007; Wissing & Temane, 2008; Wissing & Van Eeden, 2002). Thus, both models are based on the theoretical and empirical position that psychological well-being is integrated, complex, holistic and multi-faceted by nature.

The General Psychological Well-being model is made up of positive intrapersonal, interpersonal and spiritual elements of human functioning (Wissing & Temane, 2008; Wissing & Van Eeden, 2002). The Mental Health Continuum (MHC) model is operationalised and currently widely researched. It represents the upper end of positive well-being and optimal human functioning as indicated by three components, namely emotional well-being, psychological well-being, and social well-being (Keyes, 2002). The MHC model considers positive mental health within the complete state model of

health where mental health is constituted not only by the absence of psychopathology, but especially by a state of flourishing (Keyes, 2005a; Keyes, 2005b). The MHC model emanated from the theoretical conception of positive mental health as a complete positive state consisting of a set of positive indicators of emotional, psychological and social well-being (Keyes, 2002).

Emotional well-being is characterised by the presence of more positive affect than of negative affect and satisfaction with life, thus of subjective well-being. Social well-being in the MHC model comprises aspects of social acceptance, social actualisation, social contribution, social coherence and social integration; thus, of optimal functioning in interaction with others (Keyes, 1998). Psychological well-being refers to positive functioning as indicated by Ryff's (1989) six dimensions of psychological well-being and reflecting the individuals' expedition to optimal psychological adjustment. The six dimensions as conceptualised and operationalised by Ryff (1989) followed on the pioneering work of Jahoda (1958), who was the first theorist to conceptualise that psychological well-being included sound functioning in all the domains in which the human psyche/mind operates. Ryff's (1989) dimensions are self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth. These dimensions are described briefly in the paragraphs that follow.

Self-acceptance

Self-acceptance is defined by knowing the self, one's actions, motivations and feelings as well the need for positive self-regard (Ryff & Singer, 2008). This ability for self-awareness comes through the acceptance of one's personal strengths and weaknesses. Self-acceptance includes the desire for autonomy, personal growth and self-esteem (Ryff & Singer, 2008).

Positive relations with others

Positive relations with others are indicative of individuals strong in conveying emotions such as empathy, warmth, affection, the capacity to love, to engage in deep friendships and of close relationships with others (Ryff & Singer, 2008).

Autonomy

Autonomy – also referred to as self-determination or independence – is a form of behaviour regulated from within (Ryff, 1989). An environment of autonomy kindles intrinsic motivation (Chalofsky & Krishna, 2009).

Environmental mastery

The ability to create an environment which is in coherence with the psychic condition attributed to mental health is referred to as environmental mastery. This includes the capacity to act and change the environment to suit the individual's personal needs (Ryff, 1989; Ryff & Singer, 2008).

Purpose in life

Finding purpose in life is defined by clearly comprehending one's sense of directedness and intentions, which allow for a sense of meaningfulness (Ryff, 1989). Fundamental to finding purpose in life is the theory of existentialism, where meaning and direction in life are created through authentic living by utilising one's own goals and strengths (Ryff & Singer, 2008; Slade, 2010).

Personal growth

Personal growth is a positive, dynamic and continual process of developing one's own potential. This includes being open to new experiences and continually confronting the challenges with which one is faced in different stages of life (Ryff & Singer, 2008, p. 25). Personal growth is related to strengths and is often experienced through enhanced personal resources.

According to Wissing and Van Eeden (2002) and Wissing and Temane (2008), general psychological well-being thus reflects positive self-related, cognitive, affective, conative, interpersonal, social and spiritual experiences as well as the absence of lingering mental and physical symptoms of distress.

The psychological well-being of women who had experienced CSA seems to be severely compromised as indicated by the findings of Spies (2006a), Taylor and Thomas (2003) and others, as discussed previously. However, wealth of research in resilience has convincingly found that some individuals emerge from childhood adversity of a sexual nature into adulthood without resulting pathology and with personal resources and competencies to enable healthy adjustment (Luecken & Gress, 2010). It is noteworthy that Masten, Burt, Roisman, Obradovic, Long and Tellegen (2004) as well as Werner (1991) found that women were more resilient in their adjustment after childhood abuse than males. Furthermore, from the positive psychology paradigm of thinking, it is proposed that the actualising tendency of all people (Rogers, 1959 in Corey, 2009) will be an enabling directional force (Joseph & Linley, 2005) that will steer women who had experienced CSA to use their unique strengths and abilities to resile and to optimally develop their psychological well-being, as far as is possible for them (Maddux, Snyder & Lopez, 2004).

In the literature review presented in section 1.6 of the preceding exposition, the constructs of coping, posttraumatic growth and psychological well-being as conceptualised in this study of women who had experienced CSA, were explicated. For the purposes of this research, coping was conceptualised as a multidimensional dispositional ability of women to cope with the adversity of CSA, in which they use problem-focused coping skills, emotion-focused coping skills and avoidant or denial coping skills (Carver, Scheier & Weintraub, 1989). Furthermore, the self-efficacy with which they cope by using problem-focused coping, by stopping unpleasant emotions and thoughts and by getting social support, was also considered. Posttraumatic growth is conceptualised in line with the view of Tedeschi and Calhoun (2004a) as the positive psychological outcomes of women's struggle with highly adverse life crises as posed by the experience of CSA. Psychological well-being is conceptualised as mental health through emotional, psychological and social well-being (Keyes, 2002) in addition to a sense of self-worth (Rosenberg, 1965) and the absence of serious symptoms of mental distress (Goldberg & Hillier, 1979) experienced by women who had experienced CSA.

This concludes the discussion of the strengths-based theoretical constructs embedded in this study of coping, positive coping, posttraumatic growth and psychological well-being in women who had experienced CSA. The research methodology which governed this study is discussed next.

1.7 Research Methodology

In this study, multi methods were used to investigate the coping behaviour, posttraumatic growth and psychological well-being in women who had experienced childhood sexual abuse. Multi-method research can be defined as a process for collecting, analysing and “mixing” both quantitative and qualitative information at some stage of the research process within a particular study to gather meaningful data and understand the research problem more fully (Creswell & Garrett, 2008, p. 328). According to McMillan and Schumacher (2006), multi-method research has become increasingly popular as many situations are investigated thoroughly using a variety of methods.

1.7.1 Research Design

A multi-method design was used in which both quantitative (validated instruments) and qualitative (structured interviews) data were gathered in sequence (one after the other), in order to identify women who displayed constructive coping, posttraumatic growth and psychological well-being despite experiencing CSA and to explore their strengths and the factors that enabled them to cope with and grow from the CSA. These analysed manifestations and shared experiences were used to formulate guidelines and strategies that could be used to enhance such strengths and abilities in women survivors of CSA therapeutically. Using both quantitative and qualitative data in the research process in a single study has the purpose of gaining a better understanding of the researched phenomenon (Creswell, 2003), and the researcher can draw on the strengths of each method and allow for a more dynamic analysis (Tashakkori & Teddlie, 2003).

The first phase of the current investigation comprised quantitative research, in which measurements record and investigate aspects of reality using numerical data (Bless & Higson-Smith, 2000; Ivankova, Creswell & Clark, 2007). This phase was conducted with 60 willing and conveniently available participants sourced from a local university, psychologists, social workers and support group/community centres working with women who had experienced CSA. Validated psychometric instruments assessing coping behaviour, posttraumatic growth and aspects of psychological well-being were administered. The instruments will be named in section 1.7.2.2 and described in article one. Relevant biographical details were also obtained with the use of a self-constructed biographical questionnaire.

The second phase was qualitative, and explored and analysed the narrated experiences (obtained through interviews) of women who had experienced CSA and who were identified in the first phase of the study as having experienced constructive coping, posttraumatic growth and psychological well-being (Creswell, 1998). These women partook in semi-structured interviews that allowed the participants to tell their stories, as stories are a way of knowing and essentially a meaning-making process in which every word that people use in telling their stories is a microcosm of their consciousness (Greeff, 2005; Seidman, 1998). A semi-structured interview can be defined as “an interview organised around areas of particular interest, while still allowing flexibility in scope and depth” (Greeff, 2005, p. 292). It is thus an interview used to gain a detailed picture of a participant’s belief about and perceptions or accounts of a particular topic of relevance to her. The method allows the researcher greater flexibility as the participants are able to follow on interesting avenues that emerge in the interview, and through this the participant is able to give a fuller account. With semi-structured interviews, the researcher has a set of pre-determined questions or an interview schedule based on literature. However, the interview is always guided by the schedule and not dictated by it and the participant can introduce a topic the researcher had not thought of (Greeff, 2005). In this relationship, the participant can be perceived as the “expert” on the subject and is afforded maximum opportunity to tell her story (Smith, Harrè & Van Langenhoven, 1995). A visual picture or design map of the research is presented in Figure 1.9.

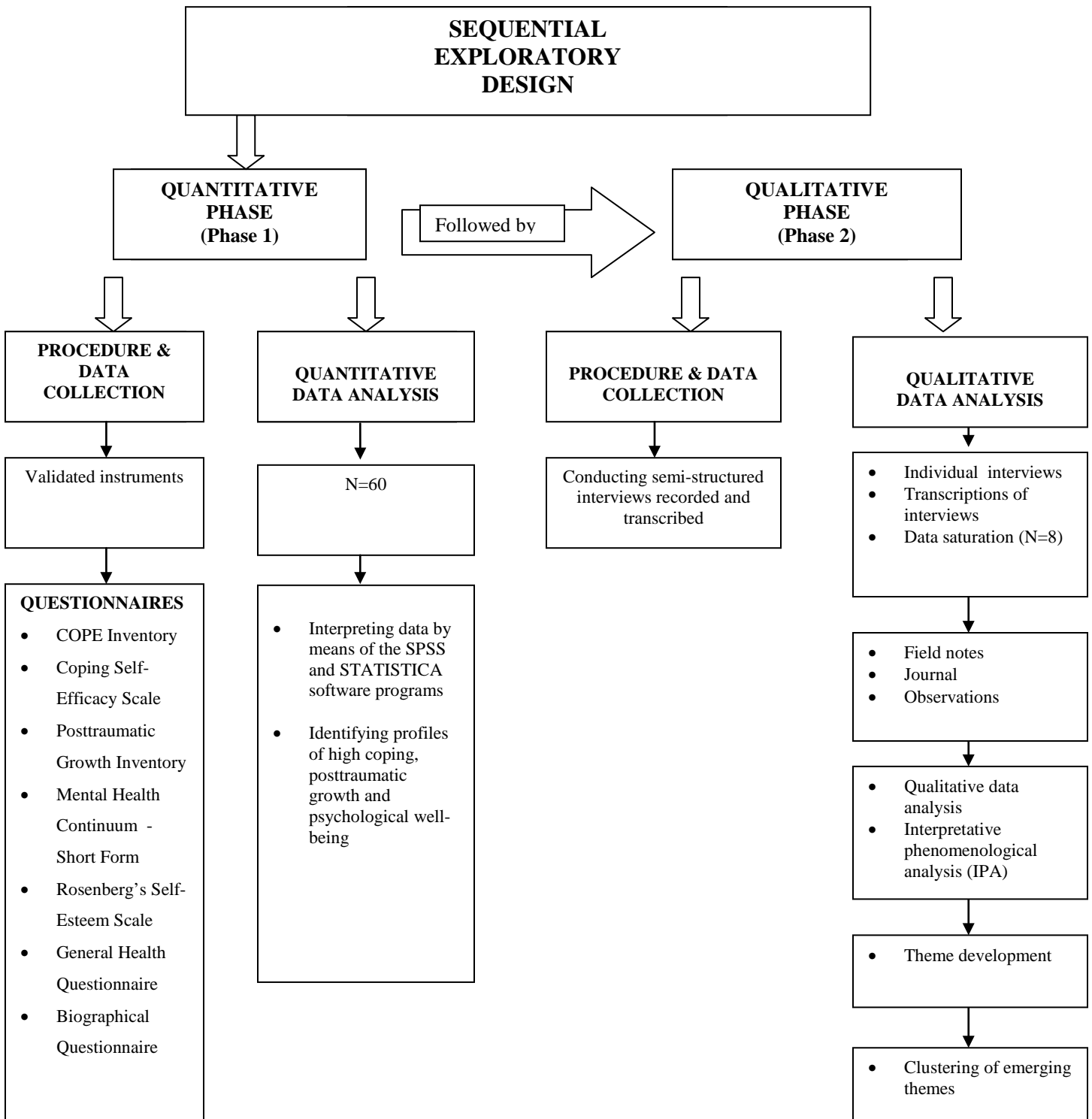


Figure 1.9: Design map of research

The analysis of the narratives shared during the semi-structured interviews, enabled the researcher to explore and analyse those phenomena which enabled the women to cope, grow from the trauma and remain psychologically well after being sexually abused as children. The information obtained assisted the researcher in formulating guidelines with strategies for an intervention programme that may be utilised to enhance positive coping, posttraumatic growth and psychological well-being in women who had experienced CSA, thereby improving their mastery and overall quality of life.

1.7.2 Research methods

The research methods included sampling, data-collection and data analysis and the role of the researcher is also discussed.

1.7.2.1 Sampling

1.7.2.1.1 Population and setting

The population in the first phase included women who had been sexually abused in childhood, who volunteered or were referred from a local university, psychologists and social workers or support groups/community centres and consented to participate voluntarily. The women who were willing to participate were sourced from the Gauteng (Vaal Triangle, Johannesburg) and North-West Province (Klerksdorp, Rustenburg) areas. The participants of the second phase were identified from the first phase and were women manifesting constructive coping, posttraumatic growth and psychological well-being.

Participants had to meet the following criteria for the first phase: they had to be willing to participate voluntarily, be a minimum age of 18 years; of female gender; had been subjected to CSA before the age of 18 years; and were able to communicate, understand and respond in English and/or Afrikaans. Participants had to meet the following criteria for the second phase: women who had experienced childhood sexual abuse and who scored in the upper third range of the measuring instruments; were willing to participate voluntarily in the second phase; were willing to share their narratives with the researcher

in a semi-structured interview; and were comfortable that the interviews were recorded and transcribed and that the data be member-checked for trustworthiness.

1.7.2.1.2 Sampling method and size

Voluntary, all inclusive non-discriminatory sampling of women who had experienced sexual abuse in childhood was done. Women were referred or volunteered from a local university, psychologist or social worker practices or support groups/community centres. A convenience sample of N=60 participants was used. In the second phase, non-probability, purposive sampling was used to select participants who were identified from the first phase as manifesting constructive coping, posttraumatic growth and psychological well-being and who were willing to share their stories until data saturation was reached. Data saturation occurs when recurrent themes evolve from the data and additional sampling provides no new information (Burns & Grove, 2005; Woods & Catanzaro, 1988). Data saturation was obvious after 8 interviews had been analysed, but as 10 interviews were conducted and transcribed all the data was analysed.

1.7.2.2 Data collection and operational context

The data in phase one was collected by means of validated psychological instruments, namely the COPE Inventory (Carver, Scheier & Weintraub, 1989), Coping Self-Efficacy Scale (Chesney, Neilands, Chambers, Taylor & Folkman, 2006), Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996), the Mental Health Continuum – Short Form (Keyes, 2002; 2005a; 2005b), the Rosenberg Self-Esteem Scale (Rosenburg, 1965) and the General Health Questionnaire (Goldberg & Hillier, 1979). Permission was obtained from the authors for use of the following scales: the Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996), the Mental Health Continuum – Short Form (Keyes, 2002; 2005a; 2005b), and the Coping Self-Efficacy Scale (Chesney et al., 2006). The remaining scales are available for use in the public domain. A biographical questionnaire was included for socio-demographic information pertaining to the participants. This subsequently established aspects of the women's CSA experiences, their perceptions of

how they coped through the ordeal, their reflections on the significance of this trauma in their present lives, and whether they felt they had grown from the traumatic experience and became stronger and why. A pilot study was conducted with 11 self-referred consenting women who had been sexually abused as children. They completed the booklet of questionnaires and reported the scales to be user-friendly and that it took approximately 45–60 minutes to complete, which is acceptable according to Brink (2006). Questionnaires, in booklet format (see Appendix 1) were distributed to all participants by the researcher, the psychologists or social workers in practice or the group facilitators at the community centres. Altogether 75 questionnaires were circulated, of which 63 were received back and 60 were completed in full. Participation was voluntary and a document explaining the nature of the research and of their participation and guaranteeing confidentiality was also issued to each participant. They were informed that their participation was voluntary and that they could withdraw from the research at any time (see Appendix 2).

In the second phase, data was collected by means of semi-structured interviews. The researcher contacted the 10 participants who manifested adaptive coping, posttraumatic growth and psychological well-being in phase one and who were willing to participate. The interviews were held individually at the researcher's office in a quiet confidential setting. The interviews took approximately 60 to 90 minutes and were recorded on a digital voice recorder.

1.7.2.3 Data analysis

Data of the first phase was electronically captured by the researcher and statistically analysed by a statistical consultant using the SPSS (2010) and STATISTICA (2010) computer software programs. Descriptive statistics, reliability of measuring instruments, cut-off points and correlations among scales measuring coping, posttraumatic growth and aspects of psychological well-being were determined. The researcher interpreted the statistical results derived from the data. The majority of the biographical information was transformed into quantitative data where the responses were categorised into discrete

categories. The remaining questions which could not be statistically coded were thematically analysed.

The analysis of the data in the second phase involved the examination of transcriptions of the interviews (see Appendix 9 for a transcription sample), with the researcher becoming fully immersed in the data (Brink, 2006). Initial data analyses were done simultaneously with data collection (Creswell, 1994). This also implied that the researcher filtered the data through a personal lens and so introspection and acknowledgement of biases, values and interests were an important part of this qualitative phase (Mertens, 2003). Interpretative phenomenological analysis (IPA) was used as the method of data analysis (Smith, 1996). The founder of IPA, Jonathan Smith, describes IPA as an attempt to unravel the meanings contained in accounts through a process of interpretative engagement with the texts and transcript and such engagement is facilitated by a series of steps that allows the researcher to identify themes and integrate them into meaningful clusters, first within and then across participants (Smith, 1999). The researcher and a co-coder (a psychologist with subject expertise and an advanced qualitative researcher) thus initially independently read and re-read the texts in order to create unfocused notes reflecting initial thoughts and observations. Thereafter they identified and labelled themes that characterised each section of the text. This was followed by the joint clustering of the emerging themes. In the final instance, a summary table of the structured themes (see Appendix 8) together with quotations from the text illustrating each theme was drawn up (Willig, 2008). Three participants were asked to comment on the interpretation of the data to ensure the truthfulness of the interpretation. The data from the summary table was integrated with data gleaned from the researcher's reflexive notes and observation.

On completion of the data collection and data analysis in the second phase, the research findings were then compared to the existing knowledge base on coping with CSA, posttraumatic growth after CSA and psychological well-being. According to Streubert and Carpenter (1999), in a qualitative study, literature control is necessary (investigation, interpretation and integration of literature) so that the findings can be discussed within

the context of what is already known. The literature thus validates the data and confirms the findings of the study (Burns & Grove, 2005), as well as other unique findings which may have emerged.

1.7.2.4 The role of the researcher

The researcher obtained permission from the local university, psychologists, social workers and support groups/community centres to conduct the research. Written, informed consent was also obtained from all the participants and referral sources. These consent letters could however not be included here due to the sensitive nature of the topic and the confidentiality agreement, but are available on request (see Appendices 4 – 6 for examples of the letters drafted). The researcher contacted the necessary role-players to inform them of the nature of the study and to request their participation in the research process (see Appendix 3). Questionnaires were hand-delivered and collected by the researcher together with the consent forms to serve as records of proof that participation was voluntary and consensual. In the second phase of the research, the researcher was the primary instrument for data collection and analysis, although a co-coder was also used to ensure creditability and trustworthiness. The researcher (a clinical psychologist) used well-developed and moulded active listening skills to encourage successful, cathartic interviews with participants.

1.8 Rigor

Rigorous research was ensured by the data collection utilised in both phases of the study, the validated psychological measuring instruments and the questions posed in the biographical questionnaire used in the first quantitative phase. In the qualitative phase, Henwood and Pidgeon's (1992) guidelines for good practice were followed to ensure rigor. These included: (a) the importance of fit – analytic categories generated by the researcher should fit the data well; (b) integration of theory – the process of integration and rationale should be apparent; (c) reflexivity – the role of the researcher needs to be acknowledged in the documentation; (d) documentation – the researcher should provide a

comprehensive account of the research process; (e) member-checking – the researcher should be aware of differences between his or her interpretation; (f) credibility – a sensitivity to negotiated realities and those of the participants; and (g) transferability – the study should be applicable to other contexts.

1.9 Ethical considerations

The researcher made use of various international ethical principles, such as those stated in the Helsinki declaration (Burns & Grove, 2005), in order to conduct the research in an ethical manner. The researcher considered certain ethical issues to ensure that the rights of the participants were observed, namely anonymity, respect for the dignity of persons, non-maleficence and confidentiality (Terre Blanche, Durrheim & Painter, 2006). Participation was voluntary and identities remained confidential. The written proposal was submitted to the ethical committee of the North-West University (NWU-00041-08-A1) (see Appendix 7), and approval was received. Informed consent was obtained from each participant. A document guaranteeing confidentiality was also issued to each participant and although the researcher (a clinical psychologist) was aware of each participant's identity, she was bound by a professional oath of confidentiality to ensure anonymity. The participants were informed that their participation was voluntary and that they could withdraw from the research at any time. A feedback session could be arranged for those participants requesting so, and psychological counselling services were available for any participant who might have experienced emotional abnormal reactions during the course of the research.

1.10 Report outline

The format of the thesis will be in the form of three articles in which results will be presented and discussed. These articles and reference lists have been styled according to the journals author specifications and are therefore in double-spacing. The articles will be submitted to the following journals for publication: *Journal of Traumatic Stress* and *Journal of Child Sexual Abuse*.

Chapter 1: Overview of the study

Chapter 2: Article 1:

The prevalence of coping behaviour, posttraumatic growth and psychological well-being in women who experienced childhood sexual abuse

Chapter 3: Article 2:

A qualitative understanding of the coping behaviour, posttraumatic growth and psychological well-being in women who experienced childhood sexual abuse

Chapter 4: Article 3:

Guidelines for an intervention to enhance constructive coping behaviour, posttraumatic growth and psychological well-being in women who experienced childhood sexual abuse

Chapter 5: Conclusions, limitations and recommendations

SECTION TWO

MANUSCRIPTS

MANUSCRIPT ONE

**THE PREVALENCE OF COPING BEHAVIOUR, POSTTRAUMATIC
GROWTH AND PSYCHOLOGICAL WELL-BEING IN WOMEN WHO
EXPERIENCED CHILDHOOD SEXUAL ABUSE**

Prepared for submission to *Journal of Traumatic Stress*

Guidelines for authors: Journal of Traumatic Stress

Target journal and guidelines for authors

The first article has been submitted to the *Journal of Traumatic Stress* for publication and this manuscript and reference list has been styled according to this journal's specifications. The following is a copy of the guidelines for prospective authors as set out by the journal.

Author guidelines

1. The *Journal of Traumatic Stress* is edited by Daniel S. Weiss (Ph.D.) and accepts manuscripts on line at:

<http://mc.manuscriptcentral.com/jots>

Information about how to create an account or submit a manuscript may be found online in the "Get Help Now" menu. Personal assistance is also available by calling 434-817-2040, x 167.

2. Three paper formats are accepted. All word counts should include references, tables, and figures. *Regular articles* (no longer than 6,000 words) are theoretical articles, full research studies, and reviews. Purely descriptive articles are rarely accepted. In special circumstances, the editors will consider longer manuscripts (up to 7,500 words) that describe complex studies. Authors are requested to seek special consideration prior to submitting longer than 6,000 words. *Brief reports* (2,500 words) are for pilot studies or uncontrolled trials of an intervention, case studies that cover a new area, preliminary data or a new problem or population, condensed findings from a study that does not merit a full article, or methodologically orientated papers that replicate findings in new populations or report preliminary data on new instruments. *Commentaries* (1,000 words or less) cover responses to previously published articles or, occasionally, essays on a professional or scientific topic of general interest. Response commentaries submitted no later than 8 weeks after the original article is published (12 weeks outside the U.S.), must be content-directed and use tactful language. The original author is given the opportunity to respond to accepted commentaries.

3. The *Journal* follows the style recommendations of the 2010 *Publication Manual of the American Psychological Association* (APA; 6th). Manuscripts should use non-sexist language. Files must be formatted using letter or A4 page size, 1 Inch (2.54 cm) margins on all sides, Times New Roman 12 point font, and double-spacing for text, tables, figures, and references.

4. The title page should include the title of the article, the running head (maximum 50 characters) in uppercase flush left, author(s) by-line and institutional affiliation, and author note (see pp. 23-25 of the APA manual).
5. An abstract no longer than 200 words follows the title page on a separate page.
6. Format the reference list using APA style: (a) begin on a new page following the text, (b) double-space, (c) use hanging indent format, (d) italicize the journal name or book title, and (e) list alphabetically by last name of first author. If a reference has a Digital Object Identifier (DOI), it must be included as the last element of the reference.

Journal Article

Kraemer, H.C. (2009). Events per person-time (incidence rate): A misleading statistic? *Statistics in Medicine*, 28, 1028-1039. doi: 10.1002/sim.3525.

Book

Cohen, J. (1988). *Statistical power analysis for the behavioural sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Book Chapter

Meehl, P.E. (2006). The power of qualitative thinking. In N.G. Walter, L.J. Yonce, W.M. Grove, D. Faust, & M.F. Lenzenweger (Eds.), *A Paul Meehl reader: Essays on the practice of scientific psychology* (pp. 433-444). Mahwah, NJ: Erlbaum.

7. Tables and figures should be formatted in APA style. Count each *full-page* table or figure as 200 words and each *half-page* table or figure as 100 words. Tables should be numbered (with Arabic numerals) and referred to by number in the text. Each table and figure should begin on a separate page. Only black and white tables and figures will be accepted (no color). Figures (photographs, drawings, and charts) should be numbered (with Arabic numerals) and referred to by number in the text. Place figures captions at the bottom of the figure itself, not on a separate page. Include a separate legend to explain symbols if needed. Figures should be in Word, TIFF, or EPS format.
8. Footnotes should be avoided. When their use is absolutely necessary, footnotes should be formatted in APA style and placed on a separate page after the reference list and before any tables.

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14. The author(s) are required to adhere to the “Ethical Principles of Psychologists and Code of Conduct” of the American Psychological Association (visit apastyle.org) or equivalent guidelines in the study’s country of origin. If the author(s) were unable to comply, an explanation is requested.

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ABSTRACT

The high prevalence of sexual abuse suffered by women as children is well documented, both internationally and in South Africa and these women often report numerous and varied long-term effects. Researchers have now begun to focus on gaining a better understanding of the risk and protective factors that affect psychological functioning in the face of childhood sexual abuse. An apparent risk factor documented in the literature considers some of the dysfunctional methods of coping that are used to deal with the trauma of childhood sexual abuse. Transformational coping or posttraumatic growth is considered as a possible protective factor where positive changes occur in individuals as the result of attempts to cope in the aftermath of the traumatic event. The aim of this study is to investigate the prevalence of coping behaviour, posttraumatic growth and psychological well-being of adult women who had experienced childhood sexual abuse. A group of South African women (N=60), all sexually abused before the age of 18 years, voluntarily completed a biographical questionnaire (21 open-ended questions) as well as measures of coping, posttraumatic growth and psychological well-being, in a cross-sectional survey design. Results showed moderate to high correlations among scales indicating conceptual coherence as indicators of constructive coping, posttraumatic growth and psychological wellness. Prevalence of constructive coping, posttraumatic growth and psychological well-being was determined and 58% of participants manifested constructive coping, 60% manifested posttraumatic growth, and 42% manifested psychological well-being. These women survivors of childhood sexual abuse had higher levels of posttraumatic growth than reported in previous studies. Information can be used to identify women who cope well, manifest growth and experience well-being for further qualitative research into these constructs.

Key words: Women, childhood sexual abuse, constructive coping behaviour, posttraumatic growth, psychological well-being, positive psychology

Introduction

The high prevalence of sexual violence and abuse suffered by women as children is well documented, both internationally and in South Africa. There is growing concern about the implications of this for women's health in general and their mental health in particular (Wilson & Strebel, 2004). Researchers have now begun to focus on gaining a better understanding of the risk and protective factors that affect psychological functioning in the face of childhood sexual abuse (CSA) (Carlson & Dalenberg, 2000).

Women who survive CSA often report numerous and varied long-term effects stemming from their experience, which include a range of symptoms such as depression, dissociation, self-destructive behaviour, anxiety, posttraumatic stress, stigmatisation, social isolation, interpersonal problems, poor self-esteem, difficulty in trusting others, a tendency toward revictimisation, substance abuse, physical complaints and sexual maladjustment (Allen, 2008; Bennett & Hughes, 2000; Beitchman, Zucker, Hood, daCosta, Akman & Cassavia, 1992; Finkelhor & Browne, 1986; Elhai, Gold, Mateus & Astaphan, 2001; Spies, 2006b; Van Rensburg & Barnard, 2005; Vigil & Geary, 2008). Thus, CSA could have a lifelong impact on its survivors and seems associated with poor psychological adjustment in adulthood (Carlin & Ward, 1992; Hobbins, 2004; Lucenko, Gold & Cott, 2000; Saywitz, Mannarino, Berliner & Cohen, 2000; Silverman, Reinherz & Giaconia, 1996). Mullen and Flemming (1998) report that the long-term effects of CSA should be understood as an interaction impacting on the developmental, psychological, social and interpersonal aspects of a person, while the relationship between specific abuse characteristics (e.g. duration of the abuse, age of child when the abuse began, child's relationship to the offender) and the long-term effects thereof, are mentioned by Draucker (1995). The impact of sexual abuse varies according to several of these factors (Louw & Louw, 2007).

Finkelhor and Browne (1986, p. 180) proposed a “traumagenic model” that organises the characteristics and long-term effects of CSA into a conceptually meaningful framework consisting of four trauma-causing factors, called “traumagenic dynamics”. This proposed model accounts in part for the manner in which CSA might influence the development of certain coping strategies in CSA victims. The model posits that four dynamics explain the psychological impact of the abuse experience, namely: traumatic sexualisation (the process in which the child’s sexuality is formed in a developmentally inappropriate and interpersonally dysfunctional way); stigmatisation (the negative associations communicated to the child around the CSA experiences, which become integrated in the child’s self-image); betrayal (the dynamic by which the child discovers that someone on whom they were almost always reliant, has caused them harm); and powerlessness (the process in which the child’s strength of character, needs and sense of efficacy are constantly disregarded) (Finkelhor & Browne, 1986).

These traumagenic dynamics are generalised dynamics, but their combination in one proposed conceptual model is what defines the trauma of CSA as unique and different to any other childhood trauma. Finkelhor and Browne (1986, p. 180) state that “these dynamics, when present, alter the child’s cognitive and emotional orientation to the world, and create trauma by distorting a child’s self-concept, world view, and affective capacities”. The authors further suggest that CSA victims may develop abuse-related schemas and coping strategies that are adaptive and reflect integration, but which may be “dysfunctional in coping with a world where abuse is not the norm” (Finkelhor & Browne, 1985, p. 533).

Coping

An apparent risk factor documented in the literature considers some of the methods of coping that are used to deal with the stress of a sexual assault, and Banyard (2003) suggests that a potential mediator of the CSA distress link that requires further exploration is that of coping behaviour. It seems that relatively little research has been done on how victims cope with the experience of having been abused sexually as a child and whether or not CSA influences a survivor's coping styles. The identification of coping strategies used by abuse survivors may contribute to a better understanding of factors that protect adaptive functioning and those that put it at risk (Futa, Nash, Hansen & Garbin, 2003).

Coping refers to a range of diverse cognitions and behaviours used to manage the internal and external demands of a stressful or threatening situation (Lazarus & Folkman, 1984). Lazarus and Folkman (1984) and Zeidner and Endler (1996) propose a prominent typology, which distinguishes between three main coping strategies that individuals use when faced with a stressful situation: problem-focused (in which a person attempts to change the situation that caused the stress), emotion-focused (in which a person attempts to reduce or manage the emotional distress cued by the situation) and avoidant (where the person seeks to avoid the problem) coping strategies. Lazarus and Folkman (1984) further divide emotion-focused coping into cognitive (reinterpreting the situation) and behavioural (engaging in an activity to regulate emotions) ways of coping. For all three coping styles, a distinction may be made between functional and dysfunctional strategies. Earlier research hypothesised that problem-focused coping was the more effective form of coping when struggling with the aftermath of CSA; however, more recent research shows that emotion-focused coping illuminates positive outcomes for trauma survivors (Reynolds & Kee Hean, 2007).

The goal of current perspectives on coping is to describe adaptations to challenges that do not simply return a person to homeostasis but instead serve to propel such person toward a better quality of life. This is not just coping, but “positive coping” and in support of a positive psychology orientation (Compton, 2005, p. 117). O’Learly and Ickovics (1995 in Compton, 2005, p. 117) term such a process as psychological “thriving”, which includes both enhanced psychological and physical functioning after successful adaptations. A person is engaged in thriving when they can adapt to stress and, as a result, can create even better adaptations and acquire even more refined coping skills, thus helping to build more effective coping resources for the future (Compton, 2005).

Widom (2000) states that childhood victimisation and violence result in the development of maladaptive styles of coping, possibly functional at the time (e.g. avoidance of feelings), but that may later create problems for adjustment and dealing with stress. Active coping strategies (e.g. confrontation, fight or escape) are usually elicited if the stressor or threat is controllable or escapable, and passive coping strategies (e.g. immobility or disengagement) are evoked if the stressor is uncontrollable or inescapable (Olf, Langeland & Gersons, 2005). The descriptive studies on coping with trauma seen in literature indicate that coping with CSA is a multi-faceted and complex process that evolves over time (Walsh, Fortier & DiLilli, 2010) and further that the experience of sexual trauma is often associated with the use of avoidant coping strategies in the short term and the use of emotion-focused cognitive coping strategies later on. Such evolving of constructive and mainly cognitive coping abilities would fit the trauma theories suggesting that integration is a critical strategy in adaptive coping. According to Tedeschi and Calhoun (2004b, p. 469), trauma related thinking must be “reconstructed so that people have useful guides for their behaviours and choices”. Such cognitive processing as part of coping is associated with posttraumatic growth.

Posttraumatic Growth

The coping task confronting the trauma victim is nothing short of overwhelming, yet in the face of their profound coping challenges, trauma survivors often discover new personal strengths and possibilities (Janoff-Bulman, 2006). Aldwin (1994) refers to this as transformational coping, which the authors Tedeschi and Calhoun (2004a, p. 1) have expanded on and termed “posttraumatic growth”. Posttraumatic growth refers to reports of positive changes in individuals that occur as the result of attempts to cope in the aftermath of traumatic life events. The empirical literature focused specifically on posttraumatic growth is rather recent and still small (Tedeschi & Calhoun, 2004a) and according to Frazier, Conlon and Glaser (2001), very few studies have examined posttraumatic growth among CSA survivors.

Posttraumatic growth is defined as the “positive psychological change experienced as a result of the struggle with highly challenging life crises” (Tedeschi & Calhoun, 2004a, p. 1). According to Linley (2003), such positive changes can underpin a whole new way of living that embraces the central tenets of positive psychology, specifically the experience of positive emotion, the finding of purpose and meaning and the building of strengths and virtues (Seligman, 2002). Positive changes that individuals experience in their struggle with trauma are reflected in a measure of posttraumatic growth, developed by the authors based on interviews with many trauma survivors (Tedeschi & Calhoun, 1996). The measurement of posttraumatic growth is divided into three general domains: changes in the perception of self, changes in the experience of relationships with others, and changes in one’s general philosophy of life, while five further domains were extrapolated from these, namely personal strength, relating to others, appreciation for life, new possibilities, and spiritual growth.

Posttraumatic growth describes the experience of individuals whose development, at least in some areas, has surpassed what was present before the crisis occurred. The individual has not only survived, but has experienced changes that are viewed as important, and that go beyond what was the previous status quo. Tedeschi and Calhoun (2004a, p. 4) report that posttraumatic growth is not simply a return to baseline; it is instead an experience of improvement that for some persons is deeply profound, thus a “movement beyond pre-trauma levels of adaptation”, it has a quality of “transformation” or a qualitative change in functioning unlike the similar concepts of resilience, a sense of coherence, optimism and hardiness. In the process of posttraumatic growth, growth does not occur as a direct result of trauma; it is instead the individual’s struggle with the new reality in the aftermath of trauma that is crucial in determining the extent to which posttraumatic growth occurs (Tedeschi & Calhoun, 2004a).

According to Tedeschi and Calhoun (2004b, p. 406), there appears to be a basic paradox that is apprehended by trauma survivors who report aspects of posttraumatic growth as “their losses have produced something of value” and there appears to be “an increased sense of their own capacities to survive and prevail”. The general explanation for posttraumatic growth is that challenged beliefs and assumptions about life can provide a basis and an opportunity for personal growth. Initially, traumatic experiences are disorientating and frightening but over time may present opportunities for people to learn deeper lessons about themselves and about life. These lessons have the potential to enhance individuals’ understanding of themselves, their relationships and what they value in life, and these lessons may further contribute to more effective coping and adjustment. Newly recognised coping skills and resources often become the basis for different choices in the way survivors live their lives (Janoff-Bulman, 2006). Any person is capable of experiencing this phenomenon; however, researchers have suggested that people who have self-esteem and who often

experience positive emotions, will be better equipped to deal with adversity (Fredrickson, 2003) as well as experience posttraumatic growth (Linley & Joseph, 2004) and overall psychological well-being.

Psychological Well-Being

The World Health Organization's (1948, p. 28) definition of optimal health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" provides a clear starting point for defining wellness in people. This definition includes both the pathogenic and the salutogenic paradigms and has added the concept of well-being to the definition of health. Furthermore, this definition provides strong clues about which domains should be considered in the measurement of health and psychological well-being (Power, 2003). When introducing the positive psychology approach to the scientific world of psychology, Seligman and Csikszentmihalyi (2000) state that psychology is not just the study of pathology, weakness and damage, but also of strength and virtue. It is a science in which the human being should be conceptualised and understood as possessing inherent potential for developing positive character traits and virtues and overcoming adversity with resilience and strength (Linley & Joseph, 2004).

Psychological well-being is defined and operationalised in the form of various constructs, models and measures (Diener, 2009; Lopez & Gallagher, 2009) and the term has been used interchangeably with such terms as wellness, happiness, life satisfaction, positive and negative affect, quality of life and the good life. Psychological well-being is a complex and holistic construct which covers a variety of domains and is seen as multidimensional, where different aspects of the self are involved, such as affect, cognition and behaviour (Walker, 1999; Wissing & Van Eeden, 2002). Keyes (2009) describes psychological well-being as the culmination of emotional, mental and social well-being into a state known as

flourishing. Flourishing is a state of wholeness where a person can deal with stressors in an effective way and maintain completeness when interacting with their environment in a positive way (Keyes, 2002).

The General Psychological Well-Being (Wissing & Van Eeden, 2002) and Mental Health Continuum (Keyes, 2002) models are two contemporary conceptualisations that consider psychological well-being from a holistic perspective. The two models recognise the overlap between the eudaimonic and hedonic dimensions of well-being at both conceptual and psychometric levels (Keyes, 2002; 2007; Wissing & Temane, 2008; Wissing & Van Eeden, 2002). The models are based on the theoretical and empirical position that psychological well-being refers to integrated, complex, holistic and multi-faceted behaviour in people that is salutary in nature. The General Psychological Well-Being model is a complex, multi-faceted yet one-dimensional factor made up of positive intrapersonal, interpersonal and spiritual elements of human functioning (Wissing & Temane, 2008; Wissing & Van Eeden, 2002) and the Mental Health Continuum model consists of three components, namely psychological well-being, emotional well-being and social well-being (Keyes, 2002).

The Mental Health Continuum (Keyes, 2002) is based partly on Ryff's (1989) multidimensional approach to psychological well-being that extracts six dimensions of well-being, which reflect the individuals' expedition to optimal psychological adjustment. These dimensions are self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth. The emotional well-being component of the Mental Health Continuum refers to the experiences of more positive emotions than negative and to a sense of satisfaction with life. The social well-being component implies social acceptance, social actualisation, social contribution, social cohesion and social integration (Keyes, 2002).

For the purposes of this study, psychological well-being was conceptualised by the Mental Health Continuum including psychological well-being, emotional well-being and social being, as well as by the presence of self-esteem and the absence of mental illness or dysphoria.

The question comes to mind whether the life outcomes of CSA survivors are generally only adverse, or whether women can manage to overcome the CSA experiences and through posttraumatic growth “survive and prevail” (Tedeschi & Calhoun, 2004b, p. 406) and even experience psychological well-being. In other words, can women who had CSA experiences, cope positively, experience personal growth after the trauma and experience psychological well-being in adulthood? The positive psychology framework that is currently winning favour in the research and practice domains of psychology would question the currently assumed adverse outcome approach to CSA and allow for open-strengths and growth-related outcomes such as the experience of psychological well-being, with manifestations of constructive coping, coping self-efficacy, self-esteem, flourishing mental health and the absence of psychological distress.

The purpose of the study being reported here was therefore to investigate the prevalence of coping behaviour, posttraumatic growth and psychological well-being of adult women who had experienced CSA. The findings indicated levels of constructive coping, posttraumatic growth and psychological well-being in a group of South African women who had experienced CSA that could be compared to those cited in literature. The results also lead to the identification of women who, despite being sexually abused as children, displayed positive coping, posttraumatic growth and psychological well-being in adulthood, so as to involve them in qualitative research in order to come to a more thorough in-depth understanding of the strengths and enabling factors that contributed to their resilience.

Research objectives

The aim of this study was to:

- determine the prevalence of constructive coping strategies, posttraumatic growth and psychological well-being in a group of women who experienced CSA, through validated questionnaires; and
- obtain and analyse the prevalence of specific aspects of CSA, coping and growth, reported by the participants in a biographical questionnaire.

Research design

This was primarily a quantitative investigation in which a cross-sectional survey design was used. In such a design, the interrelationships among variables are assessed without experimental validation. The cross-sectional design is well suited for descriptive purposes in an investigation (Shaughnessy & Zechmeister, 1997).

Research methods

Research population and sampling

The participants were 60 South African women. The mean age of the participants was 32.2 years with a range between 18 and 53 years. They had all been sexually abused before the age of eighteen years (for the purpose of this research, CSA was considered to be the use of a child, under the age of 18 years, for any form of sexual activity or behaviour by an adult or adolescent), were able to communicate in English or Afrikaans and were willing to participate in the study. They were all referred to this study on request of the researcher, by various therapists and counsellors in suburban areas of Gauteng Province in South Africa. This was thus a convenience sample based on voluntary, all inclusive and non-discriminatory participation.

Measuring instruments

A question booklet was compiled commencing with a biographical questionnaire and then followed by the six measuring instruments (see Appendix 1). The booklet also contained instructions for the completion of the questionnaires. An information letter explaining the objectives and confidential nature of the study as well as a consent form ensuring voluntary participation was also provided to all participants (See Appendices 2 & 4). Seventy-five questionnaires were circulated, sixty-three were received back and sixty (80%) were completed in full and analysed. Szelenyi, Bryant and Lindholm (2005) suggest that a response rate of 32% is acceptable in self-report surveys such as the present one.

A biographical questionnaire was designed by the researcher to gather socio-demographic information from the participants, and included 21 open-ended questions on the experience of aspects of CSA, exploring how they had coped since the CSA experience to present and whether they thought that they had experienced personal growth and/or psychological well-being after the trauma to the present.

The COPE Inventory (COPE) of Carver, Scheier and Weintraub (1989): The COPE assesses a range of coping strategies, several of which have an explicit basis in theory. It is a 53-item measure of one's coping behaviours on a scale from 1 (I usually don't do this at all) to 4 (I usually do this a lot). The COPE includes fourteen different coping strategies. Five subscales measure different aspects of problem-focused coping: active coping, planning, suppression of competing activities, restraint coping and seeking social support for instrumental reasons. Five subscales measure different aspects of emotion-focused coping: seeking social support for emotional reasons, positive reinterpretation and growth, acceptance, turning to religion and focus on and venting of emotions. Four subscales measure avoidance behaviour: denial, behavioural disengagement, mental disengagement and drug

use. In research done in the USA by Arévalo, Prado and Amaro (2008), reliability indices were reported for the COPE subscales ranging from 0.65 to 0.83. In a South African study by Joubert (2003), Cronbach alpha coefficients ranging from 0.80 to 0.90 were reported. Law (2004) reported a range of 0.42 to 0.72, while Van Zyl (2009) reported Cronbach alpha coefficients ranging from 0.71 to 0.87. In the current study, a Cronbach alpha coefficient of 0.85 was obtained for the total scale.

The Coping Self-efficacy Scale (CSE) of Chesney, Neilands, Chambers, Taylor, and Folkman, (2006): The CSE is a 13-item measure of one's confidence in coping behaviours when faced with life challenges. The scale is the short form of the original 26-item CSE measuring coping self-efficacy on a 10-point Likert scale from 0 (Cannot do at all) to 10 (Certain you can do). The scale includes three sub-scales with 6 items on problem-focused coping, 4 items on stopping unpleasant emotions and thoughts and 3 items on getting support from friends and family. Internal consistency and test-retest analyses showed these factors assess self-efficacy for different types of coping. Predictive validity analyses showed that residualised change scores in using problem- and emotion-focused coping skills were predictive of reduced psychological distress and increased psychological well-being over time (Chesney et al., 2006, p. 421–437). In research done in the United Kingdom by Chesney et al. (2006), reliability indices of 0.40–0.80 were reported for the CSE total scale and subscales. In a South African study by Wissing and Temane (2008), reliability indices of 0.86 and 0.87 for the 26-item version were reported. In the current study, a Cronbach alpha coefficient of 0.94 was obtained for the total scale.

The Posttraumatic Growth Inventory (PGI) of Tedeschi and Calhoun (1995, 1996): The PGI is a 21-item measure of positive life changes after a trauma and rated on a 5-point Likert scale, ranging from 0 (I did not experience this change) to 5 (I experienced this change to a very great degree). The PGI yields a total score and five subscale scores: new

possibilities – 5 items, relating to others – 7 items, personal strength – 4 items, spiritual change – 2 items, and appreciation of life – 3 items. The PGI has shown good reliability in previous studies of trauma survivors as demonstrated by Sears, Stanton, and Danoff-Burg (2003). In an American study conducted by Cordova, Giese-Davis, Golant, Kronenwetter, Chang & Spiegel (2007), the Cronbach alpha for the PGI total score was 0.96 and the Cronbach alpha for the PGI subscales ranged from 0.85 to 0.89. In the current study, the Cronbach alpha for the PGI total was 0.95.

Mental Health Continuum – Short Form (MHC-SF) of Keyes (2005, p. 3–11): The MHC-SF consists of 14 items rated on a 5-point Likert scale, ranging from 0 (Never) to 5 (Everyday). The items represent three sub-scales, namely emotional well-being, psychological/personal well-being and social well-being. The scale measures mental health of individuals and descriptive words used are “flourishing” for positive mental health and “languishing” for poor mental health. Individuals who are neither flourishing nor languishing have moderate mental health. The MHC-SF has shown excellent internal consistency (Cronbach alpha 0.80) and discriminatory validity. The test-retest reliability estimates range from 0.57–0.82 for the total scale (Keyes, 2007). The three-factor structure of the short form – emotional, psychological, and social well-being – has been confirmed in various American representative samples (Keyes, 2005, p. 3–11 & 2009, p. 3–29). In a study done in South Africa using the MHC-SF in Setswana-speaking Africans, a Cronbach alpha of 0.74 was reported (Keyes, Wissing, Potgieter, Temane, Kruger & Van Rooy, 2008). In the current study, a Cronbach alpha of 0.95 was obtained for the total scale.

The Rosenberg Self-esteem Scale (RSES) of Rosenberg (1965): The RSES is globally used to measure the participant’s general levels of self-esteem by means of 10 items that assess an individual’s perceptions of his/her own self-worth. There is a 4-point agreement–disagreement Likert response format for all the items in which the participant’s responses

will range from 1 (strongly agree) to a 4 (strongly disagree). The examples of items on the RSES include statements such as “I feel that I have a number of good qualities” and “I certainly feel useless at times”. The RSES has a high reliability with test–retest correlations in the range of 0.82 to 0.88 and Cronbach alpha coefficients for various samples are in the range of 0.77 to 0.88 (Rosenberg, 1965). The internal consistency of the RSES is supported by a Cronbach alpha coefficient of 0.91 found by Sinclair, Blais, Gansler, Sandberg, Bisitis and LoCicero (2010). A South African study that used the RSES was by Smit (2005), who studied the relationship between sex-role identity, attributional style and self-esteem of a multiracial group of female students (aged between 18 and 22). The current study showed a Cronbach alpha of 0.85 for the total scale.

The General Health Questionnaire (GHQ) of Goldberg and Hillier (1979): The GHQ measures aspects of mental health by assessing symptoms and signs of non-pathological mental ill-being or lack of mental well-being. It consists of 4 subscales: somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. According to Goldberg and Hillier (1979), a Cronbach alpha coefficient of 0.79 was found for the GHQ-12 in the population studied. A study done in Iran with 714 young people showed a Cronbach alpha coefficient of 0.87 (Montazeri, Harirchi, Shariati, Garmaroudi, Ebadi, & Fateh, 2003), while a study done in South Africa by Bosman (1990) found a reliability coefficient of 0.91. The current study showed a Cronbach alpha of 0.93 for the total scale.

Research procedure

Data was gathered by means of a compiled question booklet containing the measuring instruments discussed above. A pilot study was conducted and 11 participants (8 of whom were part of the current study) reported that the questionnaires were clear and user-friendly. Completion of the booklet took approximately 40 minutes. The Ethics Committee of the

North-West University approved this study (reference no. NWU-00041-08-A1) (see Appendix 7). Permission and written consent were also obtained from all the referral sources and research participants (see Appendices 4 & 6). The researcher presented the intended research project to all referral sources and participants, explaining the objectives, the ethical principles and allowing an opportunity for questions and concerns to be clarified, thus establishing a trusting rapport. Where referral sources were used these health professionals distributed and collected the questionnaires, and for the rest the researcher met with the participants and then distributed and collected the questionnaires herself.

Statistical analysis

The majority of the answers to the open-ended questions of the biographical questionnaire were transformed into quantitative data where the responses were categorised into discrete categories. The questions which could not be statistically coded were thematically analysed. Data obtained from the validated questionnaires were electronically captured by the researcher and statistically analysed by a statistical consultant using the SPSS software program (2010) and the STATISTICA software program (2010). Descriptive statistics, reliability of measuring instruments, cut-off points and correlations among coping, posttraumatic growth and the psychological well-being scales, were determined. The prevalence was determined by normalising the mean scores of the scales for coping, posttraumatic growth and well-being (COPE & CSE, PGI, RSES & MHC) and expressing the score as a value between 0 and 1, representing the level of coping, growth and/or well-being manifested by the participants. Indices thus obtained were categorised as follows: Low scorers = < 0.4 , moderate scorers = > 0.4 and < 0.6 and high scorers = > 0.6 .

Results

The results are firstly discussed with reference to findings from the open-ended questions comprising the biographical questionnaire and thereafter descriptive statistics, reliability of the measuring instruments, correlations between measuring instruments, and the prevalence of positive coping, posttraumatic growth and psychological well-being in this group of participants is presented.

Biographical information

Socio-demographic descriptives: The participants (N=60) were female and their ages ranged from 18–53 years. The age group most represented was 18–35 years of age. Of the participants, 70% were from European descent, 28% from African descent and 2% from Asian descent. Of the participants, 36% were single, 20% were married, 10% were divorced/separated, 18% were involved, 13% were in a same-sex relationship and 3% were widowed. Of the participants, 28% were students, 12% were educators, 15% were in administrative or technical positions respectively, 13% were involved in positions within the helping professions, 7% were self-employed and 10% were not employed.

Dynamics of CSA: Of the participants, 98% reported contact abuse with predominantly rape as the form of abuse. In 87% of the participants, the respondent knew the perpetrator. The duration of the CSA was on average 1–5 years. The mean age at which the abuse occurred was 8.3 years. In some cases the abuse began in early childhood (2–6 years) but was more predominant in middle childhood (7–10 years).

Disclosure: The predominant age of disclosure was between adolescence (16–20 years) and early adulthood (21–39 years). Of the participants, 25% disclosed the abuse for the first time to a friend, 18% to a psychologist or their mothers. The remaining participants disclosed to another family member, their life partner, other relatives and outside

professionals. Of the participants, 88% felt the person they disclosed to believed their disclosure, and 60% of the participants felt stigmatised after disclosing.

Traumagenic dynamics: Of all the participants, 57% experienced all four traumagenic dynamics (described previously in the introduction) and the rest at least a combination of two of the dynamics.

Therapeutic experiences: Of the participants, 47% reported therapy to be a positive experience.

Mental health: Of the participants, 52% were subsequently treated for a mood disorder.

Spirituality: Of the participants, 60% experienced religion as a positive component of their recovery process.

Difficulties after CSA: Of the participants, 48% had experienced interpersonal trust as the most prominent difficulty after the abuse, while 30% indicated problems with intimacy and close relationships, and 22% had experienced having poor self-esteem.

Personal growth: Of the participants, 88% did experience growth after the trauma, 50% related this growth to personal strengths, 23% to growth in relating to and understanding of others, 2% in the appreciation of life, 6% towards new possibilities and 7% toward spirituality.

Descriptive statistics and prevalence findings

Descriptive statistics

The descriptive statistics and Cronbach alpha reliability indices for all scales are presented in Table 1.

>include Table 1 about here<

Mean scores are used to summarise normal distributions of interval or ratio scores and standard deviation is a measure of variability that indicates how much the scores are spread out around the mean (Heimans, 2006). The mean scores and standard deviations found in this study mostly correspond with those found in literature. As shown in Table 1, the mean scores of the COPE subscales vary between 2.97 and 1.72 and compare well with those found by Law (2004) in a group of South African students and with what Van Zyl (2009) found in a group of health practitioners. The mean score (65.00) and standard deviation (30.42) for the CSE scale in this study are in line with those found by Wissing, Wissing, Du Toit and Temane (2008). The mean score (63.72) and standard deviation (24.77) found for the PGI are somewhat higher than those reported by Peltzer (2000) in a South African sample. As depicted in Table 1, the mean scores of the MHC are 7.93 (EWB), 8.53 (SWB) and 16.58 (PWB), which are slightly lower than those found reported in the study of Khumalo (2010). The mean score (63.72) and standard deviation (24.77) for the RSES scale in this study are in line with those found by Smit (2005). The mean score (4.65) and standard deviation (4.36) for the GHQ scale in this study are in line with those found by Koen (2009).

Reliability of scales

The Cronbach alpha reliability indices of all the measuring instruments as presented in Table 1 are good according to the criteria described by Steiner (2003). The high reliability indices found for the PGI, CSE, MHC and GHQ may however indicate duplication of content across items in those scales (John & Benet-Martinez, 2000). Nonetheless, the Cronbach alpha coefficients for the scales found in the current research largely correspond to those found in other comparable studies.

Correlations among measures

The correlations shown in Table 2 between scales and sub-scales used to measure the constructs of this study, range from moderate (0.258) to high (0.786), with mostly medium to large practical effect (Cohen, 1977).

>include Table 2 about here<

The significant positive correlations among the scales and sub-scales measuring aspects of coping (especially the COPE active and COPE positive with the CSE), posttraumatic growth (PGI) and psychological well-being (MHC and RSES) indicate that the underlying constructs have features in common on an empirical level which, for the purposes of this study, could be conceptualised as constructive coping together with posttraumatic growth and psychological wellness in this group of women who had experienced CSA. The significant negative correlations of the GHQ with the other positive scales and sub-scales as well as the significant positive correlations with aspects of negative coping, support what is theoretically expected, namely that women who cope well, display posttraumatic growth and are psychologically sound, would not significantly indicate symptoms of mental illness or dysphoria.

Prevalence of coping, posttraumatic growth and psychological well-being

The prevalence results are presented in Table 3.

>include Table 3 about here<

Using the following statistical categories: low scorers = < 0.4 , moderate scorers = > 0.4 and < 0.6 and high scorers = > 0.6 , the following was found as depicted in Table 3.

COPE: 35 participants (58%) displayed high scores, 23 participants (39%) displayed moderate scores and 2 participants (3%) displayed low scores on the COPE.

CSE: 25 participants (42%) depicted high scores, 12 participants (20%) depicted moderate scores and 23 participants (38%) depicted low scores on the CSE.

PGI: 36 participants (60%) presented high scores, 12 participants (20%) presented moderate scores and 12 participants (20%) presented low scores on the PGI.

RSES: 27 participants (45%) appeared to score high, 20 participants (33%) appeared to score moderately and 13 participants (22%) appeared to be low scorers on the RSES.

MHC: 25 participants (42%) showed high scores, 11 participants (18%) showed moderate scores and 24 participants (40%) showed low scores on the MHC.

Discussion

The aims of the investigation reported here were to determine the prevalence of positive coping, posttraumatic growth and psychological well-being in this group of women who had experienced sexual abuse during childhood. Data was obtained from validated questionnaires and a biographical questionnaire. The main finding was that the majority of this group of women could be described as coping constructively and having experienced posttraumatic growth, while only a moderate group manifested psychological well-being. This finding seems to support the fact that growth and distress in some cases may co-exist (Tedeschi & Calhoun, 1998).

The biographical questionnaire provided valuable information on CSA-related experiences of the participants. The finding that in about the whole group of women (98%), contact abuse with predominantly rape was the form of abuse, and most of them (87%) knew

the perpetrator, is supported by the research of Taylor and Thomas (2003), who found that the majority of CSA appears to occur within the family setting, and by Saffy (2003), who reports that in 98% of cases the abuser is known to the victim. Similarly, Fouché (2007) and Spies (2006b) found that more often than not all abused children are abused by either a family member or an acquaintance. The CSA of participants in the current study appeared to have commenced predominantly in middle childhood (7–10 years) and, according to Fouché (2007), the prevalence of CSA appears to be highest during the middle childhood years. The middle childhood phase thus seems to be a particularly vulnerable time for abuse and one wonders whether the developmental characteristics of this phase may contribute to this. It is a phase in which the child seems relatively calm and stable emotionally but cognitively curious and explorative and socially keen and open (Louw & Louw, 2007). Abusers may find that the child is now an easier target than younger children or adolescents. Further research could shed light on this matter.

The predominant age of disclosure was between adolescence (16–20 years) and early adulthood (21–39 years). This is also supported by the findings of Fouché (2007), that disclosure often occurs at a much later stage often due to the stigmatisation and fear involved, as well as the fact that the perpetrator is often in the child's home or immediate environment. Although a large group (88%) of participants felt that the person they disclosed to did indeed believe their admission, many of them (60%) felt stigmatised after disclosing, which is also indicated in the literature (Finkelhor & Browne, 1985; Staller & Nelson-Gardell, 2005). The pattern of disclosure of participants in this study corresponds to what is reported in literature, namely that family members, mothers and professionals are the most likely sources of support when disclosing (Sauzier, 1989).

About half (52%) of the participants were treated for a mood disorder, which is supported by literature reporting that the long-term effects of CSA frequently include a range

of symptoms such as depression (Allen, 2008; Bennett & Hughes, 2000; Finkelhor & Browne, 1986; Spies, 2006a). The most frequently reported effects of CSA are of an emotional nature. Victims of CSA experience emotions of degradation and humiliation leading to low self-esteem (Saffy, 2003). This also seems evident in findings that 42% of the participants experienced trust as the most prominent difficulty after the abuse, 30% experienced poor intimacy and relationships, and 22% experienced poor self-esteem. Distortions in attachment that result from sexual abuse in childhood can be toxic in all future relationships, and especially so in the areas of self-esteem, intimacy, trust and the ability to bond (Taylor & Thomas, 2003). All four traumagenic dynamics were experienced by 57% of the women and the rest experienced at least a combination of two of the dynamics. This illustrates indeed the severe and unique psychological impact of the CSA experience as reported by the authors Finkelhor and Browne (1986).

Uniquely, 47% of the participants reported therapy to be a positive experience, unlike findings reported in the literature (Baird, 1996; Liang, Williams, & Siegel, 2006) and this may be related to the 88% of the participants who reported experiencing growth after the trauma. The subjectively reported experience of posttraumatic growth on the biographical questionnaire appears much higher than when interpreted quantitatively where only 60% scored high on the PGI, and the researcher speculates that this is due to the “Janus-face two-component model” proposed by Maercker and Zoellner (2004). In this model, posttraumatic growth is considered to have a constructive self-transcending side (perhaps indicated quantitatively) and an illusory self-deceptive side (perhaps indicated qualitatively). The constructive side could be associated with functional adjustment or functional cognitive restructuring as seen in the questions of the PGI, whereas the self-deceptive side may be linked to positive illusion in the open-ended questions where the participants responded with cognitively adaptive efforts and positively distorted beliefs which enabled them to exceed

their previous form of self-perception. According to Frazier et al. (2001), even if positive changes are more perception than reality, they nevertheless are associated with positive outcomes.

Nonetheless, according to Tedeschi and Calhoun (1995), an average of 50–60% of respondents across studies endorse some degree of growth or positive change in response to a variety of traumatic events. Of the participants in this study, half (50%) related this growth to personal strength and 23% to growth in relating to others. Tedeschi and Calhoun (1995) are convinced that suffering can often yield strengthening and growth. This is further supported by Tedeschi, Park and Calhoun (1998) who report that survivors may change their life philosophy, grow in wisdom, act more altruistically (i.e. positive individual characteristics) and report that their relationships are enhanced in some way (i.e. positive social relationships). Such survivors have experienced first-hand the limits of human life and this transforms into the awareness that the trauma can be seen as a valuable learning opportunity (Harvey, 2001). Related to an awareness of vulnerability and personal limitation (Tedeschi et al., 1998) is the finding that 60% of the participants experienced religion as a positive component of their recovery process. This is further supported by the work of Gall (2006) and Gall, Basque, Damasceno-Scott, and Vardy (2007).

Descriptive statistical findings obtained from validated measuring instruments indicate that the mean scores and standard deviations for this group of women (N=60) are mostly similar to those reported in literature from research with various research groups. This suggests that this group of women, despite their traumatic childhood experiences, are not very different from the general population in their overall mental health profile (depicting their coping abilities, their growth after trauma and their psychological wellness). From the mean scores obtained for the COPE, it would seem as that this group of women made use of acceptance, religion, planning, active coping and emotion-focused coping as their most

prominent coping strategies. A narrative compiled from the items of the COPE in each of these sub-scales seems to say: “I have learned to live with what has happened and I put my trust in God to sustain me. I can however make a plan of action and then I do what has to be done, one step at a time. If necessary, I talk to someone about how I feel.” These coping strategies correspond to those found by Carver et al. (1989) in people who have to cope with a stressor that must be endured. According to Valentiner, Foa, Riggs and Gershuny (1996), such strategies are cognitive emotion-focused ways of coping that could promote healing in sexually abused women.

The reliability coefficients of the measuring instruments used were acceptable, although some scales had such high Cronbach alpha scores that it may indicate redundancy of some items in those scales, according to John and Benet-Martinez (2000) and Steiner (2003). The small group (N=60) of participants in this study could also have contributed to the high reliability indices obtained. Significant positive correlations among the scales measuring aspects of constructive coping, posttraumatic growth and psychological well-being indicate that the underlying constructs of these instruments have features in common on an empirical level which, for purposes of this study, could be conceptualised as constructive coping, posttraumatic growth and psychological health in this group of women. This finding links to that of Linley and Joseph (2003), who believe that post-traumatic growth harnesses the core principles of positive psychology such as strength, resilience, hope, gratitude and forgiveness and that these principles can be put to effective use in the therapeutic service of trauma survivors. The significant negative correlations of the GHQ measuring aspects of pathology (psychological distress) with the other scales and sub-scales measuring positive features and the significant positive correlations with aspects of negative coping support the theoretical assumption that, if women who experienced CSA could cope constructively, grow

posttraumatically and show psychological health, they would not score high on items of mental ill-health and dysphoria.

The prevalence of constructive coping, posttraumatic growth and psychological well-being was determined, and more than half of the women (58%) manifested constructive coping, while only 42% of the participants manifested coping self-efficacy. This seems to be a discrepancy but the explanation may lie in the low self-esteem manifested by these women. Only 45% obtained high self-esteem scores and this corresponds with the 42% who scored high on coping self-efficacy. These findings clearly indicate the harm that was done to essential self-related strengths in these women and is supported by the work of Saffy (2003).

Of the participants, 60% manifested posttraumatic growth, which is higher than levels of posttraumatic growth seen in previous studies (Peltzer, 2000). The low levels of self-esteem (45% had high scores) reported by the majority of these women is a common finding in research of this nature (Finkelhor & Browne, 1986; Spies, 2006a; Taylor & Thomas, 2003).

The 42% of participants who manifested psychological well-being as measured with the MHC of Keyes (2002) correspond well with the findings of Koen (2010) obtained in a sample of South African nurses working under severe stress. The percentage of well-being (flourishing) in this group of women was also much higher than the 20% found by Keyes et al. (2008), in an adult African community sample. This finding clearly points to the resilience and unique strengths of character displayed by this group of women who experienced CSA and is in line with the assumptions of positive psychology that people have the potential to overcome life's adversities by using their strengths and virtues and to live their lives with competence, dignity and mastery of challenges (Seligman, 2011).

Conclusion

In this study, women who had experienced CSA and demonstrated constructive coping, posttraumatic growth and psychological well-being were identified. Further qualitative in-depth analysis of their experiences may provide a more thorough understanding of their coping behaviours, posttraumatic growth experiences and manifestation of aspects of psychological well-being, and this may prove to be helpful in identifying guidelines on which supportive intervention programmes for the enhancement of these constructs in women who experienced CSA can be based.

A limitation of the study, namely the relatively small number of participants (N=60), was partly due to the sensitivity involved in researching such a sensitive topic in vulnerable women. The current findings thus cannot be generalised and strongly suggest the need for an extended analysis. Despite these limitations the aims of this research were achieved.

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Table 1: Descriptive statistics and internal consistency indices of the measuring instruments for the total group (N=60).

Scale	Mean	Std. dev.	Min	Max	Cronbach alpha
COPE:					
Active	2.579	0.688	1.00	4.00	0.853
Planning	2.688	0.774	1.00	4.00	
Suppression	2.225	0.642	1.00	3.75	
Restraint	2.529	0.643	1.00	3.75	
Social-Inst	2.100	0.769	1.00	4.00	
Prob-Foc	2.424	0.511	1.30	3.55	
Social-Emot	2.308	0.865	1.00	4.00	
Positive	2.546	0.741	1.25	4.00	
Acceptance	2.967	0.819	1.25	4.00	
Religion	2.704	0.853	1.00	4.00	
Venting	2.229	0.592	1.00	3.75	
Emot-Foc	2.551	0.511	1.50	3.55	
Denial	1.817	0.823	1.00	4.00	
B-Disengage	1.896	0.677	1.00	3.50	
M-Disengage	2.475	0.713	1.00	4.00	
Drug	1.717	1.059	1.00	4.00	0.942
Avoid	1.976	0.567	1.00	3.38	
CSE	65.000	30.415	0.00	126.00	
PGI	63.717	24.770	3.00	104.00	0.945
RSES	27.000	7.383	11.00	40.00	0.845
MHC: EWB	7.933	4.178	0.00	15.00	0.948
MHC: SWB	8.533	5.800	0.00	25.00	
MHC: PWB	16.583	8.714	0.00	30.00	
GHQ	4.650	4.364	0.00	12.00	0.929

Note: Social-Inst=Social Instrumental, Prob-Foc=Problem-Focused, Social-Emot=Social Emotional, Emot-Foc=Emotion Focused, B-Disengage=Behavioural Disengagement, M-Disengage=Mental Disengagement, Avoid=Avoidance; CSE=Coping Self-Efficacy Scale; PGI=Posttraumatic Growth Inventory; RSES=Rosenberg Self-Esteem Scale; MHC:EWB=Mental Health Continuum: Emotional Well-being, MHC:SWB=Mental Health Continuum: Social Well-being, MHC:PWB=Mental Health Continuum: Psychological Well-being; GHQ=General Health Questionnaire.

Table 2: Correlations of all the measuring instruments for the total group (N=60).

	COPE															CSE	PGI	RSES	GHQ
	Active	Planning	Social-Inst	Prob-Foc	Social-Emot	Positive	Acceptance	Religion	Venting	Emot Foc	Denial	B-Disengage	M-Disengage	Drug	Avoid				
CSE	0.530	0.442	0.375	0.494	0.356	0.611	0.397			0.499	-0.395			-0.273	-0.339				
PGI	0.497	0.276	0.286	0.397	0.402	0.597	0.318	0.376		0.517	-0.330			-0.342	-0.337	0.644			
RSES	0.570	0.460		0.429	0.326	0.611	0.407			0.449	-0.376	-0.613		-0.342	-0.556	0.754	0.633		
MHC: EWB	0.528	0.398	0.258	0.408	0.349	0.565	0.321			0.419	-0.533	-0.292		-0.445	-0.543	0.679	0.689	0.755	-0.715
MHC: SWB	0.479	0.344	0.285	0.381	0.419	0.574	0.268			0.459	-0.414	-0.279		-0.320	-0.437	0.553	0.638	0.652	-0.485
MHC: PWB	0.534	0.428	0.338	0.477	0.458	0.633	0.394	0.288		0.569	-0.471			-0.316	-0.413	0.725	0.751	0.786	-0.566
GHQ	-0.470	-0.432		-0.368		-0.470			0.288		0.383	0.541	0.301	0.345	0.556	-0.628	-0.464	-0.740	

Note: COPE=Coping Inventory, Plan=Planning, Social-Ins=Social Instrumental, Prob-Foc=Problem-Focused, Social-Emot=Social Emotional, Positive=Positive Reinterpretation & Growth, Emot-Foc=Emotion Focused, B-Disengage=Behavioural Disengagement, M-Disengage=Mental Disengagement, Drug=Drug Use, Avoid=Avoidance; CSE=Coping Self-Efficacy Scale; PGI=Posttraumatic Growth Inventory; RSES=Rosenberg Self-Esteem Scale; MHC:EWB=Mental Health Continuum: Emotional Well-being, MHC:SWB=Mental Health Continuum: Social Well-being, MHC:PWB=Mental Health Continuum: Psychological Well-being; GHQ=General Health Questionnaire.

Significance: $p = 0.05$: Values above 0.250

Practical effect: Medium effect: 0.30–0.50; Large effect: >0.50

Table 3: Prevalence of coping, posttraumatic growth and psychological well-being for the total group (N=60).

		COPING		GROWTH	WELL-BEING	
		COPE	CSE	PGI	RSES	MHC
High:	(>0.6)	35	25	36	27	25
Moderate:	(0.4 to 0.6)	23	12	12	20	11
Low:	(<0.4)	2	23	12	13	24
Total		60	60	60	60	60
Prevalence (%):						
High:	(>0.6)	58.3	41.7	60.0	45.0	41.7
Moderate:	(0.4 to 0.6)	38.3	20.0	20.0	33.3	18.3
Low:	(<0.4)	3.3	38.3	20.0	21.7	40.0
Total		100.0	100.0	100.0	100.0	100.0

Note: COPE=COPE Inventory, CSE=Coping Self-Efficacy Scale; PGI=Posttraumatic Growth Inventory; RSES=Rosenberg Self-Esteem Scale; MHC=Mental Health Continuum.

MANUSCRIPT TWO

**A QUALITATIVE UNDERSTANDING OF THE COPING BEHAVIOUR,
POSTTRAUMATIC GROWTH AND PSYCHOLOGICAL WELL-BEING IN
WOMEN WHO EXPERIENCED CHILDHOOD SEXUAL ABUSE**

Prepared for submission to *Journal of Traumatic Stress*

Guidelines for authors: Journal of Traumatic Stress

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The first article has been submitted to the *Journal of Traumatic Stress* for publication and this manuscript and reference list has been styled according to this journal's specifications. The following is a copy of the guidelines for prospective authors as set out by the journal.

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ABSTRACT

The research reported here aimed to understand the coping behaviours and posttraumatic growth of women who had experienced sexual abuse in childhood and how these would impact on the women's psychological well-being in adulthood. A qualitative research design with a purposefully selected sample was used. Individual interviews were conducted with 10 women between the ages of 23 and 48 years who had experienced childhood sexual abuse. Transcribed data from the interviews were analysed and reflected upon in light of the research questions. The life outcomes of women who had experienced childhood sexual abuse are generally adverse, yet some of these survivors managed to cope constructively with the abusive relationship and experienced posttraumatic growth and, through this, experienced psychological well-being. The themes identified refer to: positive coping behaviour including psycho-socio spiritual resources, made up of positive coping styles, strategies and resources such as active emotion-focused coping, positive explanatory styles, seeking social support and religious coping; posttraumatic growth including the healing process, positive outcomes of healing, the survivor and wounded healer roles; and psychological well-being including positive strengths such as self-efficacy, self-worth, inner strength and meaning. These themes and sub-themes allude to the interconnections, interrelatedness and overlap between distinct constructs of constructive coping, posttraumatic growth and psychological well-being as reported in literature, which embraces the central tenets of positive psychology.

Key words: Women, childhood sexual abuse, positive coping behaviour, posttraumatic growth, psychological well-being, positive psychology

Introduction

Prevalence studies have determined that up to one-third of women have experienced childhood sexual abuse and in South Africa it may even be higher (Perrott, Morris, Martin and Romans, 1998). The annual sixteen days of activism against the abuse of women and children upheld in South Africa in December each year, attests to the societal concern about this matter. Therefore, the opinion of Baker (2002), that sexual abuse against females is a serious problem in society and that there is a need for greater understanding of the presentation and treatment of adult survivors of childhood sexual abuse (CSA), is pertinent.

Bogar and Hulse-Killacky (2006) state that over the past two decades, the counselling literature has been replete with information about the devastating and lingering effects of childhood sexual abuse, often painting a rather grim picture of the quality of life for adults who have experienced such trauma. Various authors (Bennett & Hughes, 2000; Browne & Finkelhor, 1986; Elhai, Gold, Mateus & Astaphan, 2001; Fergusson, Boden & Horwood, 2008; Futa, Nash, Hansen & Garbin, 2003; Spies, 2006) report that CSA is a risk factor associated with the development of a number of internalising (anxiety, depression, poor self-esteem, somatic complaints, and feelings of isolation) and externalising behaviours (self-abusive behaviours, problems with relationships and poor social competence, substance abuse problems, problems related to sexual revictimisation and difficulties with sexual adjustment). The effects of CSA uniquely manifest in each individual; therefore, there is no set of symptoms that defines the profile of a sexually abused person (Futa et al., 2003). This type of trauma occurs in all communities, ethnic backgrounds, religions, cultures, and social and economic classes, and is experienced by both males and females (Hay, 1997), with severe consequences for the individual.

Coping with childhood sexual abuse

Glazer and Frosh (1993) indicate that there appears to be no universal definition of CSA although there are many *ad hoc* formulations and operational guidelines. The American Psychological Association (2001) supports this opinion. Newton (2001, p. 1), however, defines childhood sexual abuse as “contacts or interactions between a child and an adult when the child is being used for sexual stimulation of the perpetrator or another person when the perpetrator or another person is in a position of power and control over the victim”. Thus, CSA not only involves the sexual misuse of, but also the abuse of power that an adult has over a child. For the purpose of this research, CSA was considered to be the use of a child for any form of sexual activity, sexual gratification or sexual behaviour by an adult or adolescent, and the term survivor denotes any adult who was sexually abused as a child. The definition of a child as stated in the Constitution of the Republic of South Africa, is any person under the age of 18 years (Scott, 2001).

The experience of CSA may prompt the use of particular coping strategies (Walsh, Fortier & DiLillo, 2010) and consistent with this notion, Finkelhor and Browne (1985) have proposed a model termed the Traumagenic Dynamics model of CSA that describes, in part, the manner in which CSA may influence the development of coping strategies. This model posits that four dynamics explain the symptoms observed in sexual abuse victims: traumatic sexualisation, stigmatisation, betrayal and powerlessness. A “traumagenic dynamic is an experience that alters a child’s cognitive or emotional orientation to the world and causes trauma by distorting the child’s self-concept, world view, or affective capacities” (Finkelhor, 1987, p. 354). Furthermore, Finkelhor (1987, p. 355) suggests that victims may develop abuse-related schemas and coping strategies that are adaptive and reflect integration, but may be “dysfunctional in coping with a world where abuse

is not the norm". Lysaker, Meyer, Evans, Clements and Marks (2001) agree that the psychological effects of sexual trauma on the individual apparently reduce the ability to cope effectively.

Several studies indicate that disengagement and avoidant methods of coping often used by survivors of CSA lead to increased psychological distress (Burt & Katz, 1987; Frazier & Burnett, 1994; Meyer & Taylor, 1986; Santello & Leitenberg, 1993; Valentiner, Foa, Riggs & Gershuny, 1996). According to Olf, Langeland and Gersons (2005), in the context of traumatic stress, active or instrumental coping strategies, such as positive thinking or dealing actively with problems and seeking social support have been associated with a better adaptation to stress, while passive coping strategies such as avoidance are mostly considered as maladaptive coping strategies.

Carlson and Dalenberg (2000) state that researchers have begun to focus on gaining a better understanding of the risk and protective factors that affect psychological adjustment in the face of sexual assault, while Perrott et al. (1998) point out that coping responses could be risk or protective factors that intercede the effects of the abuse and related stressors. Banyard (2003) suggests that coping behaviour can be seen as a possible CSA-distress link that requires further exploration, while Spaccarelli (1994) found that the impact of CSA on adult well-being could be intervened by processes of cognitive appraisal and coping behaviour. Therefore, Newman, Kaloupek, and Keane (1996) emphasise that when working with CSA trauma survivors, it is important to assess an individual's symptoms, as well as life context, coping skills, beliefs, strengths and weaknesses, because, according to Walsh et al. (2010), coping processes are among the key pathways by which abusive experiences may impact long-term adjustment. The latter authors further state that, coping effectively with CSA is likely to occur in phases over time and involve the use of different strategies. Coping responses used in the immediate aftermath of the trauma appear to reflect avoidance behaviours whereas long-term coping strategies reflect cognitive efforts to integrate the

material. According to Futa et al. (2003), relatively little research has been done on how the experience of abuse is coped with by CSA survivors in adulthood. Much has been learned about potential consequences of CSA, but relatively little is known about the coping strategies survivors use to deal with memories of the abuse. The identification of coping strategies used by abuse survivors may contribute to a better understanding of factors that facilitate or interfere with adaptive functioning (Futa et al., 2003).

From a positive psychological perspective, such an exploration of the coping behaviour of CSA survivors will focus on strengths and abilities that enable adaptive coping and the outcome thereof.

Positive psychology: A shift in paradigm

Seligman and Csikszentmihalyi (2000) argue that for several decades, the field of psychology has focused almost exclusively on understanding human functioning within a disease-focused medical model and therefore many other salutary human experiences have been neglected. In contrast, positive psychology encourages the application of the scientific method to the full complexity of human behaviour, including positive adaptation and growth. This approach is consistent with what has been termed the post-modern perspective, which also recommends a shift away from problem-orientated approaches to those focusing on strengths that allow individuals to survive and grow even in the face of adversity (Richardson, 2002). Seen from a psychopathogenic perspective, CSA appears predictive of poor psychosocial functioning in adulthood (Lysaker et al., 2001) and CSA victims would be bound to experience numerous interpersonal problems and maladaptive behaviours that hamper their productivity and overall psychological well-being (Putnam & Trickett, 1993). However, despite exposure to such devastating traumatic events some adults do not develop

severe distress or long-standing psychopathology (Campbell-Sills, Cohan & Stein, 2006), and appear to show resilient adaptation after having experienced CSA (Zautra, Hall & Murray, 2010). The positive psychology approach, which is currently winning favour in research and practice domains of psychology, would thus query the assumed adverse outcomes of CSA and allow for open-strengths- and growth-related outcomes such as experiencing constructive coping, growing after the trauma and manifesting psychological well-being.

Positive coping

Compton (2005, p. 117) defines positive coping “as adaptations to challenges that do not simply return a person to homeostasis but instead propel a person toward a better quality of life”. In support of a posttraumatic growth and positive psychology orientation Compton (2005, p. 117) refers to such a process as psychological “thriving”, a term coined by O’ Leary and Ickovics (1995), which includes enhanced physical and mental functioning after successful coping adaptations. People are thus engaged in thriving when they resiliently adapt to stress and challenges and as a result of such adaptive processes acquire more refined coping skills. Therefore, some ways of dealing with severe stress may actually help to build more effective coping resources for the future. In this regard, Folkman (2011, p. 76) refines the definition of coping as “the cognitive and behavioural efforts used to regulate distress, manage the problem causing the distress and sustain positive well-being during stressful situations”. This definition broadens the traditional conceptualisation of coping to include positive coping. For the CSA survivor, the coping task is nothing short of daunting; yet, in the face of profound coping challenges, some trauma survivors may discover new personal strengths and possibilities (Janoff-Bulman, 2006). Aldwin (1994) refers

to this as transformational coping, on which Tedeschi and Calhoun (2004a, p. 1) have expanded and conceptualised as posttraumatic growth.

Posttraumatic growth

Previous research focused mostly on the adverse effects that occur because of sexual traumatisation, and the relevant literature available on survivors of CSA is primarily from a pathogenic perspective and reports on the adverse effects that such trauma may have on an individual (Sher, 2002). However, there is increasing evidence that people experience not only negative but also certain positive effects after confrontation with a traumatic event and according to Ryff and Singer (1998), the deepest levels of meaning, purpose and human connection may actually require confrontations with negative aspects in life. Tedeschi and Calhoun (1995) thus propose that suffering can sometimes yield strengthening and growth, and they have consequently coined the concept posttraumatic growth to refer to experiences of positive change in individuals, which occur as the result of attempts to cope in the aftermath of traumatic life events. The personal areas in which posttraumatic growth could be evidenced are: personal strength or positive aspects discovered about and developed within the inner person; relating to others where relational strengths and values are deepened; appreciation for life in which one's philosophy about life and the things that matter and have meaning becomes clear and precious; new possibilities, which entail the development of new goals and a clearer focus on one's purpose; and spiritual growth or rediscovery where ties to the higher and eternal values are valued anew (Tedeschi & Calhoun, 2004a). When considering these domains of growth that flow from posttraumatic growth, one can agree with Tedeschi and Calhoun (2004b) that posttraumatic growth may lead to a more fulfilling

and meaningful life in which psychological strengths or aspects of psychological well-being are evident.

Psychological well-being

Social scientists have lobbied for decades to define mental health as more than the absence of mental illness. Drawing on the work of Jahoda (1958) towards positive mental health, Ryff (1989) and her colleagues developed a model of psychological well-being based on universal descriptions of positive psychological and social functioning (Keyes, 1998; Keyes, Shmotkin & Ryff, 2002; Ryff & Keyes, 1995; Ryff & Singer, 1998). Originally used to describe positive functioning across the life span, Ryff's (1989) conceptualisation of psychological well-being has been extended to describe positive mental health in the form of various constructs, models and measures (Diener, 2009; Lopez & Gallagher, 2009). Psychological well-being is a complex and holistic concept which covers a variety of domains and is seen as multidimensional, where different aspects of the psyche are involved, such as self-esteem, affect, cognition and relational behaviour (Wissing & Van Eeden, 2002). Keyes (2009) further refined the construct of psychological well-being as pertaining to the culmination of emotional, mental and social well-being into a state known as flourishing or optimal functioning.

The General Psychological Well-being (Wissing & Van Eeden, 2002) and Mental Health Continuum models (Keyes, 2002) are two contemporary conceptualisations that consider well-being from a holistic perspective. The two models are based on the theoretical and empirical groundings that psychological well-being is integrated, complex, holistic and multi-faceted by nature. The General Psychological Well-being model refers to a one dimensional factor made up of positive intrapersonal, interpersonal and spiritual elements of human functioning (Wissing &

Temane, 2008; Wissing & Van Eeden, 2002). The Mental Health Continuum model represents the upper end of positive well-being and optimal human functioning as indicated by emotional well-being, psychological well-being, and social well-being (Keyes, 2002). Emotional well-being is characterised by the presence of positive affect, the absence of negative affect and a sense of satisfaction with life. Psychological well-being refers to Ryff's (1989) six dimensions of psychological well-being, namely self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth. Emotional and psychological well-being are however intrapersonal reflections of one's adjustment and do not represent a complete engagement in society and life. Social well-being consists of social integration, social acceptance, social contribution, social actualisation and social coherence, and refers to the interpersonal relations which are equally necessary for mental health (Keyes, 1998).

Thus, according to Wissing and Van Eeden (2002) and Wissing and Temane (2008), general psychological well-being reflects positive cognitive, affective, conative, interpersonal, social and spiritual experiences as well as the absence of mental and physical symptoms of distress.

From the above discussion, the question comes to mind whether the life outcomes of CSA survivors are generally only adverse, or whether they can manage to cope with and overcome the CSA experiences and through posttraumatic growth be able to "survive and prevail" (Tedeschi & Calhoun, 2004b, p. 406), and experience health, well-being and satisfaction with life. In other words, can women constructively cope with CSA, experience posttraumatic growth and in adulthood manifest general psychological wellness and even flourish?

The qualitative exploration of the coping, posttraumatic growth and psychological well-being of adult CSA survivors, will be described below.

Aim and objectives of the study

The aim of this qualitative study was to obtain in-depth understanding of the coping behaviours and posttraumatic growth of women who had experienced CSA and the way their coping and posttraumatic growth impact on their overall psychological well-being. The following objectives were used to guide the research: to explore the coping behaviours of women who had experienced CSA; to understand their posttraumatic growth; and to enquire how they manifest psychological well-being.

Method

Research design

A qualitative interpretative design was used (Creswell, 2009) in order to understand the coping, posttraumatic growth and psychological well-being in women who had experienced CSA. Women who reported positive coping behaviour, posttraumatic growth and aspects of psychological well-being were identified in a previous phase of this research (cf. Article one), in which validated instruments measuring coping behaviour, posttraumatic growth and psychological well-being were used.

Participants

The purposefully selected participants (Creswell, 2009), were 10 women who had experienced CSA but who previously reported constructive coping, posttraumatic growth and psychological well-being on measuring instruments and met the following criteria: they had been sexually abused prior to the age of 18 years, the abuse had been disclosed previously, some form of therapeutic intervention had been received and they voluntarily agreed to participate in this research. The

participants all lived in Gauteng, South Africa. From a detailed biographical questionnaire completed by the participants, the following information was gleaned:

Socio-demographic descriptives: The participants' ages ranged from 23 to 48 years, with an average age of 34.9 years. Of the participants, seven were from European descent, and three from African descent. Three of the participants were single, three were married, three were involved in a relationship and one was separated from her husband. Of the participants, two were students, one was an educator, four were in administrative or technical positions and three were self-employed.

Dynamics of CSA: All of the participants reported contact abuse with predominantly rape as the form of abuse. In all cases the perpetrator was known to the survivor. The duration of the CSA was on average 1–5 years. The abuse began predominantly between early childhood (2–6 years) and middle childhood (7–10 years).

Disclosure: The predominant age of disclosure was between adolescence (16–20 years) and early adulthood (21–39 years). Of the participants, four disclosed the abuse for the first time to their mothers, and two to a church member. The remaining participants disclosed to another family member or an outside medical professional. The majority of participants felt the person they had disclosed to believed their disclosure, although seven of the participants felt stigmatised after disclosing.

Traumagenic dynamics: The majority of participants experienced all four traumagenic dynamics (described above in coping with CSA).

Therapeutic experiences: The majority of participants reported therapy to be a positive experience.

Mental health: Six of the participants were treated for a mood disorder, and the remaining four were not treated for a mental health issue.

Spirituality: The majority of participants experienced religion as a positive component of their recovery process.

Difficulties post CSA: Of the participants, the majority indicated problems with intimacy and close relationships as the most prominent difficulties, followed by issues relating to interpersonal trust and poor self-esteem.

Personal growth: All participants had experienced growth after the trauma and the majority related this growth to personal strengths and to growth in relating to and understanding others.

Procedure of data collection

In this qualitative interpretative research, individual interviews were conducted with 10 women who met the criteria described above. The discussions were held in the researcher's office situated in a secure, comfortable and confidential location. Interviews were semi-structured and focused to provide opportunities for information to emerge somewhat spontaneously from each participant. An interview protocol was prepared, which included questions to be asked, introductory concepts and concluding introspective comments, and was used as a guide to ensure the data gathered addressed the research objectives (Creswell, 2009). This ensured that interview sessions were not limited to a particular theme, but instead many themes were integrated in a single interview session. The following questions guided the discussions: have your ways of coping changed? (constructive adaptive coping); how do you see yourself after the trauma? (post-trauma identity); how have you grown stronger? (posttraumatic growth – benefit finding); what is your philosophy of life – your view of life? (creation of meaning in the face of trauma); and has your spirituality developed or been affected by the trauma? (existential paradigm).

Interviews ranged from 90 to 120 minutes and all ten women shared their stories spontaneously, and without apparent anxiety. The interviews were audio-taped and later transcribed (see Appendix 9 for an example of an interview transcript). The researcher noted her observations, reactions and impressions throughout the process of data collection in her research journal.

Data analysis

Preliminary analysis of each transcript occurred immediately after it had been completed. The verbatim transcriptions by the researcher enabled her to become fully immersed in the data. Interpretative phenomenological analysis (IPA) was used to analyse the data gathered from the semi-structured interviews. Interpretative phenomenological analysis is a version of the phenomenological method. IPA draws on insights from the hermeneutic tradition and argues that all description constitutes a form of interpretation (Willig, 2008). There is a circularity built into the process of meaning-making referred to as the “hermeneutic circle” which means that “parts can only be understood from an understanding of the whole, but that whole can only be understood from an understanding of the parts” (Schmidt, 2006, p. 4). Thus even though IPA aims to explore the research participants experience from his or her perspective, it recognises that such an exploration must necessarily implicate the researchers’ own view of the world as well as the nature of the interaction between researcher and participant. Thus the phenomenological analysis produced by the researcher is always an interpretation of the participant’s experience. Its founder, Jonathan Smith (2004) states that IPA aims to explore in detail participants’ personal lived experience and how participants make sense of that personal experience through a process of interpretative engagement with the texts and transcripts. Such engagement is facilitated by a series of steps which allows the researcher to identify themes and integrate them into meaningful clusters, first within and then across cases. In line with these steps the researcher and a co-coder (a

psychologist with subject expertise, who is also an advanced qualitative researcher) initially independently read and re-read the texts in order to create unfocused notes reflecting initial thoughts and observations. Thereafter they identified and labelled themes that characterised each section of the text. This was followed by the joint clustering of the emerging themes. In the final instance, a summary table of the structured themes together with quotations from the text illustrating each theme was drawn up as well as a diagram representing the themes, sub-themes and essences (see Appendix 8) (Willig, 2008). This process of inductive data analysis was deductively influenced by the main constructs of the research, namely coping, posttraumatic growth and psychological well-being. Data saturation was reached after eight interviews, but all ten were analysed. The data from the summary table was integrated with data gleaned from the researcher's reflective notes and observations.

Ethical considerations

Ethical permission was obtained from the Ethics Committee of the North-West University (NWU-00041-08-A1) (see Appendix 7). The researcher (a clinical psychologist) was equipped to conduct the research and experienced promoters guided the research process. The participants were seen as autonomous and were provided adequate information regarding the objectives and the nature of their involvement in the research study. Participants partook voluntarily and could withdraw at any time without reprisal, as was explained in an introductory letter (see Appendix 2) accompanied by the informed consent form (see Appendix 5) which had to be signed by all participants as proof of voluntary participation. Confidentiality was ensured and the voice recordings and transcriptions of the interviews were identified with codes and securely stored after completion of the IPA.

Externally arranged psychological counselling services were available for any participant who might have experienced abnormal emotional reactions due to her participation in this research.

Measures ensuring accuracy and credibility

To ensure the qualitative validity (Creswell, 2009) or accuracy and creditability of findings in this study the following procedures were applied: trustworthiness, according to Hesse-Biber and Leavy (2011, p. 48), refers to the “truth” of the data, and they believe that, in qualitative research, “validity takes on the form of subjecting one’s findings to competing claims and interpretations and provoking the reader with strong arguments for your knowledge claims”. Guba’s Model of Trustworthiness was followed (Krefting, 1991) and the strategies as described below, were employed.

There was *prolonged engagement*, meaning that adequate time was spent with the participants, allowing time for the establishment of trust ensuring that participants felt comfortable and secure enough to share their sensitive CSA experiences. The researcher used well-developed and experienced interviewing skills to encourage participants to elaborate and so ensuring adequate exploration of the topic, while also showing the researcher’s sensitivity as a human research instrument. *Reflexivity* was employed to enable the researcher to maintain a critical, circular thought process throughout the data gathering process, thereby limiting the threat of becoming over-involved. This was done by documenting personal reflective notes and observations in a research journal directly after each interview. The trustworthiness of the research results were further enhanced through the use of a co-coder to verify and authenticate themes that emerged from the data. Once themes had been identified, the researcher verified these with willing participants in a process known as *member-checking*, ensuring *credibility* (Creswell, 2009), while *conformability*

was ensured by the inclusion of the researcher's journal entries and consultation with study promoters. In order to heighten the *dependability*, a clear description of the research process (data acquisition and analysis) and participants' context was provided. Findings were presented by way of rich and thick descriptions and were grounded in literature and similarities, differences and unique findings were identified (Burns & Grove, 2005). These measures were taken to enhance the *transferability* of the results.

Findings and discussion

In accordance with the more creative, intuitive characteristics of qualitative research, the essence of the participants' experiences of CSA and life thereafter, described here by means of emerging sub-themes, were integrated into broader themes conceptualised as three pillars of life reconstruction. From the data, participants' intriguing restorations of their lives crystallised and the importance of the three pillars of reconstruction namely coping, posttraumatic growth and psychological well-being became evident. Various building blocks supporting these components or pillars also emerged and will be presented as the sub-themes referred to above and indicated in bold print. The image or metaphor of reconstruction or rebuilding of shattered lives seemed appropriate to use as a symbolic representation of the processes at work in the realities of the participants who shared their stories.

1. Positive coping behaviour

The first anchoring pillar namely coping, was constructed through psycho-socio spiritual resources such as regulation of emotions, an optimistic explanatory style, cognitive restructuring, social

support, spiritual renewal and growth, religious coping and evolving refined coping skills. These enabling factors or building blocks will be discussed below.

1.1 Psycho-socio spiritual resources

Participants increasingly learned to **regulate their emotions** through approaching, connecting and learning to deal with their feelings about the abusive experiences. For the participants, this was one of the important building blocks used for their reconstruction of their lives since their initial coping responses were to avoid, minimise and deny their emotions. In identifying and confronting their emotions, clarity emerged that contributed to growth (Ho, Chan, Yau & Yeung, 2011). In this regard, the women said: *“the greatest coping skill was learning to connect, not just feeling and acting impulsively but learning to connect my feelings to my thoughts and then to my behaviour”* (Participant 2, line 69); *“I coped by confronting emotions ... I learnt to deal with the feelings ... I would listen to my feelings ...”* (Participant 12, line 239). According to Wright, Crawford and Sebastian (2007), an effective coping strategy used by CSA survivors is emotion-focused coping efforts, which attempt to regulate one’s emotions in dealing with a stressor by controlling one’s emotions.

Cultivating a **more optimistic explanatory style** was another building block. Participants developed an optimistic explanatory style for the negative event of CSA. The sexual abuse trauma was perceived as firstly external (realising that the abuse was perpetrated by the abuser and thus not their fault). In this regard, they said: *“I mean it wasn’t my fault that at the age of 12 I looked like I was 17 ... I don’t think so ... can any woman ever look for it ... and deserve it? ... I don’t think so ...”* (Participant 23, lines 78–80); *“When you accept that it’s not your fault ... because we blame ourselves ... you say maybe it’s me ... maybe it’s my fault ... it is never your fault ... you are*

helpless as a child ... you are helpless at that time ... that person has power over you ... you don't have control over the situation ... so don't blame yourself ... don't become a victim even though people think you are a victim ... you can prove people wrong ... I proved so many people wrong" (Participant 6, line 98). Secondly it was perceived as specific (coming to the understanding and realisation that the negative self-evaluations should be specifically related to the CSA experience). In this regard, they said: *"Somehow for years and years ... I was never clean enough, good enough, smart enough, beautiful enough or clever enough ... for anyone or anybody ... and it takes a hell of a lot of patience ... a hell of a lot of energy ... to stand up and say ... but you know what ... this very dark pit and hole ... cannot go on like this forever ... somewhere along the line ... someone will recognise me for who I am, and what I am ..."* (Participant 23, Lines 84–88); *"In the beginning I was very scared ... you feel so dirty ... you don't feel worthy ... you scared ... then you will start becoming more adventurous you know ... in the beginning it is hard ... my husband helped me ... he would constantly reaffirm me ... that I am beautiful and whole and pure no matter what ..."* (Participant 3, lines 47–49). Lastly it is perceived as unstable (realising that the impact of the CSA need not be totally debilitating and that they can transform from victim to survivor). They said: *"From the beginning I said to my husband ... I am the survivor ... I am not going to let this get me down"* (Participant 10, line 69); *"I kept believing that someday things would get better ... I had this belief in myself despite that ... there is light at the end of the tunnel ... it is difficult now but it will get better ... it will get easier you know ... I became a better person despite all the hurt and the pain"* (Participant 6, lines 60–66); *"I am a survivor ... I believe I am"* (Participant 3, line 74). According to Peterson, Buchanan and Seligman (1995), an explanatory style is a habitual way of explaining the causes of positive or negative events with similar patterns of attributions. One's explanatory style affects how one attributes the causes of an event and one's attribution of the

causes of an event is an important factor affecting the cognitive processing involved in rebuilding one's assumptive world (Park & Helgeson, 2006). An optimistic explanatory style for negative events (such as CSA) is seen as a tendency to explain the negative event as external, specific and unstable. From this perspective, bad events are seen as temporary features of life linked to a specific situation and not caused by oneself (Peterson & Park, 1998). Aspinwall, Richter and Hoffman III (2002) and Ho et al. (2011) propose that optimistic explanatory styles are linked to effective coping, well-being and self-perceived positive changes after a traumatic event.

Cognitive restructuring was a powerful but difficult psychological building block used in the restoration of the participants' lives. The process of re-thinking and re-evaluating their ingrained, distorted and often infantile beliefs were painful and arduous. Trying to understand and adjust their assumptions about life, themselves and others in order to find new ways of giving meaning to intra-psychic and inter-psychic queues proved to be laborious. In this regard, the women said: *"I think that's also how I try to cope with things ... I always try and understand it ... and then the moment I think OK I understand it then I can process it better ..."* (Participant 7, line 52); *"Yea, I have all these discussions going on with myself ... if I done it this way or if things had happened this way what would have been the result ... so I have this role playing going on and organising it in my mind and rationalising it ... I think understanding (makes) it is much easier for me to cope ..."* (Participant 12, line 244). According to Finkelhor (1987), long-term coping with CSA requires the integration of the abuse into present cognitive frameworks and Walsh et al. (2010) state that long-term strategies in survivors of CSA, that show cognitive efforts to integrate the abuse material of traumatic events into existing cognitive frameworks, are a form of adaptive coping.

There is no doubt that **social support** was the relational building block that strengthened the coping pillar. As accentuated by Wissing and Van Eeden (2002), relational behaviour in the form of seeking and accepting social support and obtaining professional help when needed, contributed significantly to establishing healthy coping behaviour. In this regard, the women said: *“Oh yes ... I chose two people and that was my husband and a very good friend of mine ... he has meant so much to me ... and him and my husband ... I had a wonderful, wonderful support structure and my therapist was fantastic ... I told myself, listen, you need professional help and you need to trust the therapist, he knows best for you and I really worked on that patient-doctor trust relationship you know ... and my husband also ... and I think what helped me a lot is the fact that he was so positive about me going for therapy ... a lot of people ... um ... who I’ve come to know over the years their husbands didn’t support them getting therapy; mine did”* (Participant 10, line 28); *“... I think ... like people need to understand the gravity of what happened ... they need to deal with it and I think therapy is important because you need ... help in the integration kind of process you know ... but also I think in a group setting just that social ... that social connection of I’m not the only one and other people understand what I’m going through and ... I’m still alive kind of thing ... helps”* (Participant 7, line 133); *“To me it’s an absolute miracle that I ... didn’t build walls around myself, that I allowed people close to me ... because if I look back now it could have easily gone the other way”* (Participant 10, line 10); *“I try to focus and sometimes things happen and I do get down or I do get a bit distracted but I don’t let it reach a point where I want to give up ... and if I feel like down I’ll go to someone and say you know I feel like I can’t do this right now ... like a very close friend of mine ... I usually go to her or ... I might talk to my mom”* (Participant 7, line 155); *“There’s a solution ... there are people to talk to, people who are willing to help, people who meet you half way so that you can come to ... the right conclusion or resolve the issue”* (Participant

6, line 22). Seeking social support actively (Olf et al., 2005) appears to be linked to adaptive coping, decreased symptomatology and enhanced self-efficacy (Cieslak et al., 2009; Walsh et al., 2010). The value of professional help is amplified when it is integrated into the informal network of support (Schaefer & Moos, 1998) and can have a powerful effect on survivors' perceptions of themselves, their values, and their goals in life as they become aware of general life issues beyond the traumatic events (Tedeschi & Calhoun, 1995).

A foundation for the rebuilding of their lives was **spiritual** and included a **renewed personal relationship with God** and religious coping. Participants reported a renewed sense of connection to a higher power and a spiritual awakening which had only emerged during their process of working through their trauma-related memories, emotions, fears and anxieties. Initially, there appeared to be a complete disconnection from a higher power, a sense of having been abandoned by God and related anger for having not been protected by God. In this regard, the women said: *"I always felt that I couldn't connect to God and in the beginning I was very angry at him for allowing this to happen and then I had a wonderful revelation in one of my sessions ... and I just realised that God really loves me and that he came and he saved me ..."* (Participant 10, line 37); *"I am more spiritual ... definitely ... I am more sensitive to vibrations around me ... it's a silly way of putting it ... and I read more spiritual books ..."* (Participant 2, lines 80-82); *"I had to ask God ... for life ... I really had to thank God that up to so far I have put everything unto Him ... God is the only one who do all these things ... whatever the problem is ... he is the only one who is going to go through with you ... God is my creator and I really have to take God as the one and the most important person in my life ..."* (Participant 5, lines 206-208); *"I know that sometimes God feels far away when you have challenges, when we have problems but I know in my heart that he's closer than a friend cause when I look back I know I couldn't do it alone I couldn't survive on my*

own ... I was young but I knew that prayer worked cause I saw it worked for me” (Participant 6, line 54). The eventual surrendering to a higher, caring and wise power enabled participants to find a new sense of self – an identity of belonging and value due to God’s care and love. Such a new realisation which changes a trauma survivor’s philosophy of life often involves an increased sense of existential wisdom and a greater interest in and openness to spiritual and religious matters (O’Rourke, Tallman & Altmaier, 2008; Tedeschi & Calhoun, 1996).

Religious coping was another spiritual grounding element. Prayer as potent religious strategy provided open communication with a loving, understanding and accepting powerful other. The healing power of such an accepting, warm relationship for these women was clear. In this regard, the women said: *“So prayer and my spirituality has also helped ... I pray about it, when it gets to me ... I pray about it and just tell God take it away its too heavy”* (Participant 4, lines 21–22); *“It plays a major role I mean ... had it not been for God I don’t think I would have been able to cope with everything, the stress that comes up now, and then the tears ... uh ... being strong ... Yea, I don’t think I ... I would be able to cope, I mean I pray ... and pray and pray, and He takes it away ... He does take it away”* (Participant 4, line 90); *“I serve a great God the one who promised not to leave nor forsake me ... was there for me when I was young and he is still there for me ... I don’t have parents now but I pray a lot ... I believe in God and when I am finished praying I feel a lot better”* (Participant 6, line 72). A secure relationship with a higher power provides the grounds for the construction of religious schemas that permit the creation of meaning out of traumatic events and provide unique avenues of coping for the individual, as well as promote psychological growth (Baumgardner & Crothers 2009; Pargament, 1990, 1997; Pargament, Smith, Koenig & Perez, 1998). Changes in spiritual and religious experiences seem to shift the survivor beyond their old belief system to a revised one (Calhoun & Tedeschi, 1998b). Thus, religion

becomes an important means of coping when it takes on a significant role in people's overall orientation towards life.

Over time, participants **added and honed new skills** in their coping repertoire. Old negative, isolating, defensive patterns of coping were progressively converted to more constructive ways of coping which enhanced their sense of self-efficacy and confidence. In this regard, the women said: *“Actually it made me realise in a sense my own coping skills ... you know it's like ... um ... you have certain coping skills but not all of them are very positive so ... in a way you assess your coping skills by going through that and then you find better ways of coping”* (Participant 13, line 28); *“You always find other ways of coping even now um in other situations ... not related to the trauma situation ... it's like now you know how to cope with those things because you coped with that situation ...”* (Participant 13, line 32); *“Because ... that coping mechanism that you thought was good for you at the time ... when you get hurt and crash you see ok it wasn't that good so ... you will stand up and fall down, stand up and fall down ... until ... you've learnt good coping skills ... positive ones”* (Participant 13, line 138); *“... perseverance ... perseverance ... I think at the time when I tried to ... eh ... commit suicide I really did not have those coping skills, but now I have the coping skills”* (Participant 5, line 172). According to Walsh et al. (2010), coping with sexual trauma is a multi-faceted evolving process involving different coping strategies at various stages during abuse recovery.

In the preceding discussion of ways in which the participants increasingly coped with the stress experienced due to the CSA, the newly developed resilient structure of their lives became evident. Thus the initial use of positive coping strategies was strengthened into resilience and, according to Zimmerman and Brenner (2010), coping can be seen as an integral part of the resilience process. Participants resiled by overcoming their significant traumas through redrafting

the architecture of their lives. The cognitive, emotional and behavioural abilities mastered by these women to manage the internal and external demands of their traumatic experiences seem to indicate not only the resources that they mustered up for their survival, but reminds one of the self-regulatory model of Karoly (2010), which shows how well-developed self-regulatory functions used under adverse or stressful conditions can contribute to building resilient and adaptive outcomes. Self-regulatory appraisals, belief systems, skills and competencies are evident in the coping and resilience processes described above and one concludes that these self-regulatory components served to enable the coping abilities of these women to deal with the CSA constructively (Karoly, 2010; Eisenberg & Ota Wang, 2003).

It can thus be concluded that these women not only coped with their CSA experiences but instead also overcame them and moved beyond – they resiled. The researcher proposes that this could indicate that these women resisted being rendered helpless and hopeless and that they transformed to an enabling position where they mastered psychological skills while struggling to build their post-trauma lives. Thus, it appears as if constructive coping and the resilient outcomes of such coping are building blocks for posttraumatic growth.

2. Posttraumatic growth

The second structural component or pillar, namely posttraumatic growth, contains the particulars of the dynamic process through which participants are gradually rebuilding their life-ability (Veenhoven, 2011). The symbolic architecture of this self-reinforcing renovation involves the healing process in which the insecure life and living configuration of pre-healing symptoms are acknowledged and transformed into more secure healing lives, according to new plans and roles as

survivors. The pre-healing symptoms, such as their defensive ways, worthlessness and distrust, sexual difficulties and mental and spiritual struggles, are described below.

2.1 Pre-healing symptoms

Before participants cautiously embarked on the process of reconstruction, suppression and avoidance were the **non-adaptive ways of coping** employed in an attempt to strengthen their mostly apprehensive being in the world. In this regard, the women said: *“I think in a way I coped by not really facing up to it ... by suppressing it and not talking about it”* (Participant 4, lines 12–14); *“I think in my second year ... it was when I learnt that there are defence mechanisms ... the one I’m using is suppressing my emotion, it’s called suppression”* (Participant 4, line 38); *“You kind of block that whole period out ... I can’t even explain to you ... I can’t even explain to you some parts cause it vanished ... I can’t even remember certain things ... I don’t know if the trauma just does that to you that you don’t get it all back but slowly but surely God is revealing certain parts to me and I think that helps”* (Participant 3, line 23); *“I would avoid places and people a lot ... I isolated myself a lot ... isolation was my coping mechanism ... now later isolation became a bad thing for me ...”* (Participant 13, lines 98–103). Avoidance and denial strategies appear to be commonly used and unfortunately increase levels of distress and symptomatology (Walsh et al., 2010). Furthermore, the fear of not being believed, feeling different and other forms of stigmatisation become destructive forces that contribute to disengagement methods of coping (Gibson & Leitenberg, 2001; Spies, 2006).

Participants’ feelings of **unworthiness** and sensitivity to rejection contributed to their apprehension. In this regard, the women said: *“That ... emotional abuse he [the biological father] ... kept on telling us we worth nothing ... um ... he doesn’t want us ... he doesn’t love*

us ... we were nothing to him” (Participant 12, line 104); “I am quite sensitive to rejection ... I don’t know if everyone is, if it’s a normal thing, but it is quite a sensitive thing ... I often feel rejected by someone I care about I do ...” (Participant 7, line 38); “First of all feeling really dirty and worthless you know ... you’re so scared to tell anybody because ... I don’t know ... it’s like you don’t think you’re worth the effort anymore ... you’re not worth somebody’s attention anymore, you know that’s all been stripped from you ...” (Participant 3, line 12).

Their foundation of **basic trust was shattered** by experiences of betrayal by perpetrators who were family members, friends or known members of the survivor’s community. The instinctive confidence of the young in the care and protection of grown-ups was shattered by the abuse of the adults’ position of power. Feelings of helplessness and the inability to defend against the physical and emotional offensives left deep fissures in their basic sense of security. In this regard, the women said: *“I don’t trust people ... I have a trust issue ... a big one and I don’t think it takes a year or two years to just go away ...” (Participant 13, line 42); “I mean he was like a father to me ... I would not ever in my wildest dreams imagine that that specific man could hurt me as badly as what he hurt me ... it was that blind trust ... the person that you trust the most” (Participant 23, lines 10–14); “Yea, the betrayal, the betrayal ... is the worst ... you eventually forget the physical part of it ... but not the betrayal” (Participant 23, line 136); “Even today it’s very difficult for me to trust a man even ... my husband if he drinks then he mustn’t come near me ...” (Participant 12, line 66).* Once shattered, basic trust becomes distrust and shows in the walls of all relationships and needs great care to repair. The symptoms of worthlessness (stigmatisation) and shattered trust due to betrayal are described by the traumagenic dynamics proposed by Browne and Finkelhor (1986). Survivors of CSA often continue to experience the same sense of powerlessness in adulthood which they had experienced in childhood, believing that they are

invisible and incapable of being loved (Spies, 2006). CSA damages the person's self-esteem and creates an unrealistically negative self-perception regardless of how well they perform and how they are perceived by others (Browne & Finkelhor, 1986).

The survivors' ability to be vulnerable, open, soft and trusting in their **intimate relationships** was severely compromised by their being violated. Participants indicated that the CSA had negatively affected their intimate lives and thus their sexual well-being. In this regard, the women said: *"Well sometimes the negative part is especially being married and stuff ... every now and again you will have a flashback or whatever; that could affect your intimacy"* (Participant 3, line 32); *"I might have been different especially regarding sexual things"* (Participant 7, line 73); *"I am much more comfortable being with a female because they aren't threatening ... there's no threat ... of hurt or ... I'm not sure how to put it ... but ... no penis"* (Participant 12, line 174); *"With boys it ... it has affected me sexually"* (Participant 4, line 66). CSA destroys natural sexual capacity and so survivors often disconnect from any sexual intimacy, or find it safer to connect with a person who does not represent the sex of the perpetrator, in order to avoid memories of the abuse (Spies, 2006). Maltz (2003) found that, since sexual abuse is an attack on a person's sexuality, many adult survivors of CSA will experience chronic sexual problems. Sexual dysfunction can be seen as part of the traumatic sexualisation dynamic proposed by Browne and Finkelhor (1986) as a traumagenic outcome of CSA.

Before their reconstruction processes, survivors' **moods were often despairing and dark** as they were plagued by negative emotions and depressive symptoms, which for two participants culminated in self-harm or substance abuse behaviours.

In this regard, the women said: *"There was a time whereby I was so depressed ... it was depression and they sent me to a psychiatric ward"* (Participant 5, line 117); *"I was*

confused ... then it was more of a negative coping mechanism like substance abuse and harming myself ... bad stuff” (Participant 13, line 125); *“Really I could not cope ... I tried to commit suicide three times ... it was very difficult I couldn’t cope ... ”* (Participant 5, line 82). Maltz (2003) found that victims of CSA often withdraw from social interaction or act out in ways that are harmful to the self and others. Depressive symptoms may manifest as part of the powerlessness traumagenic dynamic (Browne & Finkelhor, 1986).

In the aftermath of the traumatic quake that shook their foundations, participants’ belief in and **concept of God were shattered**. They were beset with questions regarding God’s apparent lack of love and care for them. Often their disillusionment would explode in anger at God for having deserted them. In this regard, the women said: *“Sometimes you blame ... God why? ... what was the purpose okay ... were you seeing something from me that this could happen to me ... I don’t know you”* (Participant 5, line 198); *“I could just stay there and cry and ask God all sorts of painful questions ... why me, Lord? ... why have you abandoned me? ... because that’s how I felt, I was angry with God”* (Participant 6, line 46); *“I always felt that I couldn’t connect to God and in the beginning I was very angry at Him for allowing this to happen”* (Participant 10, line 97); *“Why on earth did He not protect me that day? ... did He forget about me? ... Was He too busy? ... I mean at the age I don’t think you can put all that in perspective ... God let me down ... ”* (Participant 23, line 288); *“I’ve always been ... a very strong believer but ... my faith faltered when all of these things happened and there was a lot of confusion about everything ... you start blaming God ... you just don’t understand His ways anymore ... ”* (Participant 13, line 148). Gall (2006) found that spirituality can be a complex process for CSA survivors and involves some ambivalence. Often survivors are initially angry at God; yet, with time they reach an active stance of surrender. Alternatively, as a result of the CSA, some survivors may not be able to develop more adaptive

forms of spiritual coping and so may remain “stuck” in a maladaptive stance of discontented religion, such as being angry with God (Gall, 2006, p. 838).

2.2 The healing process

In the following part on the explication of how posttraumatic growth evolved in these women, the healing processes and outcomes, the survivor role and that of the wounded healer will be described.

Embarking on the process of healing reconstruction entailed a **conscious choice**; indeed, this choice needed to be made on a daily basis. Healing meant perseverance and conscious commitment. In this regard, the women said: *“I don’t give up that easily, I don’t know ... I can only tell you my experience is ... nobody does it for you, you have to face the fight”* (Participant 23, line 220–221); *“Yea, because I lived in this world where I thought that I can do anything I put my mind to ... that was actually one of the things that helped me survive the childhood trauma was that ... absolute perseverance and that belief that I can get through this”* (Participant 10, line 135); *“There was a time that I said I have to leave this old life, I have to start a new life because I am still young ... let me live my own life right, let me make meaning of me, the most important thing is to make meaning of yourself ... at the end you are the one who is going to take the decision ...”* (Participant 5, line 272); *“I had to learn to deal with it on my own ‘cause I didn’t have anyone to speak to really, well anyone that understood, so I think it taught me ... well, yea, I feel like I’m stronger ‘cause ... um ... I had to learn on my own and I had to learn to cope and learn to let go and make the choice of letting go for my own sake”* (Participant 7, line 75). Survivors construct their own healing process at their own pace (Spies, 2006) but before growth can take place, a choice to start restoring shattered assumptions, regain confidence and find healing at a physical, emotional and spiritual level must be made (Wong, 2003).

For the participants, healing entailed not only restructuring but also drafting and **adding new dimensions** to their life constructions. One dimension was the realisation of their own power and efficacy: In this regard, the women said: *“This has actually equipped [me] for life ... I’ve grown so much as a person”* (Participant 10, line 34); The traumatic pain and distress laid the groundwork for the realisation and unlocking of their own psychological strengths such as *gratitude* and *forgiveness*. Finding *meaning* in their experiences was one building block of healing growth. In this regard, they said: *“Yea, I wouldn’t change it now because I’ve grown from it so much ...”* (Participant 7, line 123); *“When I reflect ... it’s growth, thankfulness, humbleness ... I am so thankful, grateful that I did it”* (Participant 10, line 125); *“No, I don’t wish it didn’t happen because that for me is the pivotal point of saying that’s growth ... that was growth for me definitely”* (Participant 2, line 40); *“There is a lot of growth in me I must say a lot of change in me ... I am very calm, I am in control of myself, I don’t hold grudges anymore, I don’t get angry for more than five minutes or so ...”* (Participant 6, line 26). Discoveries made during the healing process may have motivated survivors to continue on the healing path, which created the opportunity for integration, for survivors to see themselves as a whole and experience life more fully (Spies, 2006).

Each one of the participants concurred that **forgiveness** was the corner stone of healing reconstruction. Not being able to forgive is to stagnate in anger, hate and fear. All these negative emotions were related to the perpetrator and significant others who did not protect the young, vulnerable child. There were also indispensable elements of self-forgiveness that set the wounded inner child free. In this regard, the women said: *“It goes with forgiveness, even though you can’t forgive fully, but ... trying to forgive”* (Participant 4, line 24); *“From the start, I had one thing in mind and that was to forgive ... to forgive, to heal, to get stronger and to move on with my life to go*

on with my life” (Participant 10, line 24); “*And you know to forgive, that is most certainly my biggest dream come true ... that I was able to forgive because when you forgive you let go ... and you know what’s very empowering for me is sitting here and talking to you and it is as if it happened to me years and years and years ago*” (Participant 10, line 65); “*It’s not something that sits on my mind all the time so for a lot of it I’ve learnt to make peace with it ... I mean it happened and its part of my life and well I can’t change it so I forgive and let go so that I can have peace with it*” (Participant 7, line 67). According to Baumgarder and Crothers (2009), the value of forgiveness is in terms of its potential ability to offset the debilitating effects of anger and hostility associated with an adverse event. It further has the potential to repair relationships and undo negative emotions (Compton & Hoffman, 2013).

Gratitude was a surprising and rewarding addition to their healing lives. A new appreciation of life blossomed in an awareness of the small beauties and blessings of everyday life. It was as if their trauma-blinded child’s eyes were healed. In this regard, the women said: “*Being able to sit outside and enjoy the birds and enjoy the wind and you know the rain ... and ... things that passed me by ... I always felt half dead and I’ve never really noticed it and now I can take it all in*” (Participant 10, line 83); “*I’m extremely thankful for each and every day of my life*” (Participant 23, line 244); “*Life is good ...*” (Participant 6, line 78). Gratitude often refers to an appreciation for life itself and is associated with positive feelings and adaptive coping and is one of the most reported manifestations of posttraumatic growth (Baumgarder & Crothers 2009; Calhoun & Tedeschi, 1999; Emmons & Mishra, 2011).

The **pain and despair** often experienced by these women were gritty particles that strengthened the cement used for the reconstruction of their lives. Confronting their trauma required (in different phases of healing) eventually exploring the whole of their trauma experience

– an excruciating revisiting of the physical, emotional, auditory, visual, olfactory, and visceral experiences of their CSA trauma. In this regard, the women said: *“It’s going to take time and it’s not ... well it should be painful ... if it’s not then ... you know it’s not effective, you should experience pain although it’s not nice”* (Participant 13, line 180); *“I was crying it was really so painful OK ... then I thought ... what is going to happen from now ...”* (Participant 5, line 36); *“The physical hurt ... that you forget ... as the years go by ... you forget the physical hurt ... but the emotional hell that you didn’t forget ... and the hell that you go through afterwards ... is I think at times worse than the physical hell that you’ve gone through”* (Participant 23, lines 44-82); *“I am the one who is suffering ... and I was really suffering emotionally, psychologically everything ... I was really suffering”* (Participant 5, line 95). According to Spies (2006), in order to heal from CSA, survivors must accept that they were indeed victims and this is a painful and difficult process.

Participants indicated that the **recovery was a protracted and onerous process** with no quick fixes. The rebuilding is not at all simple and linear since harrowing experiences are not dealt with on a once-off basis. The trauma related experiences were revisited over time in an upward spiral of healing where slowly multiple times of moving into the hole of darkness enabled higher levels of integration and healing. In this regard, the women said: *“It really is a process ... in the beginning you don’t ... you won’t listen to anybody because you feel like nobody understands ... it’s like in the beginning you really feel like you’re never going to get over this ...”* (Participant 3, lines 40–44); *“Really it’s a long walk ... it really ... sometimes it’s a crawl ... but you get there ... it doesn’t happen overnight ... really it doesn’t and it’s a constant process ... I mean I don’t think a day goes by where you feel like you’re not moving somewhere, but you’ve got to move past that”* (Participant 3, line 127); *“The thing is ... it’s not an instant quick fix thing ... you learn all these things from facing the trauma but it’s not a quick fix ... and I’ve always*

wanted a quick fix so... um ... yea, it's not easy it takes time but over time you learn ... to pick up certain things" (Participant 13, line 136); "It's a long process but then it's worth it ... I must say, it's a very, very long process ... it's hurting because you have to relive what happened to you ..." (Participant 6, line 22). The reconstruction of themselves and their life structures is a demanding work in process (Spies, 2006).

The understanding that what they had experienced and what they were experiencing was shared by others, that they were not alone, was experienced as empowering. **Knowledge** and awareness gained through talking, reading, studying and attending therapy was a dominant tool in the rebuilding of their lives. It made them more aware and astute in interpreting signs of possible danger. In this regard, the women said: "In a way doing psychology has helped me understand why he did it ... why I am able to cope ..." (Participant 4, line 38); "I've wanted to study psychology since I was about 14 ... it's something I can use now ... it's something that happened and I learnt ... I learnt from it" (Participant 7, line 85); "But I made an effort you know to really go and study ... I read this book of an author abused as a child ... and I bought some of her tapes ... outside of therapy I worked through it" (Participant 10, line 101); "Being streetwise, being aware ... Yea, I'm aware of people ..." (Participant 23, lines 233-234); "Sometimes it keeps me on my toes and survival ... like I said to you ... it keeps you wide awake" (Participant 23, line 280); "Yea ... and I don't think you would recognise the danger signs if you ... weren't exposed to it ... I don't think you would ... see the flashing of lights" (Participant 13, line 119). Knowledge and awareness of the trauma and its ramifications translate into the gradual decrease of denial and other psychological defences employed by survivors, and provide the basis for the understanding and acceptance necessary for healing (Cruz & Essen, 1994).

The new plans drafted for their growth and the rebuilding of their lives entailed progression, expanding on a simple helpless *victim* role plan to that of a **more nuanced survivor**. In this regard, the women said: “*If I could help someone else ... be in a room with a group of women that went through what I went through or even worse ... [I’d] say to them: Look I am living proof, you can do this ...*” (Participant 23, line 384–8); “*No, I am a survivor ... well I believe I am*” (Participant 3, line 74); “*Yea, you know from the beginning I said to my husband ... I am the survivor I am not going to let this get me down*” (Participant 10, line 69); “*It’s better to live one day as a lion instead of 100 years as a sheep*” (Participant 23, line 362); “*I am very proud of myself ... it doesn’t matter what happened to me ... I was helpless ... I was a victim but I am not going to act as a victim I am going to act as THE woman*” (Participant 6, line 100). Such a shift in perspective is an imperative ending in the “running away” behaviour and marks the commitment to healing and some engagement in a therapeutic process (Spies, 2006, p. 82).

The design of their new expectations that progressively emerged was premised on hope and **expectations of a better future**. In this regard, they said: “*And that I’m having another opportunity to life you know ... to live life to the fullest without these symptoms*” (Participant 10, line 8); “*I just want to be happy and live a normal life ... and do what I want to do and not hold back ... achieve all I want to do ... I mean I have dreams*” (Participant 4, line 50); “*We hold onto those hurts and we’re not supposed to, ‘cause it’s in the past and you can’t go back and change time ... you can’t no matter how hard you try ... it’s there and you’ve got to heal for the future, ‘cause the future’s what you’re looking to ... ‘cause you’re healing now for tomorrow ...*” (Participant 3, line 121). “*I think people can benefit from what I’ve been through ... that’s also a thing that I’ve learnt ... that it was bad and yes it hurts but focus on the future ...*” (Participant 13, line 103). According to Gardner (2010), thoughts about the future have a direct effect on how the

present is perceived, and according to Carr (2011), optimistic future-mindedness is conducive to well-being. Calhoun and Tedeschi (1999) accentuate a related aspect of posttraumatic growth as the experience of a shift in life priorities and looking to the future.

A dominant constituent of the participants' future plans was to contribute to other wounded peoples' lives. Their need to make a difference and to share their emotional and cognitive victories in a helping relationship was evident. A belief that having experienced the trauma enabled deep understanding and empathy was the ground of this need to act as **wounded healer**. Participants indicated that they often dedicate their energies to caring for others, thus finding themselves fulfilling helping supportive roles at work and at home. In this regard, the women said: *"I want to help others, because I understand their pain"* (Participant 5, line 233); *"I'm going to help others through it and I'm going to share my story with the world"* (Participant 10, line 157); *"If I wasn't hurt, I wouldn't understand that people hurt other people ... so now I can assist other people that have been hurt"* (Participant 3, line 116); *"You have a deeper meaning with people in pain ... and relationships mean a lot to me ..."* (Participant 12, line 254). Taylor, Klein, Lewis, Greunenwarld, Gurney and Upfdegraff (2000) report that in times of stress, females engage in caretaking activities or in the creation of a network of associations to protect themselves and others from a threat. They respond relationally to stress and they seek connection – the authors called this response "the tend-and-befriend response" Taylor et al., (2000, p. 411). Often people become healers through their own personal suffering – wounded healers who transform their wounds into learning; thus, enabling them to help others in need and consciously using their experiences to help others in a context of tragic helpfulness (Dunning, 2006; Harvey, 2001). Tedeschi and Calhoun (1995) state that helping others can produce a sense of closeness, and the recognition of having something precious to offer,

a gift – the intimate knowledge of the traumatic experience and an ability to empathise with similar others.

The new life plan after the abuse includes renewed **connectedness with others**, a new understanding of the valuable role others play in one’s life and healing. Participants reported that their relationships were enhanced in some way and they had a deeper connectedness to others. In this regard, the women said: “... *and relationships mean a lot to me ... I want people to accept me and like me ... I think that’s also one of the things that came out of this*” (Participant 12, line 254); “*Relationship with my clients have grown ... relationship with myself have grown and ... um ... even with my mom and dad and my sister and brother ... so everything has improved ...*” (Participant 10, line 51); “*Yes ... I think ... um ... I think going through everything enabled me to connect with people ... um ... relate to them*” (Participant 13, line 24). This reinvestment of energy and the renewed understanding of the value of relationships is a well-documented element of posttraumatic growth (Carver, 1998; Elder & Clipp, 1989; Fromm, Andrykowski & Hunt, 1996).

The **relationship with their children** was particularly important to participants. They had an overpowering need to protect their children, but also felt confident that failing they would be aware enough of the symptoms of abuse to provide help immediately. In this regard, they said: “*My son also plays a big role ... it’s not my own life anymore ... I have to live for someone else as well so he’s a motivation in my life that no matter what happens I’ve got to keep going ... I’m doing it for my child now ...*” (Participant 7, line 155); “*In the beginning, it was [my] biggest fear ... what am I going to do when one of my children get raped or molested or things like that ... then I just decided by myself what better person to help them through it ... ’cause I’ve been there ... so I’m in an advantaged position ’cause I know what to look for*” (Participant 10, line 53); “*Look, my big*

thing as a mother ... I mean you don't think something like that will affect you ... but as a mom you also doubt yourself sometimes ... I get scared because I've got a daughter, I mean even a boy ... I wouldn't want my child to go through something like that ... but if it had to happen at least I know a person can still be OK ... especially now that you've got kids ... you're weary of guys and older men" (Participant 3, line 121). According to Spies (2006), survivors of CSA may have a desire to protect their own children against any possible situation in which abuse could take place. Overprotection is an exaggeration of the healthy desire of survivors to keep their own children safe (Bass & Davis, 1988). Hooper and Koprowska (2004) indicate that CSA can have an effect on the mother-child relationship and survivors may doubt that they will be successful parents.

The themes that emerged in the discussion of the participants' growth-related perceptions and experiences above depict the healing process of these survivors of CSA and include aspects of posttraumatic growth, such as the struggle for healing reconstruction, positive outcomes of healing, the survivor and wounded healer roles. Tedeschi and Calhoun (1995; 2004b) see posttraumatic growth as a positive psychological change experienced as a result of the struggle with highly challenging life circumstances, and the participating women who engaged with the process of healing in overcoming their CSA attested to the experience of positive psychological change and posttraumatic growth. Tedeschi and Calhoun (1995) further explain that psychological growth is perceived when some change has taken place in the view of the self and the world, and has resulted in a more profound understanding of the self and the world (reflected above in the sub-themes of the positive outcomes of healing); this understanding allows for changes in behaviour that are seen to be effective in warding off future distress (reflected above in the sub-theme knowledge of syndrome and awareness); that which is lost is transformed into a more valuable present and future (reflected above in the sub-theme of the survivor role and future perspective); and lastly the

changes which occur appear to be possible because of the struggle with the challenges presented by the trauma (reflected above in the sub-theme of the survivor role).

Furthermore, Tedeschi, Park and Calhoun (1998) report that people may change their life philosophy, learning to appreciate each day to the full realising that their life is finite (reflected before in the sub-theme appreciation for life); believe themselves to be wiser, act more altruistically and have a sense of personal resilience and strength, linked with an acceptance of their vulnerabilities and limitations (reflected before in the sub-themes of the positive outcomes of the healing process); dedicate their energies to social renewal (reflected before in the sub-theme wounded healer); and report that their relationships are enhanced in some way (reflected before in the sub-theme connectedness with others).

The posttraumatic growth reported by these women illustrated the realisation of positive outcomes stemming from traumatic experiences such as CSA, in contrast to outcomes that had previously been expected such as distress and dysfunction (O'Rourke et al., 2008). Wong (2003) identifies the following pathways to posttraumatic growth: acceptance, determination, confidence, religious faith, relationships, and optimism. These attributes are reflected in the shared narratives of the participants in this study.

It can thus be concluded that the healing process includes aspects of posttraumatic growth as participants attested to positive psychological changes and growth following their struggle with the CSA experience. Growth in this healing process appears to indicate that these women were able to rebuild their life-ability (Veenhoven, 2011), revealing intra-personal strengths and abilities related to the self, which the researcher proposed as building blocks for psychological well-being.

3. Psychological well-being

The third structural component or pillar that emerged from the findings relates to the participants' self-descriptions, growing personal and interpersonal strengths and abilities, underpinning their psychological health and well-being.

Participants progressively began to redefine themselves, not as passive victims but rather as survivors and ultimately as victors who were **in control** of their own processes of renewal, independent, and confident in their ability to cope. In this regard, the women said: *"At this stage, it's very important because I need ... um ... to take control over my own healing ... because no one else is going to do it for me ..."* (Participant 10, line 55); *"Yea, because I always try to look at things for myself, you know ... its fine, people can give me advice but I will weigh it up ... I like to make a decision that I've weighed up and I do feel independent and mature enough to make the proper decision and to really think things through ..."* (Participant 7, line 83); *"... Being reliant on oneself ... I don't depend on nobody to do anything for me"* (Participant 2, lines 44-48); *"I am such an independent person and I don't mind people doing stuff for me ... but I'd rather do it myself"* (Participant 12, line 114); *"You know it happened and you have to let it go ... just to find something small is empowering yourself you know and giving you that kind of ... taking back a little control"* (Participant 7, line 145); *"It's made me more independent ... more self-reliant of learning to do things on my own and get through hard times on my own"* (Participant 7, lines 79–82). Such a strong sense of self-efficacy leads to a greater effort and success in mastering challenges (Hefferon & Boniwell, 2011). People with an internal locus of control tend to see themselves as affecting the outcomes of traumatic events (Tedeschi & Calhoun, 1995). A personal sense of control encourages emotional, motivational, behavioural and physical energy to cope with demands (Compton & Hoffman, 2013).

The women's redefinition of themselves sprung from a **deeper self-knowledge** which enabled them to shine a softer and kinder light on themselves and their self-evaluations. They became aware of aspects of the self which were unacknowledged before or which they had not given themselves credit for. This laid the foundation for positive self-evaluation of worthiness, uniqueness and the right to be seen and accounted for. In this regard, they said: "*Um ... what stands out for me is I'm the real me now*" (Participant 5, line 268); "*I also said that I will never ever live in anybody's shadow ... No-one's shadow, I have got the right to be in the sun like everybody else ...*" (Participant 23, lines 368-370); "*I mean you're valuable ... you still have this dignity ... it doesn't mean that when you are raped you don't have this dignity ... I have to tell myself that really I am the one, there isn't another me, I am the only me ...*" (Participant 5, line 138); "*What stands out ... making that really big decision ... accepting who I am*" (Participant 12, line 300); "*I think before I was like being too hard on myself ... I expected things to go so excellently and then maybe perfect ... if I may put it like that but now I realise if I make a mistake it's because I am human ... I can redo it ... try to do better ... yea, I am accepting who I am ... I understand that it's OK to make a mistake*" (Participant 6, lines 32-34); "*I am stronger because I have accepted who I am ... who I am for now ... I say to myself that I am the one who is going to live my life ... I am strong*" (Participant 5, line 168). As the person ruminates on his or her traumatic experience, positive change may occur while recognising and strengthening those aspects of self that have been tainted by the traumatic event (Calhoun & Tedeschi, 1998a; Saakvitne, Tennen & Afflek, 1998). Ryff (1989) regards self-acceptance as one of the fundamental dimensions of psychological well-being.

During their process of renovating their lives, **new strengths emerged** and were cultivated. Participants believed themselves to have a sense of personal resilience and strength due to their ability to forgive themselves and to be aware of their vulnerabilities and limitations. In this regard,

the women said: *“What doesn’t kill you makes you stronger ... is true”* (Participant 3, line 89); *“I think it has made me a stronger person ... more resilient I think”* (Participant 12, line 118); *“Yes, because if it hadn’t happened ... I wouldn’t have been such a strong person as I am today and I wouldn’t have had the guts to take the steps I have taken in my life ...”* (Participant 12, line 276); *“Like Einstein and all those people have quotes I have my own one ... mine is ... when I’m at my utmost weakest I am at my utmost strongest ... I am actually very strong when I’m weak ...”* (Participant 13, lines 107–109); *“I think that I have grown ... I’ve really grown stronger ... and stronger ... even though I ask God sometimes why, what was the purpose ...”* (Participant 5, line 198). According to Linley and Joseph (2004), the human has inherent potential for developing positive character traits and virtues and overcoming adversity with resilience and strength. Suffering can sometimes yield strengthening and growth; thus, growth and pain are inextricably linked to the post trauma recovery (Saakvitne et al., 1998; Tedeschi & Calhoun, 1995). Tedeschi et al. (1998) further imply that individuals are capable of developing beyond their previous level of functioning and thereby experience a significant beneficial change in cognitions and emotions.

Making meaning of their traumatic experiences was the crucial reinforcement of the reconstructed healing lives. The progressive shift toward acknowledging evidence of positive change post trauma does not negate the existence of the adverse effects that may result from a traumatic experience. However, participants appeared to have built a life philosophy in which the trauma of CSA was integrated. They appeared to create existential meaning by realising that God had a plan, or that things had happened for a reason. The long process of reliving the pain in order to make sense of the trauma and its devastating effects was often mentioned. For the most part, life had improved for them. This depicts the bipolar nature of the growth experienced where the presence of gains can coexist with the losses of the traumatic event. Participants reflected that there

was nothing inherently positive about the traumatic experience and yet they did not regret that it had occurred as they ended up capable of dealing with difficulties. Thus, the impetus for growth is located in the arena of struggle with the event and not with the event itself (Calhoun & Tedeschi, 1998a, Tedeschi & Calhoun, 1996).

In this regard, the participants said: *“I have created meaning out of myself ... I found that if I don’t create meaning out of myself there is no way that anyone can create meaning ...”* (Participant 5, line 264); *“Maybe to make me a better person ...”* (Participant 23, line 300); *“Um ... I think it happened for a reason, and I can’t say, it was always a very bad thing to me but now I see it as a blessing in a way because I can actually talk to people who have been through it ... and I just love that idea that God can use something bad for something good”* (Participant 3, line 105); *“The way I see things always ... with anything if something negative happens I’ll look for the lesson, I always see it as everything happens for a reason so if this happened then there must be something that I can use from it, I look for the positive in it ...”* (Participant 7, line 83); *“... I’ve searched for the positive and it’s just like I always do that ... and although I’ve wondered what the negative is I’ve never dwelled on it, I’ve never gone and focused on it I’ve always focused on what I can learn”* (Participant 7, line 117); *“I think if I hadn’t been through this ... I would not know how to be hurt in a way that you would never imagine and how to live with it and manage it ... I suppose I feel that whatever he has done to me it is up to me to see what I want to do with me at this point ...”* (Participant 4, line 24); *“I’m ... actually glad it had happened cause ... without it I definitely wouldn’t have been strong enough to help others ... so they always say God has a plan for all of us and there’s reasons why things happen and I don’t say that trauma has to happen in order for you to be able to handle things later in life but due to that He has made ... made the strength available to me to be able to cope with others’ trauma ...”* (Participant 12, line 312).

Woodward and Joseph (2003) report that the will to survive is instrumental in enabling such survivors to overcome and find meaning in their experiences and thereby ultimately heal. Tedeschi and Calhoun (2004b, p. 406) state, “there appears to be a basic paradox that is apprehended by trauma survivors who report these aspects of posttraumatic growth in that their losses have produced something of value and there appears to be an increased sense of their own capacities to survive and prevail”. This refers to the bipolar or dichotomous nature of posttraumatic growth where significant positive change arises from the struggle with a major life crisis (Baker, Kelly, Calhoun, Cann & Tedeschi 2008; Calhoun, Cann, Tedeschi & McMillan, 2000).

Themes and sub-themes about psychological wellness that emerged from the discussion with the participants strongly indicated that the well-being of these women lies in and builds on their sound sense of self or the self-related strengths that they employ. This is a rather surprising finding because in literature the negative impact of sexual abuse on the victim’s self-esteem is well documented (Allen, 2008; Bennett & Hughes, 2000; Saffy, 2003; Spies, 2006; Taylor & Thomas, 2003), and was supported in the first phase of this research, where it was found that the majority of participants scored low on a measure of self-esteem. Yet, in these few women (who reported constructive coping, posttraumatic growth and psychological well-being in phase one) it seems that the most important feature of their psychological health after mastering the abusive experience, can be found in their ability to take ownership or control and to build and maintain a healthy sense of self, described by them as being in control and possessing self-worth, self-reliance and self-efficacy. This finding corresponds with the work of Skodol (2010), who indicates that self-esteem, self-confidence or self-efficacy, self-understanding, ego-hardiness and ego-resilience are adaptive defence mechanisms that underpin resilience. Furthermore, self-esteem is essential for adaptive functioning in just about every aspect of life, and is a trait that enables a person to be competent to

cope with life challenges (Compton, 2005; Hewitt, 2009). Ryan and Deci (2000) suggest that good self-esteem is a natural by-product of healthy personal growth. Self-efficacy derived from mastery experiences and attempts to control life is the belief in people that ensures resilience to adversity and reduced vulnerability to stress and depression (Hefferon & Boniwell, 2011; Maddux, 2002). Finally, the ability to create meaning out of the CSA experiences was also indicated by the participants as an aspect of their psychological health or well-being, and in this regard, Deci and Ryan (2000) found that authentic meaning-making flows from a good sense of self.

The objectives of this research study were to describe the intricate pattern of ways of coping, posttraumatic growth and psychological well-being in adulthood of women who had experienced CSA (see Figure 1). A dense textured description of the symbolic architecture, building blocks and process skills involved in the reconstructed lives of the women who participated, has been provided.

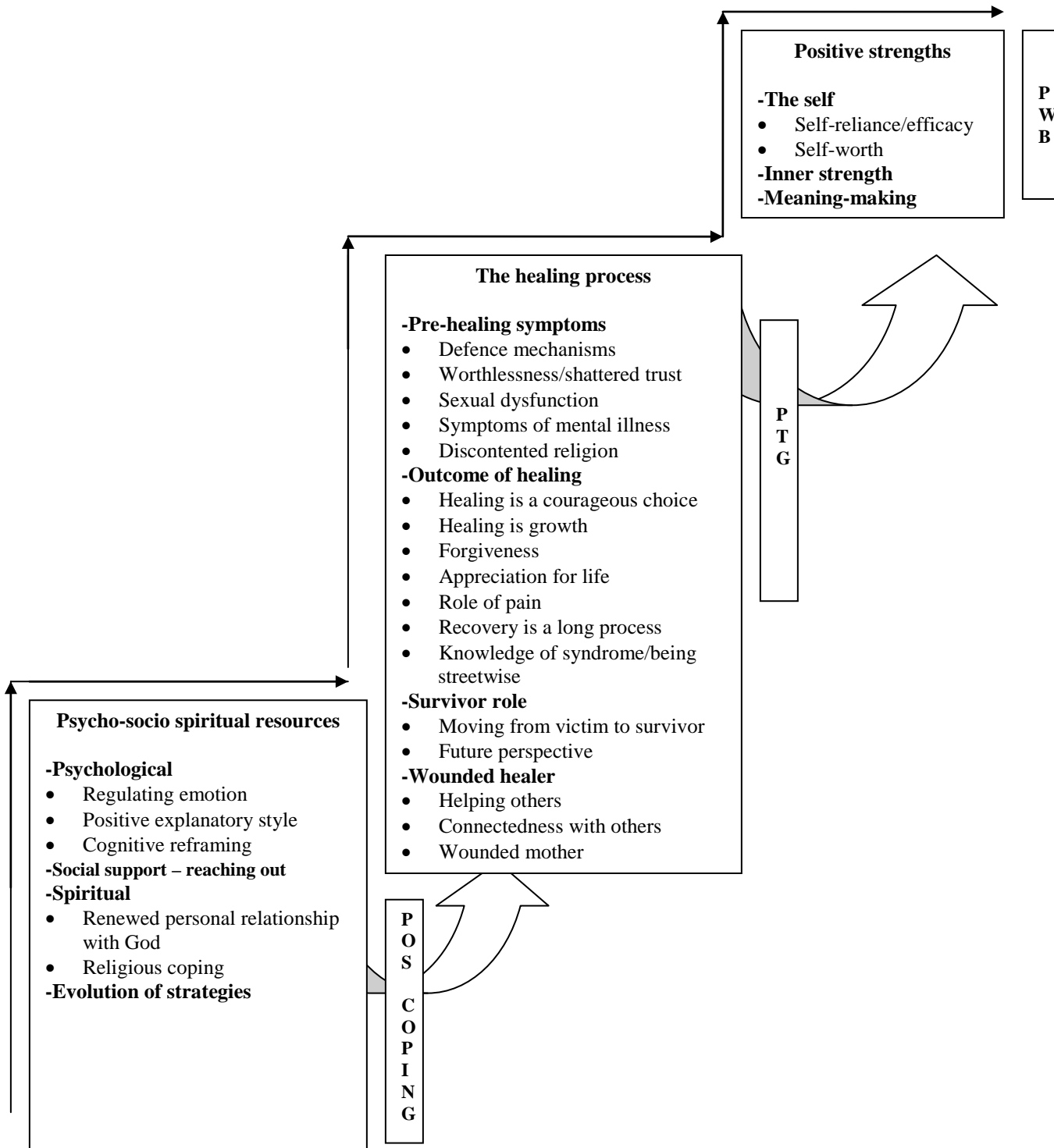


Figure 1: Positive coping, posttraumatic growth (PTG) and psychological well-being (PWB) themes emerging from the interpretative phenomenological analysis (IPA)

Conclusion and recommendations

The primary focus of the study on which this article is based, was to explore the coping behaviour, posttraumatic growth and psychological well-being of women who had experienced CSA. It was evident from the interviews with the participants that trauma can indeed provide the impetus for intra-personal and inter-personal change, as proposed by Linley and Joseph (2003). These authors suggest that people who report growth in the aftermath of trauma continue to show improved long-term adjustment and psychological well-being, and this appears to be grounded in and fostered by positive coping strategies.

The themes identified in this qualitative study refer to: psycho-socio-spiritual resources that enable coping, which includes positive coping styles, strategies and resources such as active emotion-focused coping, positive explanatory styles, seeking social support and religious coping; the healing process, which includes aspects of posttraumatic growth, including the healing struggle, positive outcomes of healing, the survivor and wounded healer roles; and positive strengths, which include aspects of psychological well-being, including self-efficacy, self-worth, inner strength and meaning. These themes and sub-themes allude to the interconnections and overlap between distinct constructs of constructive coping, posttraumatic growth and psychological well-being as reported in literature within a positive psychology paradigm (see Figure 1).

The study convincingly found that the traditional focus on negative post trauma outcomes disregards the possible unique impetus for growth that trauma may provide, transforming pain into adaptation, growth and well-being. It was evident that positive changes were constructed by these survivors' struggle experiences and that survivors – and eventually thriving victors over CSA – are capable of developing beyond their previous level of coping and functioning by recognising the meaning and benefit of their struggle with trauma. Victory entails experiences of meaningful and

beneficial changes in cognitions, emotions, and aspects relating to the self; thus, constructing a life characterised by psychological well-being. Symbolically a new architectural plan had been co-constructed by these participants, which could have relevance not only for their own lives but also for the practice fields of psychology and other helping professions. Such a new plan drafts possibilities of new assumptions severely challenging the old ones of victimhood. It also alludes to possibilities of constructive coping, posttraumatic growth and psychological well-being – a new perspective which is to be integrated into the theory and practice of trauma work. The findings of this study embrace the central tenets of positive psychology, as argued by Seligman (1998, p. 2), that “the mission of the psychological profession is not solely fixing what is broken; it is also the recognition of an individual’s strength and virtues”.

The women survivors of CSA in this qualitative study were able to articulate their perceptions of constructive coping, posttraumatic growth and psychological well-being pertinently, and these experiences were mostly in agreement with relevant theory and research findings. It is recommended that the unique strengths evident in these women who had experienced CSA and which enabled them to cope positively and to experience posttraumatic growth and psychological well-being, be used to develop an intervention guideline to aid survivors of CSA and even other traumas. Linley and Joseph (2003 p. 135), report that “post-traumatic growth harnesses the core principles of positive psychology, and [that] these principles can be put to effective use in the therapeutic service of trauma survivors”. The current research indicated that reflective discussions can be helpful as a therapeutic tool in the work with women who had survived CSA, in order to bring about their improved coping, deepened posttraumatic growth and enhanced psychological well-being.

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MANUSCRIPT THREE

**GUIDELINES FOR AN INTERVENTION TO ENHANCE CONSTRUCTIVE
COPING BEHAVIOUR, POSTTRAUMATIC GROWTH AND
PSYCHOLOGICAL WELL-BEING IN WOMEN WHO EXPERIENCED
CHILDHOOD SEXUAL ABUSE**

Prepared for submission to *Journal of Child Sexual Abuse*

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ABSTRACT

The aim of this study is to formulate guidelines and strategies through which constructive coping, posttraumatic growth and psychological well-being could be enhanced in women who experienced childhood sexual abuse. Recent trauma literature has supported a philosophical shift from a pathogenic to a salutogenic paradigm in which the focus is on positive and adaptive as well as negative and adverse post-trauma outcomes; however, empirical knowledge about such constructive outcomes of the trauma experience is scarce. Where previous trauma models only included an integrative approach based on a pathogenic model, the current guidelines and strategies incorporate a salutary or positive factor within the intervention by including a spiritual and existential dimension (“meaning section”) and a potential area for growth. There are currently no interventions available for the enhancement of coping behaviours, posttraumatic growth and psychological well-being in women who had experienced childhood sexual abuse. The specific guidelines and strategies formulated in this study were based on previous findings and theoretical frameworks of constructive coping behaviour, posttraumatic growth and psychological well-being in women who were sexually traumatised as children and merged with an integrated trauma model. An intervention as the one proposed here has the potential to facilitate constructive coping, posttraumatic growth and psychological well-being, in women who experienced childhood sexual abuse.

Key words: Women, childhood sexual abuse, positive coping behaviour, posttraumatic growth, psychological well-being, positive psychology, guidelines, strategies, intervention programme

Introduction

Childhood sexual abuse (CSA) is an all too familiar phenomenon and is not unique to any society or culture. The high prevalence of CSA has been the subject of considerable research for years, and Bogar and Hulse-Killacky (2006) report that over the past two decades, the counselling literature has been replete with information about the devastating and lingering effects of childhood sexual abuse, often painting a rather grim picture of the quality of life for adults who have survived such trauma (Wilson & Strebel, 2004). Furthermore, the non-detection and non-integration of experiences of CSA in medical and mental health services have been indicated by authors such as Campbell and Raja (1999); Dill, Chu, Grob and Eisen (1991); Laidlow and Malmo (1990); Warshaw (1993) and Wilson and Strebel (2004). CSA is thus an important contemporary community problem which needs to be addressed by means of well researched interventions, and Tsuang (2000) suggests that research into the factors that promote adaptive functioning and resilience in trauma victims, may have important clinical implications, particularly for preventative interventions.

Survivors of CSA experience numerous interpersonal problems and maladaptive behaviours that impede their productivity and quality of life. They often experience a wide range of post-trauma adjustment difficulties, including depression, problems with intimacy, struggles in their parental role, and a heightened risk for later victimisation (Arata, 2002; Briere, 1992; DiLillo, 2001; Messman-Moore & Long, 2003; Wright, Crawford & Sebastian, 2007). One particularly serious impact of CSA can be that assumptions about the safety and goodwill of the world are often crushed, which can lead to the loss of the victim's sense of life's purpose and meaning (Janoff-Bulman & Frantz, 1997; Wright et al., 2007). However, the potential for positive adjustment after the traumatic life experience of CSA certainly exists. In this regard, traumatic life experiences can

equally provide an opportunity for growth and personal change and allow individuals to reflect on themselves, their strengths and the meaning of their lives (Wright, Fopma-Loy & Fischer, 2005; Wright et al., 2007). Most of the studies found in literature to date have focused on the negative consequences of CSA-related trauma, but a growing body of research demonstrates that survivors can report growth and positive life challenges following an extremely traumatic event (Frazier, Conlon & Glaser, 2001). The Chinese word for trauma (*Chuangshang*) is the juxtaposition of two characters, creation (*Chuang*) and hurt (*Shang*). Traumatic or hurtful experiences can thus create opportunities for growth by introducing reframed perspectives to one's life, through which a person's emotional and spiritual capacities can be enhanced. The Chinese culture does not deny the presence of pain and distress in people's experiences of trauma but rather believes that distress and growth are not mutually exclusive (Chan, Chan & Ng, 2006, p. 14). In this vein, people who experience traumatic events or hurts can be helped to re-create their painful experiences into survival and growth.

Thus, helping professionals can begin to recognise trauma as an opportunity for an individual to transform their own life. If people can maximise their learning from living through a traumatic experience, they may be rewarded by an increased awareness or even enlightenment about their inner strengths and abilities to overcome the adversity and to grow towards fulfilment. Where earlier assumptions prescribed that only adverse consequences could be related to the experience of CSA, the past decade has seen the rise of strength-focused perspectives in the helping professions. These perspectives object to the obsession with victimhood and psychopathology, and aim at more than restoring the homeostasis (Graybeal, 2001). Much rather it aims at transforming the person to an enhanced intrapersonal place where they do not just survive but instead can thrive (Seligman, 2011). The strengths perspective thus shifts the focus from pathology to strength and

resilience. A helping professional should therefore acknowledge the pain but also look for strengths in people and resources in the environment, aptly argued by Saleebey (1999, p. 15), who states, “[I]t is as wrong to deny the possible as it is to deny the problem”. The strengths perspective puts clients in an active role towards restored self-actualisation. The helping professional works as a collaborator, not only healing the woundedness but facilitating growth and resilience (Chan et al., 2006). While trauma can lead to the worst of times, struggling with a crisis can provide the opportunity for psychological growth that would not have been possible without the challenges of the traumatic event. It is therefore, the very act of struggling with the many negative consequences of traumatic events that makes possible the varied forms of psychological growth, for which the authors Tedeschi and Calhoun (1995) have coined the term “posttraumatic growth”.

Previous research by the current researcher (cf. Articles 1 and 2) studied the coping behaviours, posttraumatic growth and psychological well-being, in women who had experienced CSA, using a mixed method study design. In the quantitative component of that study, women (N=60) who had experienced CSA (sexual abuse before the age of eighteen years) completed validated measures as indicators of the degree of constructive coping behaviour, posttraumatic growth and psychological well-being manifested by them. Tertiles of normalised scores indicated that 58% of the participants scored high on constructive coping, 39% scored moderately on constructive coping and 3% scored low on constructive coping. With regard to posttraumatic growth, tertiles of normalised scores indicated that 60% of the participants manifested high posttraumatic growth, 20% manifested moderate posttraumatic growth and 20% manifested low levels of posttraumatic growth. Similarly, with regard to psychological well-being, 42% manifested high levels of psychological well-being or flourishing according to Keyes (2002), 18% appeared to

display moderate levels of psychological well-being, and 40% displayed low scores or languishing (Keyes, 2002).

In the qualitative component of the above-mentioned study, the researcher explored how women who had experienced CSA managed to cope positively, exhibit posttraumatic growth and manifest psychological well-being. Ten women were identified who showed these abilities, and they were interviewed in order to understand what enabled them to cope positively, to grow and to be mentally well after the childhood trauma. The main themes and sub-themes that emerged from the interviews with the participants referred to positive coping through psycho-socio spiritual resources, posttraumatic growth through the healing process and psychological well-being through positive strengths. Psycho-socio spiritual resources include strategies such as the regulation of emotions, optimistic explanatory styles for negative events, cognitive restructuring, seeking social support, religious coping and the evolution of adaptive coping strategies. The healing process includes aspects such as pre-healing symptoms of avoidance and suppression, worthlessness, shattered trust, sexual dysfunction, symptoms of mental illness and discontented religion. Healing further comprises positive outcomes of healing, including the courageous choice to heal, growth and forgiveness, appreciation for life, the role of pain, recovery as an arduous process and knowledge of the sexual abuse syndrome, as well as the roles of survivor and wounded healer. Positive strengths include facets of the self relating to self-efficacy, self-worth, inner strength and meaning-making. In this study, these themes will be translated into guidelines for an intervention to promote constructive coping, posttraumatic growth and psychological well-being in women who had experienced CSA, which could be used for empowering such women to move forward in their recovery process. Research done on improving resilience in groups found that interventions are

often more effective when they focus on enhancing the positive behaviour instead of just eliminating the negative (Koen, 2010).

When reviewing the current literature, there is cause for concern with regard to the intervention strategies provided for traumatised women. Most survivors of CSA attempt only to survive and they are not offered an opportunity to rise above the trauma and identify strengths born from the ordeal. Despite the large volume of literature on the prevalence and impact of CSA, there are relatively few empirically supported treatment interventions available (Sikkema, Hansen, Kochman, Tarakeshwar, Neufeld, Meade & Fox, 2007). The challenge for helping professionals working in the field of sexual trauma is to incorporate post-trauma growth, salutogenesis, solution-focused interventions and strengths-based practice in their helping strategies. Interventions would aim to move traumatised women from a victimhood perspective into a healing process where they can start integrating and shifting traumatic memories (Van der Merwe, 2009). Although there may be many resources available to CSA survivors, currently no interventions exist to promote constructive coping and posttraumatic growth and to increase psychological well-being.

Positive psychology interventions

Over the past decade, research in the field of positive psychology has emerged to provide evidence-based answers and to guide practitioners. Psychological well-being is viewed from the framework of positive psychology as not only the absence of mental disorders but also the presence of positive psychological resources, including components of hedonic or subjective well-being and happiness, characterised by positive affect, life satisfaction and low levels of distress (Diener, 1984; Walker, 1999) as well as components of eudaimonic well-being characterised by self-acceptance, positive relations, autonomy and purpose in life (Ryan & Deci, 2001; Ryff, 1989). A promising approach

aimed at increasing psychological well-being is through positive psychology interventions defined as “treatment methods or intentional activities aimed at cultivating positive feelings, positive behaviours, or positive cognitions” (Sin & Lyubomirsky, 2009, p. 467) and thus enhancing well-being and improving dysfunctional behaviours. In the research of Sin and Lyubomirsky (2009), the results revealed that positive psychology interventions significantly enhance well-being; therefore, clinicians are encouraged to incorporate positive psychology techniques into their clinical work.

Purpose of the research

The purpose of the research being reported here, was to identify and formulate guidelines with appropriate strategies for an intervention, based on the research findings mentioned above and recent relevant literature. The aim of such an intervention would be to facilitate and enhance the coping behaviour, posttraumatic growth and psychological well-being in women who had experienced CSA. Such an intervention could be extended into a programme for use in counselling and other trauma recovery settings.

Guidelines and strategies: from trauma to growth

Guidelines (mostly developed in medical clinical practice) are described as a set of recommendations aimed at the development of appropriate care processes in order to enhance healthcare practices and to improve the outcomes of interventions (Shekelle, Woolf & Eccles, 1999). Strategies refer to specific actions or intentions to reach aims, or to deal with a specific situation in a specific context (Van Dyk, 1998). In this study, guidelines with strategies for developing an intervention programme were based on the insights gained from interviews with women who had experienced CSA (empirical data) and the theoretical knowledge that exists

regarding the development of interventions in psychology. The guidelines and strategies of this study are further strengths-based and are in line with theoretical assumptions of positive psychology for interventions, and would fit the theoretical frameworks of trauma theory and posttraumatic growth.

The development of low-cost effective interventions that can serve women who have dealt with CSA, would meet an unmet need and the importance of considering coping strategies and cognitive restructuring methods for inclusion when designing therapeutic interventions with survivors of CSA is stated by Wright et al. (2007). Intervention programmes for the enhancement of coping behaviours, posttraumatic growth and psychological well-being could not be found. Furthermore, the body of research supporting the efficacy of group interventions for sexual abuse survivors is small but encouraging (Kessler, White & Nelson, 2003). Thus, although factors that promote recovery from CSA are documented in research, little is known about how to move from theory to practice in order to formulate guidelines and strategies that can be used in interventions.

A positive coping, growth and psychological well-being intervention for survivors of CSA

The main objective of this intervention is to develop a supportive therapeutic intervention by means of guidelines and strategies focusing on positive coping, posttraumatic growth and psychological well-being. Existing theoretical frameworks and models that will be considered to develop a meaningful intervention, are the following:

Positive coping guidelines aimed to promote positive coping skills, were found in Carr's (2011) description of functional coping strategies. According to Carr (2011), functional emotion-focused coping strategies are appropriate for managing affective states associated with uncontrollable stresses such as the trauma of CSA. Such strategies could include: making and

maintaining socially supportive relationships in which it is possible to confide deeply felt emotions and beliefs; seeking meaningful spiritual support; reframing and cognitive re-structuring; and self-nurturing through relaxation, humour and nutrition. Functional problem-focused coping strategies aim to modify the context of stress and could include: seeking accurate information to assist growth, seeking dependable advice and help, developing realistic action plans, carrying out these plans, remaining focused on problem solving and optimistic regarding one's capacity to remedy the problem.

Posttraumatic growth guidelines were found in the Posttraumatic Growth model. Posttraumatic growth refers to the success with which individuals coping with the aftermath of trauma, reconstruct or strengthen their perceptions of self, others and the meaning of events (Tedeschi & Calhoun, 1996). Posttraumatic growth has been hypothesised to develop as a result of the rumination and restructuring that occur post trauma and is focused on changes in one's capacity to deal with the adverse events (Calhoun & Tedeschi, 1998), while recognising and strengthening those aspects of self that have been harmed by the traumatic event (Saakvitne, Tennen & Afflek, 1998). Tedeschi and Calhoun (1995; 2004a), developed an outcomes-based functional-descriptive model in which the growth process is conceptualised as detailed below. A traumatic event of seismic proportions destroys some key element of a person's important goals and worldview. This represents a challenge to higher-order goals and beliefs as well as the ability to manage emotional distress. The resulting emotional distress initiates a process of rumination and the person attempts to engage in behaviour designed to reduce distress (initially rumination is more automatic than deliberate, characterised by frequent returns to thinking about the trauma and related aspects). After the first coping success (i.e. reduction of emotional distress and disengagement from unreachable goals), rumination transforms into more deliberate thinking about the trauma and its impact on

one's life. This form of rumination in its more constructive phase is conceptualised as cognitive processing (i.e. analysing the new situation post trauma, finding meaning, and re-appraisal) and is assumed to play a vital role in the development of personal growth.

Posttraumatic growth is thus conceptualised as a multidimensional construct including changes in beliefs, goals, behaviours and identity as well as the development of a life narrative and wisdom. Pre-trauma variables within the person, social support variables and enduring distress are assumed to influence the coping process and the emergence of posttraumatic growth (Zoellner & Maercker, 2006).

Psychological well-being guidelines were based on the Mental Health Continuum model, which represents the upper end of positive well-being and optimal human functioning as indicated by emotional well-being, psychological well-being and social well-being (Keyes, 2002). Emotional well-being is characterised by the presence of positive affect, the absence of negative affect and a sense of satisfaction with life. Psychological well-being refers to Ryff's (1989) six dimensions of psychological well-being, namely self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth. Emotional and psychological well-being are however intrapersonal reflections of one's adjustment and do not represent a complete engagement in society and life. The third component of the Mental Health Continuum model set out by Keyes (2002) is social well-being, which is also necessary for mental health. This consists of social integration, social acceptance, social contribution, social actualisation and social coherence (Keyes, 1998).

In the process of building the three psychological strengths of coping, posttraumatic growth and psychological well-being into an intervention, the theoretical framework of the Wits Trauma model (Eagle, 2000) and the steps explicated therein will be used as a foundation to guide the

conceptualisation of therapeutic components in this intervention. The success of the Wits Trauma model lies in the integrative theoretical framework that proved to be ideally suited for the treatment of psychological trauma and that was devised by psychotherapists working with trauma in the South African context. Eagle (2000) argues that posttraumatic stress represents a disorder in which dysfunction occurs both internally and externally and at the interface of these two aspects of psychological functioning. Traumatic disturbance thus manifests in recognisable cognitive, behavioural and somatic symptoms and is accompanied by unconscious associations and anxieties. According to Eagle (2000, p. 301), the “ideal approach to treatment appears to be in drawing on the relative strengths of both the psychodynamic and cognitive-behavioural schools” and therefore the integrative perspective of the Wits Trauma model reflects elements of both these classic approaches in psychology. The model includes five components, which can be introduced interchangeably within an intervention, depending on the needs of the client and the natural flow of the session/s. The five components of the model are outlined as follows: (1) telling/re-telling the story; (2) normalising the symptoms; (3) addressing self-blame or survivor guilt – restoring self-respect; (4) encouraging mastery and (5) facilitating the creation of meaning.

It should be noted however, that the traditional psychotherapy approaches of the psychodynamic and cognitive-behavioural theories were pathogenic-orientated and precluded the search for salutary or positive factors within the therapeutic process, such as a spiritual or existential dimension (meaning section) and the potential for growth. The goal of an intervention is thus not only to return the survivor to a pre-crisis level of psychological functioning but instead to develop and guide them on a growth trajectory that is an outcome of adaptive coping strategies. Therapeutic interventions that only seek to resolve the abuse experiences are inevitably problem-focused and lead to the promotion of viewing the self as a victim. Instead, this positive psychology

intervention aims to reintegrate the abuse experience into new self-schemas using a resource model which builds on the strengths of the sexually abused survivor and which enables her to view herself as competent and as having control over the influence of the effects of the abuse as Briere (1989, p. 3) succinctly suggests, “[T]he goals of abuse-focused therapy should extend beyond survival and ultimately to integration and self-affirmation”. The intervention proposed in this research aimed to include such strengths-based aspects.

In implementation, the guidelines suggested in this study should be kept flexible in emphasis and technique to suit the needs of a specific vulnerable group. It is understood that the wide range of explicit dynamics encompassed in each guideline cannot be clinically dissected into the three constructs of positive coping, posttraumatic growth and psychological well-being and instead are assumed to be overlapping psychological strengths where the link between posttraumatic growth and psychological well-being is that of positive coping. Constructive coping is seen as the vehicle to posttraumatic growth, and posttraumatic growth provides the psychological energy for personal and interpersonal change leading to psychological well-being. These guidelines and strategies are inevitably an oversimplification of a very complex and multidimensional process as the trauma recovery process is not a neatly followed series of events but instead represents interrelated phenomena. In reality, recovery is neither smooth nor predictable. On the contrary, it represents a long, painful and often unpredictable journey of healing and restoration. The model developed during the current research thus represents an integrative spirallitic process of recovery in which one aspect appears to facilitate other areas of the recovery process, and vice versa.

The group context for the intervention

As stated before, the body of research supporting the efficacy of group interventions for sexual abuse survivors is small but encouraging (Kessler et al., 2003). Moving through the adversity of CSA is possible and being assisted by a supportive group is one way for the individual to achieve the transition (Van Loon & Kralik, 2008). A part of the recovery process that is specific to the group context, is the realisation that one is not alone in one's struggle to deal with the adversity, because others understand in a profound sense through shared experience. This is what Yalom (1975) called universality or the sense that one is no longer alone. Another important component of group therapy is what Meekums (2000, p. 71) refers to as "witnessing". Through witnessing other survivors, women gain an increased understanding of their experiences associated with CSA, and this awareness is likely to increase their sense of safety in the group. According to Meekums (2000), the experience of witnessing and being witnessed seems to give a sense of being benevolently seen, heard and understood, which directly contradicts the lonely experience of the abuse. In the group setting, the role of witness seems to contribute to a reframing of personal identity from lone victim-child to collective powerful adult. Therefore, group therapy provides an opportunity to explore differences and similarities in the experience of each individual group member, within a supportive, structured and contained environment.

According to Calhoun and Tedeschi (1999, p. 67), "group settings also provide unique and helpful means for the development of posttraumatic growth". The reports of other survivors can be an impetus that allows group members to consider their own growth possibilities. Furthermore, group therapeutic interventions become fertile ground for the revision of personal schemas essential for the experience of growth.

Survivor inclusion criteria

It is the researcher's opinion that women in the early stages of treatment for CSA are not to be considered for such a group intervention. Referral to this proposed intervention programme should be a secondary referral, meaning that the initial disclosure, assessment and intervention had been done previously and was facilitated by a qualified helping professional. This intervention is not intended to focus on crisis management; thus, those who participate in such an intervention must have adopted a survivor role which implies the personal ego strength and security to venture into the narratives of the trauma with some functional coping and the absence of self-destructive behaviours and addictions. Due to the wide range of explicit dynamics involved in each participant's experience, the intervention strategies are to be applied with good clinical judgement.

Guidelines and strategies for the intended intervention to enhance the constructive coping, posttraumatic growth and psychological well-being of women who experienced CSA are presented next.

Guidelines: From victim to survivor to “thriver”

Guideline 1 – Building safety, rapport, a common identity and purpose for the group

In a previous qualitative research (cf. Article 2), participants reported that trust was a significant area of vulnerability, that initiating contact with a professional was difficult and that the need for a sense of personal safety was an imperative part of their recovery. It was thus important to consider that CSA experiences result in feelings of distrust and apprehension; therefore, the group setting needs to be a safe and therapeutic environment for such women and a platform where they can disclose their experiences safely and trustingly.

Discussion of evidence

There is evidence in the existing literature for the importance of establishing a sense of safety in any therapeutic intervention (Meekums, 2000). According to Cruz and Essen (1994), the adult survivor of CSA who participates in a therapeutic intervention is usually hesitant to disclose painful experiences and feelings. The initial task of the therapist or counsellor is to create and maintain a safe and secure therapeutic environment free from experiences that in any way would be exploitative or that could re-victimise the survivor. Engaging the participants in an active role rather than a passive recipient role allows them to regain control of their lives as adults while letting go of the helplessness they felt as children and in so doing encourages the use of their inherent potential (Cruz and Essen, 1994).

Strategy: we commit to building a unique group space – safe and with common purpose

Aim: To create a safe therapeutic space

Actions:

1. Commence with an ice-breaker focused on allowing the group to develop rapport such as “a name game” (Meekums, 2000, p. 140).
2. Draw up the group’s “bill of rights” – the goals of the group intervention including their rights (Meekums, 2000, p. 142–143).
3. Share what would be important boundaries for the unique group space and possible consequences for overstepping these boundaries.
4. Set the confidentiality limits, non-judgemental nature of the group and other ethical concerns.
5. Emphasise that each member has the right to say “no” to participation in any activity – they are adults who may withdraw at any time; not the powerless children who were abused (Meekums, 2000, p. 72).
6. Address any questions or uncertainties and share emergency contact numbers.

Outcome: The participants would understand and experience the safety of a therapeutic group.

Guideline 2 – The trauma – telling and owning my story – how I have survived

This involves the description of the survivors’ traumatic sexual experience/s as they recall it in sequence including the facts, feelings, cognitions and sensations necessary to bring about intentional rumination in preparation for cognitive processing and restructuring. In recounting the trauma as a sequential story that is comprehensible to the other group members with similar experiences, the material becomes transformed into rational, realistic and understandable information. In recounting the event in detail, the survivor is encouraged not to avoid the aversive

stimuli but rather to tolerate it and experience its reduction in a safe space with the other group members and therapist as a source of protection. It is important for the participants to acknowledge where they are at in their process of recovery and to reflect on their coping attempts to date. This allows the participants to centre themselves in the here and now of their recovery and to overcome the avoidance-coping often used. Furthermore, this aims at allowing the survivor awareness of the narrative process from first disclosure to the present and of how her coping behaviour may have evolved. The above guidelines are based on what was reported by the participants in the qualitative interviews.

Discussion of evidence

According to Eagle (2000), this act of remembering can be cathartic and could enable the survivor to express the unexpressed feelings and experiences associated with the trauma within the safety of the therapeutic context. Carr (2011) describes catharsis as a functional emotion-focused coping strategy necessary in the reintegration of the CSA. The story-telling allows the client to create some cognitive structure around the event; thus, facilitating the process of assimilation and accommodation into existing cognitive frameworks and this, in turn, facilitates the internalisation of new constructions (Eagle, 2000). The goal is to explore, reflect upon, and re-examine the experiences with the view to helping the persons reconcile themselves with the reality of what took place and the role they played in the experience, while containing the emotional impact and protecting their sense of self (Eagle, 2000). Active cognitive processing of the event is necessary for integration and resolution of the trauma (Wright et al., 2007). The therapeutic space can become what Winnicott (1971) terms a transitional space, or what the researcher calls “a transformational space” in which the trauma can be relived in the realm of symbolism rather than reality and so become accessible to cognitive reprocessing. According to Meekums (2000, p. 100), the need to

speaking or expressing oneself in some way and being truly “heard” or witnessed appears to be central to the survivor’s therapy, as the CSA is often marked by secrecy, disbelief and even judgements of the victim.

Strategy: we commit to telling and owning our story

Aim: To tell their story in the here and now in a safe, contained “heard” space

Actions:

1. Prior to disclosure, the group members are encouraged to share the ways they have survived over the years – they can draw an image or use a flip chart or just narrate (Meekums, 2000).
2. Group members partake in the metaphorical “container exercise” – which is a projective way of addressing the need for containment in telling the story and thus providing a level of safety (Meekums, 2000, p. 158).
3. Group members are encouraged to tell the story of their CSA in this safe, contained, therapeutic context assisted with the “house-and-community plan” technique (Fouché, 2006, p. 219 & 254).
4. Group members are to narrate in the present tense bringing them to the here and now of their recovery process – the metaphor of watching a film on a big screen in slow motion can be used to facilitate the process (Eagle, 2000) or a chosen symbolic object may also be used to assist in the story-telling (Meekums, 2000).
5. Other group members are encouraged to offer support and encourage witnessing.
6. Group members create a trauma time line or life map visually presenting their experiences (Meekums, 2000).
7. Group members can summarise, reflect and integrate their survival and coping to date.

Outcome: The survivors would own their traumatic experience in a present, safe, contained, therapeutic space.

Guideline 3 – Normalising the symptom checklist – traumagenic dynamics

Participants in the previous research indicated that they experienced an array of negative dysfunctional symptoms after the CSA experience, such as not feeling worthy and being sensitive to rejection, feeling dirty, experiencing sexual intimacy problems, shattered trust, betrayal, etc. These symptoms appear to correspond with the four trauma-causing factors or traumagenic dynamics proposed by Finkelhor and Browne (1986). It could be pertinent to attend to manifestations of stigmatisation, self-blame, powerlessness, loss and betrayal, sexual traumatisation and impairments in trust and social relatedness.

Discussion of evidence

A critical focus of an intervention such as this one, is on exploring past experiences and awareness's to help the individual understand the impact of traumatic experiences, such as shame, guilt, emotional triggers and relationship patterns, as well as to challenge current behaviours that contribute to continued victimisation beliefs (Kessler et al., 2003). In this guideline, the primary objective would be psycho-education and normalising the symptoms and messages associated with the abuse, so as to reduce the victim response. These traumagenic dynamics refer to the internal environment of sexually traumatised individuals and the ways in which they relate to the world (Van der Merwe, 2009), since survivors of sexual trauma often define their inner cores in terms of their traumatic experiences (Van der Merwe, 2009). The behavioural and emotional responses to trauma are ways to cope and attempts to adapt to their environment, which includes the abuse (Mudaly & Goddard, 2006). As their narratives are believed and the traumagenic dynamics normalised within a safe therapeutic group environment, they begin to positively shift their self-awareness. The particular nature and meaning of presenting symptoms is discussed and empathised with while education about post-trauma symptoms is provided (Eagle, 2000). Anxiety reduction is

an important component of normalising the symptoms and prevents the development of irrational thinking (Eagle, 2000). Furthermore, addressing the four trauma-inducing dynamics unique to the experience of CSA, namely traumatic sexualisation, stigmatisation, betrayal of trust and powerlessness (Finkelhor & Browne, 1986) is crucial, thus linking the trauma experience with symptoms experienced and internalisations formed. Finkelhor and Browne (1986), report that these traumagenic dynamics alter the victim's cognitive and emotional orientation to the world and create trauma by distorting the victim's self-concept, worldview and affective capabilities. James (1989, p. 4) refers to traumagenic states as the "secrets and dysfunctional behaviour that victims often engage in after sexual trauma, as well as distortions in cognition, worldview, relationships and self-concept". Traumagenic states have close links to internalisations, and Spies (2006, p. 53) defines internalisations as "the assimilation and processing of the meaning of outer experiences as they relate to the self". The focus of an intervention should be the damaged or distorted sense of self in victims due to the various internalised messages. A core aspect leading to self-blame in the context of sexual trauma is purely biological, namely the fact that the body of the victim often responds positively to genital touch (Drauker & Martsolf, 2006, p. 62), and James (1989, p. 23) refers in this regard to the fact that the child may experience part of the abuse as "physiologically thrilling". Intervention should thus focus directly on this aspect, by discussing the normal functioning of genitals that are biologically intended to react positively to touch (Van der Merwe, 2009). Self-blame is often rooted in the passivity of the victim and the direct assignment of blame from parents and family after the child disclosed. This may lead to withdrawal and isolation and translate into self-punishing and self-mutilating behaviours, substance abuse and suicidal ideation (Van der Merwe, 2009).

Strategy: we commit to reclaiming our power from the trauma symptoms and dynamics

Aim: To reduce the negativity of the associated symptoms

Actions:

1. Use the “garbage bin” metaphor to illustrate internalisations or internalised messages, and their effects on behaviour, thinking and feelings and the importance of cognitively re-processing these in order for healing to commence (Fouché & Williams, 2005).
2. Address internalisations stemming from the traumagenic dynamics (Fouché & Williams, 2005, p. 4 & 20; Spies, 2006).
3. Reprocess internalised messages of stigmatisation, self-blame, powerlessness (lack of control), sexual negligence and traumatisation.
4. Awareness of automatic irrational negative thoughts causing internalisations and coaching into replacing them with positive self-affirmations (Williams & Poijula, 2002).
5. Use “childhood photographs” to represent the reality of how small and defenceless they were against the adult abuser – this is important in releasing the guilt and blame and throwing it at the abuser (Fouché, 2006, p. 254; Meekums, 2000, p. 160).
6. Activities aimed at letting go of the guilt and shame and the acceptance of it not being their fault (Williams & Poijula, 2002).
7. Create an image of the trauma-causing factors and related feelings and then physically engage with the image by tearing it up, stamping on it, throwing it away, burning it, etc. (Meekums, 2000).
8. Use creative sensory means to release negative emotions such as anger and rage using i.e. clay, balloons, etc. (Van der Merwe, 2009).

9. Psycho-education to normalise the associated body sensations and experiences thereby reframing the expected physiological reaction to sexual stimulation (Van der Merwe, 2009).
10. Use the “robot technique” to understand the physical symptoms experienced (Fouché & Yssel, 2006, p. 254).
11. Utilise progressive relaxation and secure visual imagery of a safe place in order to manage the anxiety and negative emotions associated with the trauma (Williams & Poijula, 2002).
12. Use anxiety-reduction techniques by learning to rate their subjective units of distress (SUD scales) and thus promoting self-awareness of their own anxiety levels (Williams & Poijula, 2002).
13. Implement self-esteem exercises using the “strong foot” metaphor (Fouché & Williams, 2005, p. 18; Williams & Fouché, 2008).
14. Acknowledge symptoms as proof of their struggle to survive the CSA (Meekums, 2000).
15. Creative writing and journaling are included here (Williams & Poijula, 2002).

Outcome: The survivors will be able to manage the symptoms associated with the trauma.

Guideline 4 – Committing to the healing process – making the choice to heal

Participants in previous research indicated that the journey of recovery was a long, arduous, often painful process with no quick fixes. Confronting such traumatic experiences took perseverance and complete commitment and a conscious choice was needed to enter into the healing process of recovery. Participants also indicated that through their traumas they were encouraged to grow their knowledge base of the topic and had a heightened sense of awareness to areas pertaining to CSA.

Discussion of evidence

The retelling of traumatic experiences can open old wounds but, importantly, it provides an opportunity for the survivors to describe how they would like to experience their recovery process (Turner & Cox, 2004, p. 8).

Strategy: we commit to being the builder of our own healing life reconstruction

Aim: To commit to the process of recovery

Actions:

1. Develop a metaphor for the recovery process which they envisage ahead (Williams & Poijula, 2002).
2. Guided imagery on the process ahead and a survivor character of perseverance and determination.
3. Illustrate “the end of the rainbow” – what does she see after recovery (Meekums, 2000, p. 142).
4. List the “provisions needed for the building process”. These need to be placed symbolically into a real or imagined trunk and discussed (Meekums, 2000, p. 142).
5. Symbolical metaphorical “images of protection”, for the process ahead, can be anchored into the session (Meekums, 2000, p. 145).
6. Keep a growth journal.

Outcome: The survivors would have enrolled on the voyage of recovery, which brings discovery.

Guideline 5 – Forgiveness – making the choice to forgive

Participants previously reported that they could not continue on their healing process without acknowledging the several losses experienced and the need for forgiveness.

Discussion of evidence

According to Baumgardner and Crothers (2009), the value of forgiveness is in terms of its potential ability to offset the debilitating effects of anger and hostility associated with an adverse event. Forgiveness further has the potential to repair relationships and undo negative emotions. True forgiveness is therefore not forgetting, denying or minimising the hurt or condoning what was done; it is recognising and acknowledging that a transgression had occurred and finding ways to move beyond the transgression and break free from both the wrong that was done and the person who had committed the wrong (Compton, 2005).

Strategy: we commit to forgiveness

Aim: To commit to the process of forgiveness

Actions:

1. Address the numerous losses experienced – loss of their childhood, safety, trust in the world, parent figure, etc.
2. Psycho-education in discussing Kübler-Ross's five stages of grief (Kübler-Ross, 2005).
3. Empty-chair work to verbalise and process losses experienced (Van der Merwe, 2009).
4. Letters can be used as a form of creative writing to channel the loss and encourage forgiveness (Meekums, 2000; (Fouché & Yssel, 2006, p. 260).
5. A “lullaby” can be created and sung to the inner child (Meekums, 2000, p. 163).
6. Metaphorical burials can be incorporated for closure (Meekums, 2000).
7. Create a before forgiveness and after forgiveness collage.

Outcome: The survivors would have dealt with losses ultimately leading to forgiveness.

Guideline 6 – Telling my story for “a change”-making sense of the struggle with my trauma as a positive subjective experience (benefit-finding)

In the semi-structured interviews of previous research, the participants reported that, although there was nothing inherently positive about their traumatic experience in childhood, they paradoxically could not regret that it did occur. They ended up stronger than they were prior to the CSA and, when reflecting, these participants could denote their own personal gain to be found in suffering. Attempts should thus be made to allow these survivors to verbalise this paradox and acknowledge the positive change that has come about after the trauma.

Discussion of evidence

The literature depicts that individuals reflect that there is nothing inherently positive about the traumatic experience and yet they cannot regret that it had occurred as they ended up better people than they were prior to the tragedy. The impetus for growth is thus located in the struggle with the aftermath of the traumatic event and not with the event itself (Calhoun & Tedeschi, 1998, Tedeschi & Calhoun, 1996). Woodward and Joseph (2003) report that this insight is instrumental in enabling women to survive CSA, to seek meaning in their experiences and ultimately to heal. Tedeschi and Calhoun (2004b, p. 406) state, that “there appears to be a basic paradox that is apprehended by trauma survivors who report these aspects of posttraumatic growth: their losses have produced something of value and there appears to be an increased sense of their own capacities to survive and prevail”.

Baker, Kelly, Calhoun, Cann and Tedeschi (2008) report on the bipolar or dichotomous nature of posttraumatic growth. According to Morris, Shakespeare-Finch, Rieck and Newbery (2005) and Fournier (2002), the traditional focus on negative post-trauma outcomes and symptom relief has been to the detriment of the underlying process of adaptation and growth.

The need for successful integration of a traumatic event into one’s life is prevalent in the trauma literature and appears to be one of the ultimate steps in recovering from trauma (Sewell & Williams, 2001). Cognitive restructuring is therefore an important coping strategy that focuses on changing one’s perspective regarding a traumatic event. An individual may engage in one or more forms of restructuring, such as meaning-making and benefit-finding, which are two closely related but separate forms of the coping strategy of cognitive restructuring (Wright et al., 2007). Current theories regarding the posttraumatic growth process, although acknowledging that growth can occur soon after a trauma, generally assume that growth is the result of a long recovery process and

the number of benefits survivors report generally increase over time (Calhoun & Tedeschi, 1998; Schaefer & Moos, 1998).

Strategy: we commit to re-telling our story for “a change”

Aim: To acknowledge the positive subjective experience of the trauma by telling their story for “a change” – what change occurred in their personal experiences of themselves

Actions:

1. Telling their stories from both ends – the devastating trauma and the recovery which prompted “change” – what changes have you observed in yourself since this happened – cognitive reframing.
2. Discuss the paradox of “change” and how it relates to each member and create a ritual of acknowledgment for the positive subjective experiences gained.
3. Explore how this change has been implemented, what has altered their view of vulnerability versus strength.
5. Reinforce behaviours, thoughts or strategies which were effective and indicative of mastery throughout trauma experience (Eagle, 2000).
6. Explore the illusionary component of posttraumatic growth (Zoellner & Maercker, 2011).

Outcome: The survivors would reflect on their own positive personal experiences post trauma.

Guideline 7 – Survivor role – post-trauma world view and identity (meaning-making) – altered philosophy of life as a survivor

The participants previously reported that, in order to make sense of their trauma, they had to adjust their world view and philosophy of life, and in order to reach a pivotal point in their healing process they had to reintegrate this new altered world view and identity as a survivor of CSA.

Discussion of evidence

According to Janoff-Bulman (1989; 1992), individuals who are violated by traumatic events have to rebuild their assumptions or schemas of the world (e.g. whether it is a just world or not), especially those assumptions related to the purpose of life, and this reframing of a coherent world view can be seen as successful coping with the trauma. Survivors who are still struggling to find meaning in life have a poorer quality of life (Tomich & Helgeson, 2002), and those who have a sense of purpose, display less psychological distress and better emotional and social functioning (Vickberg, Duhamel, Smith, Manne, Winkel, Pappadopoulos et al., 2001). Tedeschi, Park and Calhoun (1998) further imply that individuals are capable of developing beyond their previous level of functioning and can experience a significant beneficial change in cognitions and emotions. Often survivors speak of some alteration to how they see themselves and their world, not only in the aftermath of the trauma, but as a consequence of reflecting over time in the intervening years (Turner & Cox, 2004). Assisting in the establishment of meaning usually involves engaging with the person's belief system, be this at a cultural, political, spiritual or existential level. Discussion in these areas is designed to be respectful of the person's existing beliefs in "attempting to assist the person to derive some salutary meaning from the experience and to engender hope and some future perspective without denying the damage done" (Eagle, 2000, p. 318). Creation of meaning can be understood as representing the person's transition from the more damaged position to the healthier position manifesting in the ability to integrate good and bad (Eagle, 2000). The person may feel a sense of new wholeness in embracing a self who has encountered attack and survived (McCann & Pearlman, 1990). It must be emphasised, however, that attempts to direct clients in a constructive direction must not be imposed or ill-timed as this could lead to a shattering of the therapeutic alliance (Eagle, 2000). In many cases, the capacity to derive some meaning from the experience is a

long-term project which requires the greater distance from the experience brought about by time (Eagle, 2000) and the derivation of meaning may also be more important in complex than simple trauma. This guideline can be understood as enhancing the person's ability to internalise or understand themselves and the world post trauma, to be a survivor rather than a victim, and to live this altered view of themselves and the world in a way in which their future path is enhanced (Eagle, 2000). Exposure to sexual trauma presents victims with schema-discrepant information and, according to McCann and Pearlman (1990, p. 138–141), five primary schemas are disrupted by trauma namely safety, trust, power, self-esteem and intimacy. Meichenbaum (1994) stated that people shape their own mental representations about the world. These schemas or beliefs are disrupted by traumatic exposure, and linked to this, Brewin (2003) mentions core schemas disrupted by trauma leading to vulnerable identities in traumatised victims, namely experiencing themselves as powerless, inferior, non-existent or futureless, and experiencing others as abandoning, hostile and betraying. Roth and Batson (1997) mention trauma themes, which have to be processed during intervention, namely helplessness, rage, fear, loss, shame, alienation, restoring a benign meaningful world view, viewing people as trustworthy and the self as worthy, addressing self-blame and guilt, and restoring reciprocity. The psychological impact of the powerlessness experienced through CSA may manifest as a lowered sense of self-efficacy and adopting a victim identity (James, 1989). Victims may actively grieve for lost identities, environments and relationships, as well as for the sense of wholeness that is lost (Van der Merwe, 2009). According to Neimeyer (2001), finding and re-defining the meanings of life are not merely a coping strategy but also a pathway to positive transformation.

Strategy: we commit to making the move from victim to survivor

Aim: To acknowledge their altered identity as a CSA survivor and what this means to their current worldview

Actions:

1. Share a narrative or drawing of the “before” and “after” identity and in this way enhance positive mastery (Williams & Poijula, 2002), and define the characteristics of their post-trauma identity – how do they make sense of this identity?
2. Free-writing exercise on the “meaning of the trauma journey” (Meekums, 2000).
3. Explore how this post-trauma identity has created an altered sense of self and reframed life philosophy.
4. Create and share a diagram of this survivor life philosophy.
5. Share the lessons they could teach future survivors from their trauma experience.

Outcome: The survivor identity will be embraced and acknowledged.

Guideline 8 - The wounded becoming the healer – acknowledging the changed sense of self

Participants in previous research emphasised that their energies were often focused on social rekindling and wanting to care for others, being able to deeply empathise with others and often finding themselves fulfilling helping or supportive roles at work and at home. The “mothering role” also appeared to be accentuated through the healing of their traumatic experiences.

Discussion of evidence

According to Taylor, Klein, Lewis, Greunenwarld, Gurney and Upfdegraff (2000), in times of stress females engage in caretaking activities or in the creation of a network of associations to protect themselves and others from threat, they respond relationally to stress and they seek connection –

the authors call this response the tend-and-befriend response. Dunning (2006) suggests that often people become healers through personal suffering – wounded healers transform their wounds into a positive experience and consciously use this experience to help others. According to Harvey (2001), trauma survivors embrace this positive approach to life within a context of tragic hopefulness. They have experienced firsthand the limits of human life and this transforms into the awareness that trauma can be seen as a valuable learning opportunity enabling them to help others in need and thus prevail as the survivor. This need for outreach restores the woman's sense of belonging and control and is critical to surviving and healing from such trauma as CSA. It embodies the process of reconnection and claiming one's personal power (Ross, 2003). According to Briere (1989), one of the foremost needs of survivors of CSA is to regain a sense of control over their lives. Control was taken from them when they were abused and the symptoms they suffer continue to rob them of control. According to Turner and Cox (2004), during recovery, survivors view others, particularly those with the same traumatic framework, with empathic compassion and their relationships with others change for the better. Cognitive reappraisal can produce resilient schemas and even positive outcomes, including the development of new convictions and directions for one's life, while such transcendence of adversity may allow the person to become a role model for others, which is in itself a positively reinforcing behaviour (Eagle, 2000, p. 319).

Strategy: we commit to reaching out

Aim: To commit to reaching out to other survivors

Actions:

1. Create a mantra of their life as a survivor.
2. Share what it means to be able to help others and reach out.
3. Explore and share the importance of emotional boundaries (Williams & Poijula, 2002).
4. Assist them to recognise their worth, using positive affirming in the group.
5. Become the voice for future survivors – giving advice to future survivors – becoming an advocate for other survivors.

Outcome: To acknowledge the real self as wounded yet capable of healing others through their own healing.

Guideline 9 – Renewed relationships – positive social relationships

Participants previously reported that their relationships were enhanced in some way, and they expressed how much more they valued their friends and family. They were more content with simple things and with the people that mattered most to them.

Discussion of evidence

Research reporting on positive change after traumatic experiences indicates that growth can occur in a number of areas in a person's life (Morris et al., 2005), such as positive changes in relationships with family and others, attitudes, skills, knowledge, confidence (Carver, 1998; Elder & Clipp, 1989; Fromm, Andrykowski & Hunt, 1996). Closeness is also renewed in relationships. Posttraumatic growth can involve an experience of deepening of relationships, increased

compassion and sympathy for others and a greater ease at expressing emotions (Calhoun & Tedeschi, 1999; Turner & Cox, 2004).

Strategy: we commit to building personal relationships and resources

Aim: To acknowledge building meaningful personal relationships

Actions:

1. Discuss the importance and function of their meaningful relationships and social support.
2. Explore the value of defining and reclaiming personal space (Williams & Poijula, 2002) and engage in the “room-to-breathe” exercise (Meekums, 2000, p. 172).
3. Assist them to create “action plans” for positive changes in relationships.
4. Use the “ball-of-wool” exercise illustrating the web of positive connections made in the group (Meekums, 2000, p. 179).

Outcome: The survivor will identify meaningful personal relationships.

Guideline 10 – Active approach coping strategies

Participants reported in previous research on engaging in positive thinking, dealing actively with problems and refusing to dwell on the past, as well as accessing social support networks. Cognitive distortions relating to the trauma appear to be reconstructed around themes of “It is not my fault”, “I will not be a victim”, etc. Participants account for having to learn to deal with negative emotions, for not relying on passive destructive coping skills as before, such as avoiding, denying, or seeing themselves as failures and living by unrealistic expectations.

Discussion of evidence

Olf, Langeland and Gersons (2005) report that active coping strategies have been associated with a better adaptation to stress and that seeking social support is another active coping

strategy in dealing with traumatic stress. Belle (1987) has found that women are more likely to mobilise social support in times of stress. Many defences found in the destructive coping patterns of victims stem from their internalisations or traumagenic states, i.e. minimising, rationalising, denial and repression, avoidance, resistance, control issues, escape strategies and isolation (Bass & Davis, 2002).

Strategy: we commit to using constructive coping strategies

Aim: To build constructive coping strategies and a growth-enhancing orientation in survivors

Actions:

1. Provide opportunities to master constructive coping strategies such as:
 - making and maintaining socially supportive relationships (in which it is possible to confide deeply felt emotions and beliefs in a process of catharsis)
 - seeking meaningful spiritual support
 - cognitive re-structuring
 - self-nurturing through relaxation, humour and nutrition
2. Share constructive coping strategies and learn from one another and reinforce mastery.
3. Explore the negative effects of destructive coping strategies on themselves and their families and discuss alternative ways of coping.
4. Use stress management techniques.

Outcome: To build resilience through positive re-integration after coping effectively with the CSA experience and further building effective coping strategies.

Guideline 11 – Emotional well-being

Participants reported in previous research that the regulation of emotions and the use of positive emotions was one of the important building blocks used for the rebuilding of their lives. They also experienced a sense of life satisfaction.

Discussion of evidence

The importance of emotional well-being and living with confidence, and enjoying life is evident in the literature (Bandura & Locke, 2003; Liebenberg & Ungar, 2008; Seligman, 2002). Emotional well-being is characterised by the presence of positive affect rather than of negative affect and being satisfied with life (Keyes, 1998). This positive outlook involves a range of interrelated innate or learned positive psychological characteristics and can have enduring effects on enhancing psychological well-being (Fredrickson & Branigan, 2005; Peterson, 2006; Seligman, 2002).

Strategy: we commit to investing in our emotional well-being

Aim: To cultivate positive emotions in order to optimise psychological well-being

Actions:

1. Provide opportunities to talk about emotions and the effects of these on behaviour.
2. Group discussion on the broaden-and-build theory of positive emotions (Fredrickson, 2002, 2008). Create opportunities for positive emotions, fostering the feeling good, better, best action plan.
3. Facilitate emotional growth using guided imagery, psycho-drama enactment or role-plays (Williams & Poijula, 2002), illustrating scenarios where emotions and humour were effectively utilised in certain contexts.
4. Reframing of guilt as a cognitive defence and replacing it with a suitable emotion in order to restore emotional control and self-esteem (Fouché & Williams, 2005, p. 26).

5. Reflect on the self-esteem exercise done using the “strong foot” metaphor (Fouché & Williams, 2005, p. 18; Williams & Fouché, 2008).
6. Metaphor of a “road map” used to transform irrational to rational thoughts and unhealthy feelings to healthy broadening emotions (Fouché & Williams, 2005, p. 26).
7. Use personal enrichment and growth interventions (such as Fordyce’s Happiness Training Programme) which aims to increase subjective well-being where positive emotion is a strong feature (Compton, 2005).
8. Encourage a belief in themselves and have a congratulatory ceremony on their journey to now and achievements logged to date, thus encouraging emotional well-being.
9. Psycho-education on emotional intelligence (Compton, 2005).

Outcome: To experience positive emotions, meaning in life and the emotional skill to deal with negative affect.

Guideline 12 – Spiritual well-being

A large proportion of the participants previously indicated that their spiritual beliefs helped them to heal. Spirituality appeared to act as a source of support, to aid in the process of meaning-making and to provide a source of inner strength and belief in self for these women survivors. Some participants were angry at God and it was useful to discuss this within the group.

Discussion of evidence

Some individuals report a greater appreciation for life, a changed set of life priorities and in making positive changes in religious, spiritual or existential matters (Calhoun & Tedeschi, 1999). Positive forms of spiritual coping reveal a greater sense of attachment and reliance on a Higher power for comfort and security and a concomitant active seeking of support from this Higher power in times

of stress. Positive spiritual coping has been related to better well-being for individuals who experience extreme life stress situations that are out of their control. Such coping may operate primarily as a form of emotion-focused coping (Pargament, Koenig & Perez, 2000) and since emotion-focused coping is more prevalent among CSA survivors and are related to their positive adjustment, spiritual strategies may thus be of importance to CSA survivors. CSA survivors may turn to spiritual behaviours, such as prayer for support, and so attempt to mobilise spiritual resources (Pargament, Smith, Koenig & Perez, 1998). Participants may however respond with spiritual discontent coping where they are angry with God (Gall, 2006). As a result of the CSA, an adult may not have been able to develop more adaptive forms of spiritual coping and may remain stuck in a maladaptive stance, such as being angry with God (Gall, 2006, p. 838). According to Kane, Cheston and Greer (1993), despite CSA survivors having a difficult relationship with God, they still rely on their spirituality as a source of healing, and Gall (2006) reports that survivors of CSA reported using spiritual support and coping as a means to resolution.

Strategy: we commit to cultivating our spiritual well-being

Aim: Cultivating spiritual awareness

Actions:

1. Discuss spirituality under the theme of discontentment and contentment.
2. Explore spiritual coping methods and how to anchor these into daily life and support structures.
3. Facilitate spiritual growth using meditation and other mindful strategies (Carr, 2011).

Outcome: To experience spiritual well-being.

Guideline 13 – Self-nurturing techniques

Previous research indicated that psychologically and physically nurturance was important to such women who had felt cut off from their bodies after the trauma of the CSA.

Discussion of evidence

According to Bass and Davis (2002, p. 37), sexually traumatised individuals lose their “natural sexual capacity” and their process of normal sexual development is short-circuited. Sexual abuse creates a sense of being damaged, dirty or unclean. Brown (1991, p. 170) and Lee (1995, p. 51) refer to the “damaged-goods syndrome” to describe the multifaceted feelings, beliefs and attitudes victims may have about themselves as women, and years after the incident they may still think that their bodies are damaged inside and look different from those of other people. According to Simonds (1994), it is crucial that the body itself be a major topic in therapy due to the impact of the sexual trauma on the body. This should be incorporated after the survivor has considerably explored the abuse and there has been some resolution of the trauma (Sanderson, 1995). Simonds (1994) further reports that art and movement can serve as a bridge between the unconscious and conscious mind.

Strategy: we commit to nurturing the sensual women within

Aim: To build and reconstruct a positive image as a sensual woman

Actions:

1. Discuss how they feel about themselves as sensual women and the use of self-nurturing techniques such as introspection, positive self-talk, visualisation techniques, recreation, hobbies, exercise, etc.
2. Diarise a weekly self-nurturing technique to be implemented in their weekly routine.
3. Address the “damaged-goods syndrome” (Brown, 1991, p. 170; Lee, 1995, p. 51).

4. Use the “mirror technique” to point out their self- or group-admired physical attributes (Williams & Fouché, 2008).
5. Share these positive affirmations in the group – affirm one another.
6. Use free-dancing to feel comfortable and in touch with their bodies.
7. Use body awareness techniques of massage (Sanderson, 1995).
8. Use current photos to de-stigmatise and re-integrate with the body.
9. Assist them to actively celebrate and affirm changes to each person’s sense of self.
10. Use previously discussed anxiety management for anxiety-provoking symptoms.
11. Provide a consultation with a sexologist.

Outcome: Self-nurturance and restoration, being able to nurture the sensual women within.

Guideline 14 – Strategising ongoing recovery – from surviving to thriving

Related to the strength of will-power seen in these survivors who participated in the previous research, was the need to strategise recovery and allow some structure for the way forward. They need to forge new pathways in their journey towards recovery. Participants need to devise their own recovery pathways, otherwise they will feel as if they are not important to those delivering the facilitation. The client has to meet self-defined weekly goals. It is important that goals are attainable and manageable so that the client experiences success in mastering the impact of the trauma.

Discussion of evidence

Strategising recovery relates to setting goals and working towards these goals in the ongoing recovery process. Sometimes these goals reflect the strengths of the survivor and often, in retrospect, they are able to see how their strength and will-power triumphed (Turner & Cox, 2004,

p. 6). There is no finite period in which people ought to recover from traumatic events and it is an important consideration for survivors that recovery should be seen in terms of years rather than months (Turner & Cox, 2004, p. 7). Recovery is highly individualised and is dependent upon a myriad of variables, including a strong desire to remain resolute in the face of obstacles and having an internal locus of control (Turner & Cox, 2004, p. 8). Engaging participants in an active role, rather than having them simply be passive recipients of advice or guidelines, allows them to regain control of their lives while letting go of helplessness and encourages the use of their inherent potential (Cruz & Essen, 1994).

Strategy: we commit to continuing the rebuilding of our lives using goal setting

Aim: To commit to setting short-term realistic, specific and measurable goals

Actions:

1. Set short-term goals and devise a plan for working step by step to the next goal.
2. Discuss what future goals could include, share and explore these goals.
3. Goals need to be realistic, specific in aim and description and measured by a cut-off point in order to ensure mastery of the goal.
4. Goals can be ranked from easiest to most difficult – sometimes the goal is to get through a particular day, while at other times the goal may be to venture into a sexual situation.
5. Use guided imagery or metaphorical discussions envisioning a future full of promise and potential.
6. Actively involve them in their own care trajectory schedule.

Outcome: To actively set up a responsible life-management mechanism.

**Guideline 15 – Surviving to thriving – well-being strengths emerging after trauma –
psychological well-being**

The survivors who participated in the previous research, reported on personal strengths emerging through the recovery process. This interventions emphasis thus lies in not only restoring the person to an efficient level of functioning but also to instilling a further developed competent and fulfilling level of functioning. The person is then encouraged to mobilise existing support structures and own her signature strengths as adaptive potentials. She is given the opportunity to share her story with supportive others, thereby validating the evidence of the positive change which has taken place.

Discussion of evidence

According to Eagle (2000), it is the function of trauma intervention to enable the person to function meaningfully once again, and this enhances their sense of self-mastery. The mastery of a trauma could involve the restoration and enhancement of the individual’s ability to tolerate strong affect, to be alone without anxiety, and to preserve the wholeness in a sense of self (McCann & Pearlman, 1990). These endeavours of self-mastery become self-reinforcing and an attitude of greater optimism can be engendered (Eagle, 2000).

Strategy: We commit to “being” our post-trauma well-being strengths

Aim: To acknowledge life as it is now and gratitude for building strength after the trauma

Actions:

1. Discuss possible areas of gratitude in their current lives.
2. Use a gratitude journal and share aspects of gratitude with one another.
3. Explore a future perspective and the role of an internal locus of control.
4. Take stock of their inner strengths emerging from the group process.
5. Utilise Peterson’s virtues and signature strengths (Peterson, 2006).

6. Complete the online Values in Action (VIA) strengths assessment (Compton, 2005, p. 195)
7. Give a strength “gift” to themselves and each other (Meekums, 2000, p. 178).

Outcome: An enhanced awareness of their personal ability in signature strengths, autonomy and self-regulation capabilities manifesting in responsible life management.

Discussion

The purpose of this article was to formulate broad guidelines with specific strategies for an intervention aimed at the development of a programme to facilitate and enhance constructive coping behaviour, posttraumatic growth and psychological well-being in women who had experienced CSA. Previous research on the topic with women who reported constructive coping, posttraumatic growth and aspects of psychological well-being was used as empirical grounds for the guidelines. Relevant theory and literature on research done into the phenomenon was used as theoretical evidence to support the guidelines. Strategies flowed from these guidelines and were intended as the practical therapeutic ways in which these guidelines could be implemented. The guidelines further expanded on theoretical frameworks of the three constructs including Carr’s (2011) constructive coping strategies, Tedeschi and Calhoun’s (1996) posttraumatic growth model and Keyes’ (2002; 2005) model of psychological well-being. These constructs were grounded theoretically in an integrated trauma model designed by Eagle (2000), known as the Wits Trauma model. The therapeutic process intended by the guidelines focused on the telling of the story by a victim of CSA who grew into a survivor, with the aim of eliciting cognitive integration through constructive coping, meaning-making, benefit-finding, emotional, social and spiritual well-being, which culminates in psychological well-being. These guidelines have the potential to facilitate both

constructive coping and posttraumatic growth, which is necessary and essential for the survivor to become victorious and experience psychological well-being.

In developing the proposed intervention the researcher by no means claims for completeness and the exclusion of other dimensions of growth and healing relating to coping, posttraumatic growth and mental wellness. The proposed intervention does however contain the main features required to therapeutically influence the disruptive effect of CSA on every functioning domain of the survivor. The proposed intervention shows both conceptual and practical correspondence to the skills training approach developed by Cloitre, Koenen, Cohen and Han (2002) for post-traumatic stress disorder related to childhood abuse. These authors addressed two major symptoms found in adult survivors of childhood abuse namely affect dysregulation and interpersonal difficulties. They developed a skills training programme of sixteen sessions, eight in affect and interpersonal regulation and eight in modified prolonged exposure. They focused on the labelling and identifying of feelings, emotion management, tolerating distress, accepting feelings and working toward positive emotions, awareness of trauma related interpersonal schemas, understanding trauma generated feelings, dealing with power and control and creating their own flexibility. The skills developed in this programme were achieved through describing the abuse events in detail and with emotion, using coping skills to modulate feelings and the identification of trauma-bound schemas that interfere with adaptive schemas of personal resources. Coping skills and the formation of new schemas were major dimensions of this programme. It is thus clear from the conceptual correspondence with the approach of Cloitre et al. (2002), that the proposed intervention of this study has a theoretically sound base and has the potential to achieve therapeutically sound outcomes.

As far as applicability is concerned, it seems apparent that each woman had a unique story to narrate, with her own unique construction of healing. However, without a safe space and a competent facilitator the journey toward healing can be seriously compromised. The researcher believes that, although much can be done to enhance constructive coping behaviour, posttraumatic growth and psychological well-being, the process will have to be guided by the woman's own pace of healing and her strengths profile to prevent re-traumatisation. Once these women can embark on their own process of meaning-making, they can engage with their creation of happiness and growth, and actively seek out people that are positive and supportive. The proposed intervention aims at steering activities of participants to improve their self-efficacy and autonomy, thereby cultivating a positive sense of self and achieving a constructive coping repertoire, posttraumatic growth and psychological well-being. According to Tedeschi and Calhoun (1995), the treatment for trauma may never be complete; thus, these authors advise considering a respectful intervention where, with time, the prolonged suffering associated with CSA can be turned into an adaptive process with a trajectory toward health and well-being.

Programmes based on the guidelines and strategies for an intervention aimed at enhancing constructive coping behaviour, posttraumatic growth and psychological well-being in women who had experienced CSA, can be context-specifically developed for women who have initially disclosed the sexual abuse and who are, by professional opinion, sufficiently emotionally contained and equipped to confront the aftermath of the CSA and to attempt the empowering transition from victim to survivor to victorious "thrivers", crucially facilitated by a qualified helping professional. Evaluations of the effectiveness of such programmes will be the next step, after which further adaptations can be made to enhance target-specific effectiveness. The implementation of these strategies does not have to be enormously expensive as costs can be substantially curtailed with

creative and careful use of existing resources. This supportive intervention is to be used in conjunction with individual psychotherapy in order to maintain the progress and therapeutic effectiveness. One might expect more posttraumatic growth with increasing time after the trauma as more time will then be available for cognitive processing (Sears, Stanton & Danoff-Burg, 2003); thus, significant healing time should have lapsed before the participant enters the programme.

Perhaps the finding of this study that is most clearly echoed in the literature is that a changed sense of self and philosophy of life can emerge from a trauma, as suggested by Calhoun and Tedeschi (1999) and Turner and Cox (2004).

Conclusion

Psycho-traumatology has too long focused solely on the detrimental effects of traumas and has thus confined the understanding of trauma recovery to a deficit-orientated model. The results of this study and specifically the proposed intervention support the ethos of positive psychology and aim at enhancing healthy coping, growth from trauma and overall wellness of body and mind – it is not seen as “medicine for troubled minds” (Zautra, Hall & Murray, 2010, p. 21). The intervention is not only compensatory or rehabilitative in nature but intends sound development in the survivors of CSA along competence trajectories. The key to their healthy coping, growth and wellness lies in the mastery of greater self-awareness leading to personal hopes and social mastery.

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SECTION THREE

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS AND RECOMMENDATIONS

1. Introduction

In the preceding manuscripts, the realisation of each phase of the research, research results, conclusions and guidelines with strategies were described. These results, conclusions, guidelines and strategies were synthesised, and are presented in the following part as the conclusions and recommendations derived from this research study. It is a retrospective evaluation of the research. Limitations of the research are discussed and two narratives are presented.

2. Evaluation of the study

The evaluation of this research is divided into a critical reflection of the central theoretical argument followed by a personal narrative of the researcher.

As a point of departure, the broad research questions for this research are listed below as:

- What are the coping behaviours of women who had experienced CSA in adulthood, have they shown posttraumatic growth and do they manifest psychological well-being?
- What enabled these women to cope optimally, grow through the experience and manifest psychological well-being?
- What should be included in a proposed intervention programme aimed at enhancing the coping behaviour, posttraumatic growth and psychological well-being of female survivors of CSA in adulthood?

Thereafter the researcher formulated the following argument: The quantitative investigation of the coping behaviours, posttraumatic growth and psychological well-being of women who had experienced childhood sexual abuse will lead to the identification of women survivors who reported constructive coping, posttraumatic growth and psychological well-being. Qualitative interviews conducted with this sample

will identify the enabling factors that led to their coping, growth and well-being as adaptive outcomes of the abuse experiences. Guidelines with strategies for an intervention programme aimed at facilitating and enhancing the constructive coping, posttraumatic growth and psychological well-being in women survivors who had experienced CSA were identified and such an intervention was developed.

Data was collected and analysed using a mixed research method. The investigation and interpretation of the prevalence of constructive coping, posttraumatic growth and psychological well-being in the first quantitative phase provided useful information. The main finding was that aspects of coping, posttraumatic growth and psychological well-being could be reliably and validly measured by the measuring instruments used for this purpose. The results of these findings made it possible to identify women who coped constructively, grew personally from their CSA experiences and manifested aspects of psychological well-being. The majority of this group of women could be described as coping constructively and having experienced posttraumatic growth, while only a moderate group manifested psychological well-being. The biographical questionnaire provided valuable information on CSA-related experiences of the participants that mostly agreed with what is reported in literature about the CSA phenomenon. In the second qualitative phase of the study, the stories of ten (N=10) women (those who scored in the higher range on the coping, posttraumatic growth and psychological well-being measurements) were explored through semi-structured interviews focusing on their experiences of CSA and the strengths or enabling factors they employed. Although, surprising findings and results that emerged regarding their coping abilities, healing processes and psychological strengths were all supported by the literature. These findings were used in the formulation of guidelines with specific strategies for an intervention that could be proposed to develop a programme aimed at enhancing constructive coping, posttraumatic growth and psychological well-being in women survivors who had experienced CSA.

2.1 Personal narrative

The journey I undertook with this research led to the reflection of my own journey as a therapist and woman. In my training as a clinical psychologist, I realised the importance of learning from and walking with clients and, most importantly, the impact that trauma can leave on survivors thereof and then vicariously on you as a helping clinician. As a woman, I have implicitly begun to value my innocent safe childhood where I experienced a healthy sexual development and maturity (thanks to my informative brother-in-law, a medical doctor, and a very wise free-spirited grandmother). Perhaps my clear and protected sexual development encouraged me to lead trauma survivors on a healing pathway to meaning-making and benefit-finding and so for them, to rediscover and reclaim a lost piece of their childhood journey and inner child.

This research was inspired by my work done with sexual offenders for three consecutive years where a colleague, inspirational mentor and friend, Dr Ansie Fouché, and I developed a management programme for childhood sexual abuse offenders (Williams & Fouché, 2008). During this time, I became pregnant and gave birth to my son and something shifted dramatically: I became a mother, an extension of each and every sexually abused child and thus I could no longer invest my clinical expertise in these perpetrators and needed to redeploy my enthusiasm, curiosity, focus and attention to wanting and needing to assist the victim-survivors of such heinous crimes. I have an immense respect and empathy for those victims still wanting and needing to survive despite the traumatic suffering they had to endure. So, while investing in my natural niche as a psychotherapist, I began to unravel the world of “strengths” and the importance of “positive clinical psychology” and this gave rise to my dedication of wanting to delicately weave posttraumatic growth into the lives of these women, using the field of clinical psychology and practice through research.

Spending time in clinical settings and hearing the stories of these women made me realise how important it is to understand their experiential world and to accept, support and acknowledge these survivors unconditionally. Their stories of personal struggles and

triumphs, and the compassion, wisdom and bravery that they expressed have made me – the researcher – even more determined to investigate this field in order to present imperative, valuable, practical clinical guidelines and strategies from which to develop a positive psychology intervention aimed at enhancing constructive coping, posttraumatic growth and psychological well-being in women who had experienced sexual abuse traumas. Such guidelines and strategies are intended to empower and enable these women in their healing journeys, making sure that they acknowledge their constructive coping efforts; make meaning and allow growth to emerge from the traumatic experiences; explore their inner unique strengths and psychological virtues during the course of recovery; and thus use their reflective healing process to contribute to their overall existence as a stronger woman, survivor, and victorious “thrivers”.

The laborious PhD journey has proved to be a great learning curve and a time of deep reflection and growth. Reflecting on the research journey, I now know that I have acquired self-confidence and a deeper awareness of my own inherent strengths on which to build. I have also identified areas in which to invest as a woman, clinician, researcher and lifelong scholar. The voyage consumed the better part of my existence and required complete devotion and focus. It consisted of exuberant highs and desperate lows, moments of epiphany and astounding discoveries, and then periods of intense writer’s block but it all culminated in a wonderfully inspiring and addictive “birthing” process. The article format that was chosen for reporting the research proved to be challenging at times, as it was difficult to adhere to the restriction on the number of words for the manuscripts and I struggled to part with some of the information. My empathy and connection as a therapist deepened and I am extremely proud to have contributed to the field of positive psychology with an intervention for women who have survived CSA. I am convinced that the findings of this research study will prove to be a valuable therapeutic tool and contribute significantly to the lives of courageous, humanly strong thriving women who experienced trauma, as well as in the professional journeys of the helping professionals assisting in this critical area of trauma.

3. Limitations of the research

This research was limited by the following factors:

- The sequential exploratory design was demanding, expensive and both energy- and time-consuming. The first quantitative phase was the most difficult as the researcher had to obtain at least 60 completed questionnaires (although a small sample, it was still significant) for the study to be valid. A total of 73 questionnaires were circulated to survivors and only 60 were returned. Sourcing CSA participants was problematic due to the sensitivity of the research topic, which appeared to make some women sceptical of participating. It seemed that most women who had experienced traumagenic dynamics were apprehensive to partake and that past negative therapeutic experiences also influenced their decisions not to participate. This should serve as a reminder to researchers to take the sensitivity and trust barriers of this phenomenon into account in future studies.
- The delay and lack of assistance from psychologists in practice contributed to the difficulty of sourcing participants. There appears to be a lack of camaraderie in the networking spheres of professionals in common areas, as of the more than twelve private practitioners approached only four referred possible participants to the research study.
- The constantly changing context of the healing process, the risk of revictimisation and the increased vulnerability of these women made it difficult to measure coping, posttraumatic growth and psychological well-being. The researcher realised this and used a mixed research method in an effort to provide new and useful information about coping behaviours, posttraumatic growth and psychological well-being in women who had experienced CSA.
- The findings of this study are based on a small sample size and therefore cannot be generalised. The psychometric properties of the scales used were most likely also influenced by the low (N=60) number of respondents.
- It is important to acknowledge that the recovery entry points were variable for each participant in this study.

4. Conclusions

The findings together with the conclusions and the guidelines with strategies for an intervention programme developed from the data are all considered in order to reach the overall conclusions, and these are related to the objectives of the research.

4.1 Literature conclusions

Based on the literature explored, interpreted and integrated for the purpose of this study, it was clear that the constructs of coping, posttraumatic growth and psychological well-being in women who had experienced CSA are challenging concepts to define and measure. The multi-dimensionality of the constructs was evident, but the potential gains of understanding the constructs and the theoretical and practical importance made it a worthwhile choice for the research. Literature drawn from the field of psychology and positive psychology offered information relating to the theoretical underpinnings of constructive coping behaviours, posttraumatic growth and psychological well-being in women who had experienced CSA. A great deal has been written on the effects of CSA and aspects relating to the coping outcomes; much less however about the perceived benefits and adaptive coping after CSA and spanning into adulthood. Thus, much of earlier research in CSA focused on the adverse outcomes and risk factors, while more recent research appears to be shifting the focus to more adaptive enabling outcomes and protective factors. The studies examined varied in the way the constructs were measured although a general pattern of results emerged from the literature.

Although a wealth of information is available on the theoretical aspects of CSA, coping, psychological well-being and a little less on posttraumatic growth, nothing could be found in the literature to date on how to move from theory to practice in order to intervene by developing practical and functional guidelines and strategies to enhance constructive adaptive coping, posttraumatic growth and psychological well-being. However, in the literature control (exploration, interpretation and integration of the literature) performed by the researcher, useful information could be found about adaptive

coping in the aftermath of CSA, posttraumatic growth and psychological well-being. The positive psychology movement's focus on positive interventions, positive strengths and qualities identified by authors and the inclusion of positive psychology in clinical practice, all proved to be useful in the formulation of these guidelines with strategies for the intervention programme. The themes identified from the semi-structured interviews were integrated with theoretical frameworks of the three constructs for constructive coping, posttraumatic growth and psychological well-being, as well as a model for trauma intervention, for the development of the guidelines and specific strategies for the proposed intervention aimed at facilitating and enhancing constructive coping, posttraumatic growth and psychological well-being in women who had experienced CSA.

Thus, as far as CSA in women is concerned it was fairly easy to find literature and trace studies that focused on the adverse outcomes. Few studies however reported on positive aspects like constructive coping, posttraumatic growth and psychological well-being. The scarcity of information on the constructs measured in this study from a positive psychology perspective emphasises the importance and value of this study.

The literature review was aimed at understanding the nature of how women who experienced CSA coped in adulthood, and moreover whether they could indeed benefit in the aftermath of the trauma and experience posttraumatic growth and psychological well-being. The constructs were conceptualised, defined and explored in the overview of this study. This provided clarity on the multi-dimensionality of the constructs and theoretically related concepts and measures to be used and explicated.

4.2 Empirical conclusions

The mixed method chosen for this study, employing both quantitative and qualitative methods followed sequentially in the two phases of the study and proved to be successful, as the objectives stated to guide the research study were achieved. The questionnaires used to measure the constructs in the first quantitative phase were found to be reliable for this research group.

4.2.1 Conclusions drawn from the first phase of the study (Article one)

- The aims of the investigation were to determine the prevalence of constructive coping strategies, posttraumatic growth and psychological well-being in a group of women who had experienced CSA, through validated questionnaires, and to obtain and analyse the prevalence of specific aspects and dynamics of CSA, coping growth and well-being reported by the participants in a biographical questionnaire. The stated objectives were reached.
- The main finding was that the majority of this group of women could be described as coping constructively and having experienced some posttraumatic growth, while only a moderate group manifested psychological well-being.
- Descriptive statistical findings obtained from the validated measuring instruments indicated that the mean scores and standard deviations for this group of women (N=60) were mostly similar to those reported in various groups in the literature. This suggested that this group of women, despite their traumatic childhood experiences, were not very different from the general population in their overall mental health profile (depicting their coping abilities, growth after trauma and aspects of psychological wellness).
- The reliability coefficients of the measuring instruments used were acceptable, although some scales had rather high Cronbach alpha scores, which may indicate the redundancy of some items in those scales. The small group (N=60) of participants in this study could also have contributed to the high reliability indices obtained.
- Significant positive correlations among the scales measuring aspects of constructive coping, posttraumatic growth and psychological well-being indicated that the underlying constructs of these instruments have features in common on an empirical level, which, for purposes of this study, could be conceptualised as constructive coping, posttraumatic growth and psychological health in this group of women.
- The significant negative correlations of the General Health Questionnaire measuring aspects of pathology (psychological distress) with the other scales, sub-scales measuring positive features and the significant positive correlations with aspects of

negative coping support the theoretical assumption that if women who had experienced CSA could cope constructively, grow posttraumatically and show psychological health, they would not score high on items of mental ill-health and dysphoria.

- From the mean scores obtained for the COPE it would seem that this group of women made use of acceptance, religion, planning, active coping and emotion-focused coping as their most prominent coping strategies.
- The prevalence of constructive coping, posttraumatic growth and psychological well-being was determined, and more than half of the women (58%) manifested constructive coping, while only 42% of participants manifested coping self-efficacy. This seems to be a discrepancy, but the explanation may lie in the low self-esteem manifested by these women. Only 45% obtained high self-esteem scores and this corresponds with the 42% who scored high on coping self-efficacy. These findings clearly indicated the harm that was done to essential self-related strengths in these women.
- Of the participants, 60% manifested posttraumatic growth, which is higher than levels of posttraumatic growth seen in previous studies, while the low levels of self-esteem (45% had high scores) reported by the majority of these women is a common finding in research of this nature and is theoretically expected.
- Of the participants, 42% manifested psychological well-being as measured by the Mental Health Continuum of Keyes (2002), which corresponds well with findings in other South African samples. The percentage of well-being (flourishing) in this group of women was also much higher than the 20% found by Keyes et al. (2008) in an adult African community sample. This finding points to the resilience and unique strengths of character displayed by this group of women who had experienced CSA and is in line with the assumptions of positive psychology.
- In terms of the dynamics of the abuse, about the whole group of women (98%) experienced contact abuse with predominantly rape as the form of abuse and the majority (87%) knew the perpetrator. The CSA of participants in this study appeared to have commenced predominantly in middle childhood (7–10 years). The predominant age of disclosure was between adolescence (16–20 years) and early

adulthood (21–39 years). Although a large group (88%) of participants felt the person they disclosed to did indeed believe their admission, many of them (60%) still felt stigmatised after disclosing. About half (52%) of the participants were treated for a mood disorder. Of the participants, 42% experienced trust as the most prominent difficulty after the abuse, 30% experienced poor intimacy and relationships and 22% experienced poor self-esteem. All four traumagenic dynamics were experienced by 57% of the women, and the rest experienced at least a combination of two of the dynamics. Almost half of the participants reported therapy to be a positive experience which seems to be a unique finding in this study and is perhaps related to the 88% of the participants who reported experiencing growth after the trauma. Of the participants in this study, half (50%) related posttraumatic growth to personal strength, 23% to growth in relating to others and 60% experienced religion as a positive component of their recovery process as supported by the findings of Tedeschi and Calhoun (1995).

- In this study, the subjectively reported experience of posttraumatic growth appeared much higher than when interpreted quantitatively, where only 60% scored high on the Posttraumatic Growth Inventory. The researcher speculates that this is due to the “Janus-face two-component model” proposed by Maercker and Zoellner (2004).
- The results of the first phase (Article 1) made it possible for the researcher to identify women who coped constructively, grew after the trauma and manifested psychological well-being in order to move to the second phase, where the experiences of these women could be qualitatively obtained and analysed in an attempt to develop a thorough understanding of what constituted and enabled the coping behaviour, posttraumatic growth and psychological well-being in women who had experienced CSA.

4.2.2 Conclusions drawn from the second phase of the study (Article two)

- The objective of this investigation was to identify strengths and other protective factors by employing qualitative research methods with quantitatively identified women who displayed constructive coping, posttraumatic growth and

psychological well-being, in order to gain a thorough understanding of these constructs as enabling factors for psycho-social well-being in women who had experienced CSA. This objective has been reached and strengths and adaptive characteristics of CSA survivors who coped constructively, achieved posttraumatic growth and manifested psychological well-being have been identified from the semi-structured interviews conducted with them.

- The characteristics emerging in this phase of the study correspond with many concepts identified in the literature describing aspects of constructive coping, posttraumatic growth and psychological well-being. The enabling features of these participants emerged as: namely psycho-socio spiritual resources, which include positive coping styles, strategies and resources such as active emotion-focused coping, positive explanatory styles, seeking social support and religious coping; the healing process, which includes aspects of posttraumatic growth, including the healing struggle, positive outcomes of healing, the survivor and wounded healer roles; and positive strengths, which include aspects of psychological well-being including self-efficacy, self-worth, inner strength and finding meaning.
- These themes and sub-themes allude to the several interconnections, interrelatedness and overlap between distinct constructs of constructive coping, posttraumatic growth and psychological well-being as reported in literature, which embraces the central tenets of positive psychology and discards the traditional pathogenic psychological approaches documented in the literature.
- The themes and sub-themes emerging from this phase of the research study are depicted in the following narrative built from the interviews with the participants: “We deal actively with our experiences of CSA and refuse to dwell in the past as we are not to blame for the trauma, we were helpless victims left with a myriad of negative symptoms and so we cannot rely on our destructive coping strategies used before. Instead we must evolve in our coping by positively regulating our emotions, cognitively reframing our distorted thoughts, setting goals and looking to the future with hope. We reach out and access social support and professional intervention, we use religious coping and we rely on a Higher Power for answers

to our unanswered debates. The healing process brings growth and allows us to let go of our negative defence mechanisms (perhaps once functional in a shattered world of sexual abuse). It is a courageous choice to enter into this long, tough and painful journey of recovery but it brings growth, forgiveness, a deeper gratitude for life, and makes us “streetwise”. Through this, we have become survivors (and mothers) who can heal and connect with others and we have become self-worthy and self-reliant. We have discovered our inner strength and have made remarkable meaning of our lives as victorious “thrivers” after CSA.”

4.2.3 Conclusions drawn from the third phase of the study (Article three)

- The objective of this research phase was to formulate guidelines and strategies based on the previous research findings and supported by relevant literature with a view to the development and proposal of an intervention programme to facilitate and enhance the constructive coping, posttraumatic growth and psychological well-being of women who had experienced CSA. This objective was met.
- In the first phase of the study, the prevalence of coping behaviour, posttraumatic growth and psychological well-being in women who had experienced CSA was investigated with the help of validated measuring instruments, and women who displayed constructive coping, posttraumatic growth and psychological well-being were identified. Thereafter their stories and experiences were obtained through semi-structured interviews, analysed, and the data gained was then used in the formulation of guidelines with specific strategies for an intervention programme aimed at enhancing constructive coping, posttraumatic growth and psychological well-being in such women. The aim has been met in that guidelines with specific strategies for an intervention programme were formulated based on the findings from the interviews of the ten women displaying constructive coping, posttraumatic growth and psychological well-being (empirical data) and evidence obtained through the literature control (theoretical data).
- Guidelines with specific strategies were formulated, based on previous findings with the target group, as well as other literature on constructive coping, posttraumatic

growth and psychological well-being. The guidelines focused on: (1) building safety and rapport and a common identity and purpose for the group; (2) introducing the trauma – telling and owning my story – how have I survived; (3) normalising the symptom checklist – traumagenic dynamics; (4) committing to the healing process – making the choice to heal; (5) forgiveness – making the choice to forgive; (6) telling my story for “a change” – making sense of the struggle with my trauma as a positive subjective experience (benefit-finding); (7) survivor role – posttraumatic worldview and identity (meaning-making) – altered philosophy of life as a survivor; (8) the wounded becoming the healer – acknowledging the changed sense of self; (9) renewed relationships – positive social relationships; (10) active approach coping strategies; (11) emotional well-being; (12) spiritual well-being; (13) self-nurturing techniques; (14) strategising ongoing recovery – from surviving to thriving; and (15) surviving to thriving – well-being strengths emerging posttraumatic psychological well-being.

- The guidelines focused on telling their CSA story as a victim and then as a survivor with the aim of eliciting cognitive integration through constructive coping, meaning-making, benefit-finding, emotional, social, spiritual and psychological well-being. These guidelines have the potential to facilitate constructive coping, which results in posttraumatic growth, which is necessary and essential in the survivor experiencing psychological well-being.
- Posttraumatic growth is not only a new perspective which is to be integrated into the grain of clinical practice but also a new treatment modality to unfold within psychotherapy, which could offer new interventions for dealing with traumatic events by coping constructively and relying on emerging aspects of psychological well-being.

4.3 Recommendations

The research was undertaken to obtain a deeper understanding of the coping behaviours, posttraumatic growth and psychological well-being in women who had experienced CSA.

4.3.1 Recommendations for the helping professional

- It seems that posttraumatic growth is an imperative component of transformational coping, which is achieved through various steps of cognitive restructuring and benefit-finding. The posttraumatic growth approach and model can thus be seen as an important modality in the treatment of trauma in practice. This needs to be incorporated as a respectful intervention because clients need to have adopted the survivor role and have discovered the ability to move forward in a conscious choice to recover, before this intervention can be incorporated therapeutically.
- The intervention programme to enhance constructive coping, posttraumatic growth and psychological well-being would be incorporated into standard trauma practices, with the hope that the general guidelines could be used for any specific type of trauma.
- Clinicians should be encouraged to incorporate positive psychology interventions into their current practices where a move is made towards understanding and enhancing subjective well-being and effective functioning as well as towards alleviating subjective distress and maladaptive functioning. The focus is on amplifying strengths and not just on repairing the weaknesses of clients. According to Maddux (2008, p. 67), positive psychology interventions emphasise the enhancement of people's strengths and assets and is secure in the belief that "strengthening the strengths will weaken the weaknesses". Clinicians should however be cautioned about the fact that intensive psychotherapy may often need to take place before a strengths-based approach could be incorporated and that, as clinicians, they can only support the process of growth but they cannot create it for the survivor.
- The therapeutic relationship is imperative in the recovery of the survivor of CSA as this may be the first adult relationship of equal power where trust and security could be fostered. Clinicians should thus not underestimate the need for rapport and the absolute sensitivity needed to pace the survivor and create an environment where in she would become an active participant and not just a passive powerless recipient.

4.3.2 Recommendations for future research

- The specific sexual abuse dynamics obtained from the biographical questionnaire could be statistically analysed using structural equational models and other inferential methods. Moderator variables influencing the relationship between the constructs could be investigated.
- Similar research could be conducted on coping, posttraumatic growth and psychological well-being with trauma survivors but with a larger sample.
- Questionnaires could be translated into African languages and in this way be utilised in larger African sample groups owing to the documented prevalence of CSA in African cultures.
- Longitudinal research on aspects of coping behaviour, posttraumatic growth and psychological well-being is recommended.
- Further research could be conducted to investigate predictors of posttraumatic growth to aid in the process of the long-term recovery of such trauma survivors.
- It is further recommended that strengths specific to the various cultures from which these women originated, be further explored. Although the researcher recognises and acknowledges the significance of culture in constructive coping, posttraumatic growth and psychological well-being, this was not explored.
- The intervention programme to enhance constructive coping, posttraumatic growth and psychological well-being could be implemented and validated. It could also be recommended to test the long-term effectiveness of such an intervention in different clinical settings.
- Furthermore, it is recommended that the application of this intervention be assessed in other types of traumatic events, in diverse cultures and/or adapted for use with children and adolescents.
- The findings could be useful in therapeutic and counselling settings and could be made available through professional and/or popular publications, presentations and/or workshops. The training of therapists and counsellors could be enhanced by the current findings.

4.3.3 Significance and contribution of the study

- The significance of this study lies in the fact that it contributes to new knowledge as well as the existing knowledge base of psychology and more specifically that of positive psychology and positive psychology interventions in that constructive coping, posttraumatic growth, and psychological well-being have been indicated as enabling factors for women who had experienced CSA.
- The results of this study met the need for the development of a positive psychology intervention programme for CSA survivors, which is unique and the first of its kind.
- The research results contribute to new knowledge and a practical intervention in the practice fields of clinical and counselling psychology and traumatology where it can be applied as theoretical, therapeutic and/or psycho-educative in counselling settings by therapists and trauma counsellors. It can also be made available to non-profit organisations and community trauma clinics or sexual abuse support groups such as People Opposing Women Abuse (POWA), Lifeline Southern Africa and the Family and Marriage Association of South Africa (FAMSA).
- Training workshops could be offered to helping professionals on the use and effectiveness of this intervention programme with the hope of expanding the availability of the intervention to survivors nationally and internationally.
- The knowledge generated and the intervention could further contribute to the training curriculum of future clinical or counselling psychologists, social workers and trauma counsellors.
- The long-term contribution of this study and the intervention programme is to integrate teaching, training, research, service provision and the implementation of expertise and in so doing produce research publications and opportunities for collaboration with other helping professionals in order to contribute to the recovery of trauma survivors in South Africa and abroad.
- The researcher further aims to draft a proposal, obtain ethical approval and apply for seed funding from, for example, the National Research Foundation (NRF) or other national and international sources in order to develop and implement the intervention programme. This could be a lifetime process of discovery and development to

validate and refine the existing knowledge and/or to generate new knowledge in the field and in so doing develop and publish a workbook on enhancing constructive coping, posttraumatic growth and psychological well-being in women who had experienced CSA.

- The researcher has been invited by the professionals and institutions who aided as referral sources for this study to present the research findings. Consequently, the researcher will present her results at the International Congress of Psychology in July 2012 in Cape Town, South Africa.

5. Final conclusion

It may be concluded that the objectives of this research study have been reached. By investigating the prevalence of coping behaviours, posttraumatic growth and psychological well-being in women who had experienced CSA, women who coped positively and who had experienced posttraumatic growth and psychological well-being were identified and their CSA experiences analysed, compared and documented. The analysed stories of these survivors revealed positive coping attributes, themes of posttraumatic growth and psychological well-being strengths as enabling factors in trauma survivors. Guidelines with strategies could then be deduced that could be proposed as an intervention programme to facilitate and enhance the constructive coping, posttraumatic growth and psychological well-being in women who had experienced CSA. The outcome of this study could promote the development of supportive holistic positive strengths-based interventions for such women. This research endeavour was a deeply meaningful experience for the researcher and hopefully for all those involved.

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SECTION ONE AND THREE: OVERVIEW, CONCLUSIONS AND RECOMMENDATIONS

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APPENDICES

APPENDIX 1

TEST BOOKLET

RESEARCH STUDY

**COPING BEHAVIOUR, POSTTRAUMATIC GROWTH AND
PSYCHOLOGICAL WELL-BEING IN WOMEN WHO EXPERIENCED
CHILDHOOD SEXUAL ABUSE**

Please read the instructions of each questionnaire carefully before responding

Thank you for your participation in this study

**Researcher – Hayley Williams
Cell number – 082 496 4105
Email address – Hayley.williams@nwu.ac.za**

Participant's Information

Name: _____

Age: _____

Contact number: _____

Questionnaires

Questionnaire Number: _____

A: Biographical questionnaire

B: Construct Questionnaires

PGI	1
CS	2
CSE	3
RSEI	4
MHC-SF	5
GHQ	6
BIO	7

A. Biographical Questionnaire (Socio-demographic Data)

Instructions: Please read the following statements and write the answer in the space provided

	QUESTIONS	YOUR RESPONSE
1.	How old are you?	
2.	What is your relationship status?	
3.	What is your current occupation?	
4.	Type of sexual abuse endured?	
5.	Perpetrator: Known (if so relationship) Unknown Multiple	
6.	Time period or length of sexual abuse?	
7.	Age abuse began?	
8.	Age abuse stopped?	
9.	Age of disclosure?	
10.	Who did you first disclose to?	
11.	Did the person/s you disclose to believe you?	
12.	Did you feel stigmatized after disclosing?	
13.	After the abuse did you experience: (Specify which or all) Feelings of traumatic sexualisation? Feelings of powerlessness? Stigmatization? Betrayal?	

14.	<p>Age when you commenced counselling or therapy?</p> <p>If you attended therapy was it a positive or negative experience?</p> <p>How?</p>	
15.	<p>Have you ever been treated for depression, anxiety, posttraumatic stress disorder or any other mental disability?</p>	
16.	<p>How have you coped up until now?</p>	
17.	<p>If you imagine how you coped thus far what comes to mind?</p>	
18.	<p>Who or what played a role in you surviving the trauma?</p>	
19.	<p>Did religion play a positive or negative role during & after disclosure?</p> <p>How?</p>	
20.	<p>If you reflect on your life what difficulties have you experienced due to you being a victim of childhood sexual abuse?</p>	
21.	<p>If you reflect on your life what growth have you experienced (if any), due to you being a victim of childhood sexual abuse?</p>	

Posttraumatic Growth Inventory (PGI)
Tedeschi & Calhoun (1996)

Indicate for each of the statements below the degree to which this change occurred in your life as a result of your crisis, using the following scale.

- 0 = I did not experience this change as a result of my crisis.
 1 = I experienced this change to a very small degree as a result of my crisis.
 2 = I experienced this change to a small degree as a result of my crisis.
 3 = I experienced this change to a moderate degree as a result of my crisis.
 4 = I experienced this change to a great degree as a result of my crisis.
 5 = I experienced this change to a very great degree as a result of my crisis.

		0	1	2	3	4	5
1.	I changed my priorities about what is important in life.						
2.	I have a greater appreciation for the value of my own life.						
3.	I developed new interests.						
4.	I have a greater feeling of self-reliance.						
5.	I have a better understanding of spiritual matters.						
6.	I more clearly see that I can count on people in times of trouble.						
7.	I established a new path for my life.						
8.	I have a greater sense of closeness with others.						
9.	I am more willing to express my emotions.						
10.	I know better that I can handle difficulties.						
11.	I am able to do better things with my life.						
12.	I am better able to accept the way things work out.						
13.	I can better appreciate each day.						

		0	1	2	3	4	5
14.	New opportunities are available which wouldn't have been otherwise.						
15.	I have more compassion for others.						
16.	I put more effort into my relationships.						
17.	I am more likely to try to change things which need changing.						
18.	I have a stronger religious faith.						
19.	I discovered that I'm stronger than I thought I was.						
20.	I learned a great deal about how wonderful people are.						
21.	I better accept needing others.						

COPE (CI)**Carver, Scheier, & Weintraub (1989)**

We are interested in how people respond when they are confronted by difficult or stressful events in their lives. There are lots of ways to try to deal with stress. The questionnaire asks you to indicate what you generally do and feel when you experience stressful events. Obviously, different events bring out somewhat different responses, but think about what you usually do when you are under a lot of stress. There is no right or wrong answer, and responses must indicate what **you** do rather than what “most people” do. Indicate how much your reaction is described by each statement.

Please make a visible and clear cross (X) over either 1, 2, 3, or 4.

		I usually don't do this at all	I usually do this a little bit	I usually do this a medium amount	I usually do this a lot
1.	I ask people who have had similar experiences what they did.	1	2	3	4
2.	I refuse to believe that it has happened.	1	2	3	4
3.	I try to grow as a person as a result of the experience.	1	2	3	4
4.	I force myself to wait for the right time to do something.	1	2	3	4
5.	I put aside other activities in order to concentrate on this.	1	2	3	4
6.	I take additional action to try to get rid of the problem.	1	2	3	4
7.	I get used to the idea that it happened.	1	2	3	4
8.	I talk to someone about how I feel.	1	2	3	4
9.	I think about how I might best handle the problem.	1	2	3	4
10.	I put my trust in God.	1	2	3	4
11.	I sleep more than usual.	1	2	3	4
12.	I drink alcohol or take drugs, in order to think about it less.	1	2	3	4
13.	I admit to myself that I can't deal with it, and quit trying.	1	2	3	4
14.	I let my feelings out.	1	2	3	4
15.	I try to get emotional support from friends or relatives	1	2	3	4
16.	I say to myself: "This isn't real".	1	2	3	4
17.	I try to see it in a different light, to make it seem more positive.	1	2	3	4
18.	I make sure not to make matters worse by acting to soon.	1	2	3	4
19.	I try hard to prevent other things from interfering with my efforts at dealing with this.	1	2	3	4
20.	I make a plan of action.	1	2	3	4
21.	I learn to live with it.	1	2	3	4
22.	I try to get advice from someone about what to do.	1	2	3	4
23.	I do what has to be done, one step at a time.	1	2	3	4
24.	I pray more than usual.	1	2	3	4
25.	I turn to work or other substitute activities to take my mind off things.	1	2	3	4
26.	I give up the attempt to get what I want.	1	2	3	4

		I usually don't do this at all	I usually do this a little bit	I usually do this a medium amount	I usually do this a lot
27.	I get upset and let my emotions out.	1	2	3	4
28.	I get sympathy and understanding from someone.	1	2	3	4
29.	I pretend that it hasn't really happened.	1	2	3	4
30.	I look for something good in what is happening.	1	2	3	4
31.	I restrain myself from doing anything too quickly.	1	2	3	4
32.	I take direct action to get around the problem.	1	2	3	4
33.	I accept that this has happened and that it can't be changed.	1	2	3	4
34.	I talk to someone who could do something concrete about the problem.	1	2	3	4
35.	I try to come up with a strategy about what to do.	1	2	3	4
36.	I go to movies or watch TV, to think about it less.	1	2	3	4
37.	I try to find comfort in my religion.	1	2	3	4
38.	I focus on dealing with this problem, and if necessary let other things slide a little.	1	2	3	4
39.	I reduce the amount of effort I'm putting into solving the problem.	1	2	3	4
40.	I feel a lot of emotional distress and I find myself expressing those feelings a lot.	1	2	3	4
41.	I talk to someone to find out more about the situation.	1	2	3	4
42.	I act as though it hasn't even happened.	1	2	3	4
43.	I learn something from the experience.	1	2	3	4
44.	I hold off doing anything about it until the situation permits.	1	2	3	4
45.	I concentrate my efforts on doing something about it.	1	2	3	4
46.	I keep myself from getting distracted by other thoughts or activities.	1	2	3	4
47.	I think hard about what steps to take.	1	2	3	4
48.	I accept the reality of the fact that it happened.	1	2	3	4
49.	I discuss my feelings with someone.	1	2	3	4
50.	I just give up trying to reach my goal.	1	2	3	4
51.	I seek God's help.	1	2	3	4
52.	I daydream about things other than this.	1	2	3	4
53.	I get upset, and am really aware of it.	1	2	3	4

Coping Self-Efficacy Scale (CSE)

Chesney, et al. (2006)

Instructions: When things aren't going well for you, or when you're having problems; how confident or certain are you that you can do the following:

Please rate the extent that you believe you can do each of the activities below on a scale. Where 0 = cannot do at all, 5 = moderately certain you can do, 10 = certain you can do

		0	1	2	3	4	5	6	7	8	9	10
1.	Break an upsetting problem down into smaller parts.											
2.	Sort out what can be changed, and what cannot be changed.											
3.	Make a plan of action and follow it when confronted with a problem.											
4.	Leave options open when things get stressful.											
5.	Think about one part of the problem at a time.											
6.	Find solutions to your most difficult problems.											
7.	Make unpleasant thoughts go away.											
8.	Take your mind off unpleasant thoughts.											
9.	Stop yourself from being upset by unpleasant thoughts.											
10.	Keep from falling sad.											
11.	Get friends to help you with the things you need.											
12.	Get emotional support from friends and family.											
13.	Make new friends.											

Rosenberg Self-Esteem Scale (RSE)
Rosenberg (1965)

Please indicate whether you strongly agree, agree, disagree, or strongly disagree by marking the applicable box with an (X).

		1	2	3	4
	STATEMENT:	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
1.	I feel that I am a person of worth, at least on an equal plane with others.				
2.	I feel that I have a number of good qualities.				
3.	All in all, I am inclined to feel that I am a failure.				
4.	I am able to do things as well as most other people.				
5.	I feel I do not have much to be proud of.				
6.	I take a positive attitude toward myself.				
7.	On the whole, I am satisfied with myself.				
8.	I wish I could have more respect for myself.				
9.	I certainly feel useless at times.				
10.	At times I think I am no good at all.				

Brief Description of the Mental Health Continuum Short Form (MHC-SF)

Keyes (2005)

Read each item carefully. Using the scale shown below, please select the number that best describes YOU and mark with a cross (X) in the block describing you the best.

	In the past month, how often did you feel ...	Never	Once or twice	About once a week	2 or 3 times a week	Almost every day	Everyday
1.	Happy.	0	1	2	3	4	5
2.	Interested in life.	0	1	2	3	4	5
3.	Satisfied.	0	1	2	3	4	5
4.	That you had something important to contribute to society.	0	1	2	3	4	5
5.	That you belonged to a community (like a social group, neighbourhood, or city).	0	1	2	3	4	5
6.	That our society is becoming a better place for people.	0	1	2	3	4	5
7.	That people are basically good.	0	1	2	3	4	5
8.	That the way our society works makes sense to you.	0	1	2	3	4	5
9.	That you liked most parts of your personality.	0	1	2	3	4	5
10.	Good at managing the responsibilities of your daily life.	0	1	2	3	4	5
11.	That you had warm and trusting relationships with others.	0	1	2	3	4	5
12.	That you have experiences that challenge you to grow and become a better person.	0	1	2	3	4	5
13.	Confident to think or express your own ideas and options.	0	1	2	3	4	5
14.	That your life has a sense of direction or meaning to it.	0	1	2	3	4	5

General Health Questionnaire (GHQ)
Goldberg & Hillier (1979)

Please indicate to which extent the following applies to you by marking a cross (X) over the option you choose.

	HAVE YOU RECENTLY:	1	2	3	4
1.	Been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2.	Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3.	Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4.	Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
5.	Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6.	Felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7.	Been able to enjoy your day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8.	Been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
9.	Been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10.	Been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11.	Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12.	Been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual

APPENDIX 2

**LETTER OF REQUEST TO WOMEN WHO EXPERIENCED
CHILDHOOD SEXUAL ABUSE TO PARTICIPATE IN THE
RESEARCH STUDY**



NORTH-WEST UNIVERSITY
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PO Box 1174, Vanderbijlpark
South Africa, 1900

**School of Behavioural Science
Psychology Department**

Tel: (016) 016 910 3416

Cell: 082 496 4105

Email Hayley.williams@nwu.ac.za

Dear Participant

REQUEST TO PARTICIPATE IN THE RESEARCH ENTITLED:

**COPING BEHAVIOUR, POST TRAUMATIC GROWTH AND
PSYCHOLOGICAL WELL-BEING IN WOMEN WHO EXPERIENCED
CHILDHOOD SEXUAL ABUSE**

I am a senior lecturer and clinical psychologist currently employed on a full-time basis at the North-West University Vanderbijlpark Campus, School of Behavioural Sciences, Psychology Department.

I am completing a PhD and am conducting research on the above topic. I would appreciate your participation in the study.

The objectives of the research are to:

- Investigate the coping behaviour and post traumatic growth of women who experienced child sexual abuse (CSA) and how this experience impacts on their psychological well-being in adulthood (literature / questionnaires).
- Identify possible strengths and other protective factors from the narrative stories of women who experienced child sexual abuse (CSA) employing qualitative research methods (interviews).
- To formulate guidelines on what should be included in an intervention programme aimed at enhancing these women's positive coping behaviour, post trauma growth and their overall psychological well-being in adulthood.

Participation in this two phase study is voluntary and you reserve the right to withdraw at any time. Your name will not be disclosed during the research or publication of the results. You will not be remunerated for your participation.

Should you consent to participate in the study other women survivors will benefit in that the narratives and outcomes of the research will lead to the formulation of guidelines for a programme aimed at enhancing psychological strengths after enduring this traumatic life changing ordeal. This programme will be made available to community organizations and psychological helping professionals who will be able to assist many victims who are either not able to access helping resources or who are not psychological ready to do so.

You will be entitled to feedback on request regarding the research results and programme guidelines. If you are currently involved in psychotherapy the outcomes of your psychometric questionnaires and/or interview and the strengths on which you base your coping can with consent be disclosed to your psychotherapist or counsellor to be used as an intervention tool in future psychotherapy sessions.

Once you have consented to participate in the above research and completed the attached consent form the researcher will make contact with you or your psychotherapist/counsellor telephonically to set up an appointment to provide you with the questionnaire booklet and arrange a follow-up appointment to collect the completed booklet. This will conclude phase one of the study.

Once the questionnaires are processed you may be identified to partake in the second phase of the research. If you are willing to participate in the second phase the researcher will then make contact with you telephonically to set up an appointment at her office. During this appointment you will be interviewed in order to share the narrative story of your sexual abuse experiences during childhood. The interview will take approximately one hour. The interview will be recorded on a digital voice recorder. This recording will be confidential between the researcher and her study promoters. The recordings will be transcribed for data analysis.

These recordings will be treated confidentially, only the researcher and her study promoters and research assistant will have access to these recordings and they will be kept in a lock up facility.

Should you experience any mental discomfort or distress during or as a result of your participation in this study, emotional support will be arranged by the researcher who is a trained clinical psychologist with ten years experience in practice.

Permission for this research has also been obtained from the Ethical Committee of the North-West University (NWU-0041-08-S1).

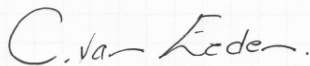
You are kindly requested to complete the attached consent form to indicate that you are willing to participate in this research. If you have any queries please feel free to contact me at your earliest convenience on 082 496 4105.

Thanking you in anticipation.



Mrs H.J. Williams

Researcher



Prof. C. van Eeden

Study Promoter

APPENDIX 3

**LETTER OF REQUEST TO HELPING PROFESSIONALS TO
ASSIST IN REFERRING PARTICIPANTS TO PARTAKE IN THE
RESEARCH STUDY**



NORTH-WEST UNIVERSITY
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**School of Behavioural Science
Psychology Department**
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Cell: 082 496 4105
Email Hayley.williams@nwu.ac.za

Dear Colleague

**REQUISITION TO ASSIST IN REFERRING PARTICIPANTS FOR THE
RESEARCH ENTITLED:**

**COPING BEHAVIOUR, POST TRAUMATIC GROWTH AND
PSYCHOLOGICAL WELL-BEING IN WOMEN WHO EXPERIENCED
CHILDHOOD SEXUAL ABUSE**

I am a senior lecturer and clinical psychologist currently employed on a full-time basis at the North-West University Vanderbijlpark Campus, School of Behavioural Sciences, Psychology Department.

I am completing a PhD and am conducting research on the above topic. I would appreciate your assistance in referring suitable participants from your practice or organization for participation in the study.

The objectives of the research are to:

- Investigate the coping behaviour and post traumatic growth of women who experienced child sexual abuse (CSA) and how this experience impacted on their psychological well-being in adulthood (literature / questionnaires)
- Identify possible strengths and other protective factors from the narrative stories of women who experienced child sexual abuse (CSA) employing qualitative research methods (interviews)

- To formulate guidelines on what should be included in an intervention programme aimed at enhancing these women's positive coping behaviour, post trauma growth and their overall psychological well-being in adulthood

In order for the objectives of this study to be realised questionnaires need to be completed by at least 50 – 70 women who experienced CSA so as to identify those women who manifest constructive coping, post traumatic growth and psychological strengths in adulthood. These women will then be invited to participate in an interview to share their narrative story of their sexual abuse experience during childhood. From these findings guidelines will be formulated for a programme aimed at enhancing constructive coping, post traumatic growth and overall psychological well-being in these women.

The criteria for inclusion in the study are the following:

- Minimum age of 18 years
- Female gender
- Was victim to CSA before the age of 18
- Can understand and respond to English and Afrikaans
- Is willing to participate freely and give consent to the research

As a mediator, you are kindly requested to identify possible clients and then to distribute the questionnaires to these women if they are willing to participate. The researcher will arrange a follow-up appointment to collect the completed questionnaires. Please kindly provide a list of the participants' names and telephone numbers to the researcher in order for her to follow through with the second qualitative phase of the research. These interviews will be conducted on request with the identified participants at the researcher's office. All names of the participants will be treated confidentially and will not appear in the research results or for publication. Participation in this study is voluntary and the participants reserve the right to withdraw at any time. Participants will not be remunerated for their participation.

With your clients consent the outcomes of the psychometric questionnaires and/or interview and the strengths profile can be provided to you to be used as an intervention tool in future psychotherapy sessions.

Permission for this research has also been obtained from the Ethical Committee of the North-West University (NWU-0041-08-S1).

You are kindly requested to complete the attached consent form to indicate that you are willing to assist in referring participants for this research study. Your prompt response in this regard would be greatly appreciated.

If you require any further information please feel free to contact me at your earliest convenience on 082 496 4105.

Thanking you in anticipation.



Mrs H.J. Williams
Researcher



Prof. C. van Eeden
Promoter

APPENDIX 4

CONSENT FORM: PARTICIPANTS (QUANTITATIVE STUDY)



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**School of Behavioural Science
 Psychology Department**
 Tel: (016) 016 910 3416
 Cell: 082 496 4105
 Email Hayley.williams@nwu.ac.za

CONSENT TO PARTICIPATE IN RESEARCH

**RESEARCH TOPIC: COPING BEHAVIOUR, POST TRAUMATIC GROWTH
 AND PSYCHOLOGICAL WELL-BEING IN WOMEN WHO EXPERIENCED
 CHILDHOOD SEXUAL ABUSE**

I _____ hereby consent to participate
 voluntarily in the above research project. The objectives, benefits, risks and obligations of
 the research are clear and I understand the implications of participation. I am willing to
 complete a biographical questionnaire and other relevant questionnaires.

Contact Number: _____

Participants Name Printed

Participants Signature

___/___/___

DD MM YYYY

APPENDIX 5

CONSENT FORM: PARTICIPANTS (QUALITATIVE STUDY)



NORTH-WEST UNIVERSITY
 YUNIBESITHI YA BOKONE-BOPHIRIMA
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INFORMED CONSENT TO PARTICIPATE IN THE RESEARCH ENTITLED:
COPING BEHAVIOUR, POST TRAUMATIC GROWTH AND PSYCHOLOGICAL WELL-
BEING IN WOMEN WHO EXPERIENCED CHILDHOOD SEXUAL ABUSE

I _____ hereby consent to the following:

- To complete a biographical and other related questionnaires.
- To partake in a 60 – 90 minute interview sharing certain narratives of my sexual abuse experiences during childhood.
- The interview will be recorded on a digital voice recorder.
- The recordings will be transcribed for data analysis.
- The recordings will be treated confidentially and kept in a lock up facility.
- My name will not be disclosed during the research or publication of the results.
- Participation in this study is voluntary and confidential.
- I reserve the right to withdraw at any time.
- Should I experience any mental discomfort or distress during or as a result of my participation I will inform the researcher who will provide emotional containment and support and referral on if necessary to an external helping professional.
- I shall not be remunerated for my participation.

The objectives, benefits, risks and obligations of the research are clear and I understand the implications of my participation.

Participants Name Printed

Participants Signature

___/___/___
DD MM YYYY

APPENDIX 6

CONSENT FORM: REFERRAL SOURCE



NORTH-WEST UNIVERSITY
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 Psychology Department**
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 Cell: 082 496 4105
 Email Hayley.williams@nwu.ac.za

**CONSENT TO ASSIST IN REFERRING PARTICIPANTS FOR THE
 RESEARCH STUDY**

**RESEARCH TOPIC: COPING BEHAVIOUR, POST TRAUMATIC GROWTH
 AND PSYCHOLOGICAL WELL-BEING IN WOMEN WHO EXPERIENCED
 CHILDHOOD SEXUAL ABUSE**

I _____ hereby consent to assist
 voluntary in referring participants from my practice or organization to partake in the
 above research project. The objectives, benefits, ethical implications and obligations of
 the research are clear and I understand the implications of my assistance.

_____ / / _____
Professionals Name Printed Professionals Signature DD MM YYYY

HPCSA Registration Number and Practice Number: _____

Address and Contact Number: _____

APPENDIX 7

ETHICAL APPROVAL FOR THE RESEARCH STUDY



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Dr AW Nienaber
Bussie 136

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: (018) 299-4900
Faks: (018) 299-4910
Web: <http://www.nwu.ac.za>

Ethics Committee
Tel +27 18 299 4850
Fax +27 18 293 5329
Email Ethics@nwu.ac.za

2009-06-10

ETHICS APPROVAL OF PROJECT

The North-West University Ethics Committee (NWU-EC) hereby approves your project as indicated below. This implies that the NWU-EC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title		Coping Behaviour and Quality of Life in Women Survivors of Child Sexual Abuse																																																				
Ethics number:	<table border="1"> <tr> <td>N</td><td>W</td><td>U</td><td>-</td><td>0</td><td>0</td><td>0</td><td>4</td><td>1</td><td>-</td><td>0</td><td>8</td><td>-</td><td>A</td><td>1</td> </tr> <tr> <td colspan="3">Institution</td> <td colspan="3">Project Number</td> <td colspan="3">Year</td> <td colspan="3">Status</td> </tr> <tr> <td colspan="15"> <small>Subst. = Submission, P = Re-Submission, P = Provisional Authorisation, A = Authorisation</small> </td> </tr> </table>												N	W	U	-	0	0	0	4	1	-	0	8	-	A	1	Institution			Project Number			Year			Status			<small>Subst. = Submission, P = Re-Submission, P = Provisional Authorisation, A = Authorisation</small>														
	N	W	U	-	0	0	0	4	1	-	0	8	-	A	1																																							
Institution			Project Number			Year			Status																																													
<small>Subst. = Submission, P = Re-Submission, P = Provisional Authorisation, A = Authorisation</small>																																																						
Approval date:	29 May 2009						Expiry date:	28 May 2014																																														

Special conditions of the approval (if any): None

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principle investigator) must report in the prescribed format to the NWU-EC:
 - annually (or as otherwise requested) on the progress of the project,
 - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-EC. Would there be deviation from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-EC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-EC retains the right to:
 - request access to any information or data at any time during the course or after completion of the project;
 - withdraw or postpone approval if:
 - any unethical principles or practices of the project are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the NWU-EC or that information has been false or misrepresented,
 - the required annual report and reporting of adverse events was not done timely and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

Yours sincerely

Prof MMJ Lowes
(chair NWU Ethics Committee)

Prof HH Vorster
(Chairman: NWU Ethics Committee: Author)

APPENDIX 8

DATA ANALYSIS SUMMARY

		<ul style="list-style-type: none"> • Religious coping 	<p>P 10 L 147-148 P 4 L 14 P 4 L 21-22 P 4 L 90 P 6 L 42 P 6 L 72</p> <p>P 13 L 28 P 13 L 32 P 13 L 138 P 5 L 172</p>	<p>Prayer and faith as a religious strategy.</p> <p>New coping methods are developed and existing destructive coping methods are converted to constructive ones.</p>
<p>/Posttraumatic growth</p> <p>-Healing process</p>	<p>-Pre-healing symptoms</p>	<ul style="list-style-type: none"> • Defence mechanisms • Worthlessness and shattered trust • Sexual dysfunction • Mental illness symptoms 	<p>P 7 L 44 P 4 L 12-14 P 4 L 38 P 3 L 23 P 13 L 98-103 P 12 L 56-59</p> <p>P 10 L 4 P 5 L 276 P 12 L 104 P 7 L 32 P 7 L 38 P 3 L 12 P 7 L 101 P 13 L 42 P 23 L 10-14 P 23 L 136 P 12 L 66</p> <p>P 3 L 32 P 7 L 73 P 12 L 74 P 4 L 66</p> <p>P 5 L 82 P 5 L 117 P 13 L 125 P 13 L 125</p>	<p>Suppression and avoidance as non-adaptive functional coping.</p> <p>Feelings of worthlessness, rejection and shattered trust due to experiences of betrayal.</p> <p>Sexual dysfunction, disconnected from sexual capacity and intimacy problems.</p> <p>Negative emotions, depressive symptoms, substance abuse or self-harm.</p>

	-Outcome of healing	<ul style="list-style-type: none"> • Discontented religion • Healing is a courageous choice • Healing is growth • Forgiveness • Appreciation for life • Role of pain • Recovery is a long process 	<p>P 5 L 198 P 6 L 46 P 10 L 97 P 23 L 288 P 3 L 14 P 13 L 148</p> <p>P 5 L 272 P 7 L 8 P 5 L 257 P 7 L 75 P 23 L 88 P 7 L 77 P 6 L 82 P 6 L 122 P 10 L 41 P 23 L 220-221 P 10 L 135 P 10 L 40 P 6 L 122</p> <p>P 10 L 34 P 7 L 123 P 10 L 125 P 2 L 40 P 6 L 26</p> <p>P 4 L 24 P 10 L 24 P 10 L 65 P 7 L 67</p> <p>P 10 L 83 P 23 L 244 P 6 L 78</p> <p>P 13 L 180 P 5 L 36 P 23 L 44-82 P 5 L 95</p> <p>P 3 1 40-44 P 3 1 99 P 3 1 127 P 13 1 136 P 6 1 22</p>	<p>The belief in God was shattered and anger at God for deserting them.</p> <p>Healing is a conscious choice fuelled by perseverance and commitment.</p> <p>Discoveries (meaning, gratitude, forgiveness etc.) made in the healing process becomes the vehicle to growth.</p> <p>The need to forgive is imperative in order to continue in the healing process.</p> <p>Deep gratitude and appreciation for life.</p> <p>The journey of recovery is painful.</p> <p>The recovery process is a long arduous process with no quick fixes.</p>
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		<ul style="list-style-type: none"> • Knowledge of syndrome and being streetwise • Moving from victim to survivor • Future perspective • Helping others • Connectedness with others • Wounded mother 	<p>P 4 L 38 P 7 L 85 P10 L 101 P 23 L 233-234 P 23 L 280 P 13 L 119 P 23 L 166</p> <p>P 23 L 388 P 3 L 74 P 10 L 69 P23 L 362 P 6 L 100</p> <p>P 10 L 8 P 4 L 50 P 3 L 121 P 13 L 103</p> <p>P 5 L 233 P 10 L 157 P 3 L 116 P 12 L 254 P 13 L 103</p> <p>P 12 L 254 P 4 L 56 P 10 L 51 P 13 L 24</p> <p>P 7 L 155 P 10 L 153 P 3 L 121 P 7 L 95 P 12 L 124</p>	<p>Knowledge of the CSA topic and a heightened sense of awareness to areas pertaining to CSA.</p> <p>Moving from the helpless victim role and making a conscious commitment to heal and become the survivor of the ordeal.</p> <p>Focusing on their future and their will to live.</p> <p>Being dedicated to caring for others, being able to empathize with others and fulfilling helping or supportive roles.</p> <p>Relationships are enhanced, they have a deeper connectedness to others.</p> <p>A need to protect their own children from the horror which they experienced as a child.</p>
<p>/Psychological well-being</p> <p>-Positive strengths</p>	<p>-The self</p>	<ul style="list-style-type: none"> • Self-reliance and self efficacy 	<p>P 10 L 55 P 5 L 272 P 7 L 83 P 2 L 44-48 P 6 L 92 P 12 L 114 P 5 L 136 P 7 L 145 P 7 L 79-82</p>	<p>Taking control of their own recovery and lives, being independent and self-reliant and having confidence in their coping ability.</p>

		<ul style="list-style-type: none"> • Self-worth 	<p>P 5 L 268 P 23 L 368-370 P 5 L 186 P 5 L 138 P 6 L 124-127 P 12 L 300 P 5 L 278 P 121 L 316 P 5 L 270 P 6 L 32-34 P 10 L 137 P 10 L 119 P 5 L 168 P 5 L 238</p>	<p>An awareness of Self, evaluating themselves as worthy and unique.</p>
		<ul style="list-style-type: none"> • Inner strengths 	<p>P 3 L 89 P 12 L 118 P 5 L 166-168 P 5 L 170 P 5 L 196 P 12 L 138 P 12 L 144 P 12 L 276 P 6 L 18 P 23 L 340 P 13 L 109 P 5 L 198</p>	<p>Acknowledging a sense of personal resilience and strength related to their ability to forgive themselves and to be aware of their own vulnerabilities.</p>
		<ul style="list-style-type: none"> • Making meaning 	<p>P 5 L 264 P 23 L 300 P 3 L 105 P 4 L 60 P 7 L 83 P 7 L 117 P 7 L 121 P 6 L 66-70 P 4 L 24 P 3 L 82 P 12 L 312</p>	<p>The construction of an existential life philosophy in which the CSA trauma is integrated into their assumptive worlds and to acknowledge the bipolar nature of their growth where the presence of gains can coexist with the losses due to the CSA.</p>

APPENDIX 9

EXAMPLE OF AN INTERVIEW TRANSCRIPT

Example of an interview transcript:

Line		Transcript	Coding
115.	Researcher	Like you said earlier ... a horror movie ...	
116.	Participant	Yes, a horror movie	
117.	Researcher	Yeah	
118.	Participant	Because you know if, if ... if all the details come out ... it is a horror movie ... how can a man, he was then what 30 some odd, 35 somewhere around there ... um ... how could he have done that?	
119.	Researcher	Mmm ...	
120.	Participant	I mean forcing himself onto a child that knew nothing about this	
121.	Researcher	Mmm yeah you were powerless	
122.	Participant	I was powerless because number 1 you are tied down, number 2 he's twice, three times your size ...	
123.	Researcher	Mmm ...	
124.	Participant	OK ... what do you do	
125.	Researcher	And you trusted him	
126.	Participant	And I trusted him	
127.	Researcher	You didn't expect him to hurt you	
128.	Participant	Exactly, we are going to play a game, fine what game are we playing ...	
129.	Researcher	Mmm ...	
130.	Participant	How many times did we, me and him not play, you know like pillow fights	
131.	Researcher	Mmm ...	
132.	Participant	My mom and dad's house had a very long passage and we used to play and throw each other with the pillows whatever ... I mean I started, I started swimming when I was 6 years old ... I did my first gala when I was 9 years old, and that man was always, if he knew that I was at the gala he would be there, you know what I am saying ...	
133.	Researcher	Mmm ...	
134.	Participant	That is what I couldn't understand ... I couldn't understand it ...	
135.	Researcher	Was that the hardest part for you that betrayal?	
136.	Participant	Yeah the betrayal, the betrayal ... because like I say to you eventually you forget the physical part of it ... you, you have to put it behind you ... otherwise you will never be able to love, care, respect another human being in your life	

		again, and do you really want to go through life alone?
137.	Researcher	Mmm ...
138.	Participant	I don't want to go through life alone, I hate it, I can't stand it ...
139.	Researcher	Mmm ...
140.	Participant	But then yet again I had to work out ... and see ... you can't blame everybody and say everyone rejects you ... that's not right either ... so surely something must come from you ... you either, like I say to you, you die in the hole you are in
141.	Researcher	Mmm ...
142.	Participant	Or you get out, and you know what ...
143.	Researcher	And ...
144.	Participant	And you learn to trust
145.	Researcher	To learn to trust?
146.	Participant	Yes ... and they have to earn it
147.	Researcher	Yes
148.	Participant	Trust is not commanded, it's not a given thing
149.	Researcher	Yeah
150.	Participant	Um ... I talk about these things ... easily today
151.	Researcher	Yes it appears you do ...
152.	Participant	It's fine ... they always laugh at me though 'cause I always say they must give me a man like that ... I will make an example of only one
153.	Researcher	Mmm ...
154.	Participant	And no other man will touch a child
155.	Researcher	Mmm ...
156.	Participant	I always say I will castrate him without an anaesthetic ... and I will start pulling out all his nails
157.	Researcher	Mm
158.	Participant	And so on and so forth until he begs me to stop ...
159.	Researcher	Mmm ...
160.	Participant	'Cause to put them in jail is nothing, nothing absolutely nothing
161.	Researcher	Mmm ...
162.	Participant	So, yes I think that's that anger still in me that I want to hurt those men as badly as what the one hurt me
163.	Researcher	Mmm ...
164.	Participant	That I still haven't quite worked out (laughs) I haven't let ... sort of let go of that
165.	Researcher	Mmm ...

166.	Participant	But that is what keeps me safe, that's what keeps me careful
167.	Researcher	Mmm ...
168.	Participant	You know what I am saying, um ... um
169.	Researcher	So being in touch with your anger allows you to be ...
170.	Participant	You are more aware
171.	Researcher	Aware of?
172.	Participant	You are awake and you sort of, although I make friends very easily ... and I get along with most people on this earth
173.	Researcher	Mmm ...
174.	Participant	Sometimes I get into a company of a man that I, that I uh-uh
175.	Researcher	Don't feel comfortable with?
176.	Participant	Yes, I don't feel comfortable, and I'm married and I got two beautiful daughters, and I will say to my husband I don't like that guy ... and he will say why don't you like him ... and I say it's just something that is not gelling
177.	Researcher	Mmm ...
178.	Participant	You know and right then and there I cannot give you the answer but I, you become careful, you are, I became careful ... with the people that I allow around me, or too near me
179.	Researcher	Yeah